A systematic review of mental health care access in disadvantaged communities in South Africa.

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ABSTRACT

Background:
Access to mental healthcare in disadvantaged rural communities in South Africa faces numerous challenges, particularly due to cultural beliefs that impact help-seeking behaviours. Systematic reviews provide critical insights into the barriers and facilitators of healthcare access in such contexts. This review aims to evaluate the available literature on mental healthcare access in rural South African communities, with a specific focus on the influence of cultural beliefs on help-seeking behaviours

Methods:
A systematic search was conducted across databases, including PubMed, Scopus, and Web of Science, to identify studies published between 2010 and 2023. Studies were included if they examined barriers to mental healthcare access in rural South African settings and involved culturally relevant factors. Screening, selection, and appraisal of studies were carried out using PRISMA guidelines, with data extracted and synthesized through qualitative thematic analysis

Results:
A total of 24 studies met the inclusion criteria. Key findings identified barriers such as financial constraints, scarcity of mental health facilities, stigma, long distances to services, language barriers, and cultural beliefs. Cultural practices, such as attributing mental distress to witchcraft or ancestral displeasure, were found to influence perceptions of mental health and discourage professional intervention, with traditional healers and community elders frequently being the preferred resource. Some community members, despite limited knowledge, utilized smartphones for mental health applications, while others relied on traditional practices and community support networks.

Conclusion:
This review underscores the need for a culturally sensitive, integrated approach to mental healthcare in rural South Africa, blending traditional and modern practices. Recommendations include conducting rural needs assessments, fostering collaboration between mental health practitioners and traditional healers, and enhancing teacher training

Keywords: *Mental healthcare access, rural South Africa, cultural beliefs, help-seeking behaviour, traditional healers, systematic review*

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1 CHAPTER ONE-BACKGROUND AND RATIONALE

1.1 INTRODUCTION

Access to mental healthcare remains a critical issue in underprivileged areas of South Africa, where a combination of socio-economic, geographical, and cultural factors restricts the availability and utilisation of mental health services. Individuals in these communities face multiple barriers, including limited financial resources, inadequate healthcare infrastructure, and deep-rooted cultural beliefs that often shape perceptions of mental illness and influence help-seeking behaviours. These barriers result in a significant gap between mental health needs and the resources available to address them. Addressing this gap is essential for improving mental health outcomes in rural and underserved areas, where alternative sources of support, such as traditional healing, often take precedence over professional mental health services. This chapter serves as the introductory section of the review. Its primary aim is to articulate the rationale for undertaking this research. Furthermore, it outlines the specific research questions that direct the empirical data collection process concerning access to mental healthcare in underprivileged areas of the country. Following this, the chapter provides a contextual framework that underpins the justification for conducting the present systematic review.

1.2 CONTEXT OF STUDY

According to the World Health Organisation (WHO;2022), mental well-being is a state defined by an individual's capacity to realise their abilities, manage life's challenges, work productively, and contribute to their community, thereby fostering resilience. Historically, however, mental well-being has often been deprioritised in favour of other health issues across many regions, including South Africa (WHO,2022). This skewed focus is starkly evident in South Africa’s healthcare system, as underscored by then Deputy Minister of Health Sibongiseni Dhlomo in a recent speech (National Department of Health, 2023), where he stated, "our focus, post the COVID-19 pandemic, is a growing burden of mental health in the country" (p. 3).

Globally, mental health receives less than 2% of total healthcare funding (World Health Organisation WHO, 2021). In middle-income countries, over 70% of the expenditure on mental health is allocated to psychiatric institutions (WHO), 2022). Furthermore, approximately half of the world's population resides in countries where there is only one psychiatrist and

psychologist for every 200,000 or more inhabitants (WHO, 2022). Access to affordable essential psychotropic medications remains inconsistent, particularly in low-income nations (WHO, 2022). These international comparisons highlight the pressing need to address mental health disparities and promote mental well-being.

The Minister's remarks suggest that the government's failure to prioritise mental health during the COVID-19 pandemic has left it struggling to address the ensuing challenges. These challenges have been exacerbated by the fact that health funding in South Africa is predominantly directed towards diseases such as HIV/AIDS, tuberculosis, and malaria, leaving mental health services significantly underfunded (Mahomed, 2020).

South Africa's mental health landscape has become increasingly dire. Petersen et al. (2016) found that only 27% of the South African population with severe mental conditions, such as schizophrenia, severe bipolar disorder, and major depression, receive treatment. Since the onset of the COVID-19 pandemic, the situation has worsened, with a significant increase in mental health challenges across the country. The pandemic has exacerbated existing mental health issues, including anxiety, depression, and substance use disorders, while also revealing the deep gaps in the mental healthcare system. According to the South African Depression and Anxiety Group (SADAG, 2020) there has been a marked increase in calls to mental health helplines, particularly related to stress, anxiety, and depression, with a reported 40% increase in demand during the pandemic period

Recent studies indicate that mental health conditions, particularly anxiety and depression, have become more prevalent. WHO (2021), reports that global rates of anxiety and depression increased by more than 25% during the pandemic, and South Africa, like many other countries, experienced a rise in these conditions. Despite the growing need for mental health services, access remains limited, and the gaps in service provision are further compounded by the stigma surrounding mental health issues, as well as the insufficient availability of trained mental health professionals. Service shortages, especially in rural areas, and limited funding for mental health services have only intensified these disparities. This trend highlights the urgent need for enhanced mental health policies, better resource allocation, and more accessible mental health services across the country.

Primarily, evidence indicates that three-quarters of individuals in developing countries, including South Africa, do not have access to mental health services (Petersen et al., 2016).

Recent studies reinforce this finding, showing that access to mental health services has remained disproportionately low, particularly in rural and underserved communities. According to WHO (2021), despite the growing recognition of the mental health crisis, many countries still struggle with inadequate mental health infrastructure, a shortage of trained professionals, and limited financial resources for mental health care. In South Africa, the situation is compounded by the scarcity of mental health professionals, with fewer than 2,000 psychiatrists and psychologists serving a population of over 60 million people (WHO, 2022).

The COVID-19 pandemic exacerbated this issue, as the demand for mental health services surged due to increased stress, anxiety, and depression, yet service delivery was severely disrupted. In addition, stigma around mental health and cultural barriers continue to prevent individuals from seeking professional care, often opting for traditional healers or community support instead (Petersen et al., 2022). As a result, many people, particularly in low-income and rural areas, still face significant barriers in accessing appropriate mental health care, further widening the treatment gap. These challenges underline the urgent need for comprehensive, accessible, and culturally sensitive mental health services, along with increased investment in mental health systems, especially in resource-constrained settings like South Africa.

In South Africa, several structural barriers limit access to mental healthcare services. These include prohibitive costs, a lack of mental health promotion policies, insufficient education about mental health conditions, and widespread stigmatising attitudes towards those with mental health problems (Schnierenbeck et al., 2013). Muhorakeye and Biracyana (2021) also emphasise the acute need for clarity in defining mental health literacy, particularly in understanding the diverse conceptualisations of mental health across different contexts.

One of the key studies in this area, conducted by Kometsi et al. (2020) in the Sisonke District of South Africa, illustrates the complexity of public perceptions of mental illness. Based on a survey of 787 African participants, the study reveals that the public's conceptualisation of mental illness aligns with that of health professionals. Both groups recognise the social, psychological, and medical dimensions of mental illness, using terms such as loneliness, mental disturbance, depression, and spirituality to describe it. These findings provide a context-specific understanding of mental health, shaped by factors such as low literacy levels, stigma, and discrimination (Monteiro, 2015).

The barriers to accessing mental healthcare in South Africa extend beyond conceptualisations of mental health. A study by Benjamin et al. (2021) in rural areas revealed

a lack of knowledge about mental health, alongside limited structural and human resources and widespread stigmatisation. The situation is further compounded by inadequate infrastructure, with only a few facilities equipped to treat severely mentally ill individuals (Monteiro, 2015).

Additionally, language has been identified as a significant barrier to accessing mental health services in South Africa, particularly among Black South Africans (WHO, 2021). Many disadvantaged communities speak diverse languages, while the majority of healthcare professionals in state hospitals speak English. Marovic (2020) situates the current study within a rural context to demonstrate how the dynamics of mental health-seeking behaviour in disadvantaged communities have been insufficiently explored. Such communities face numerous forms of disadvantage that have not been adequately addressed in research. Therefore, focusing on this context within South Africa will contribute to a better understanding of mental health-seeking behaviours. The main purpose of the study is to systematically identify and analyse the barriers to accessing mental healthcare in disadvantaged communities in South Africa. This includes examining the socio-economic, cultural, geographical, and systemic factors that impede individuals from seeking or receiving appropriate mental health services. The study aims to provide a comprehensive understanding of the challenges faced by these communities, with a particular focus on how cultural beliefs, stigma, language barriers, and the availability of resources contribute to limited access to mental healthcare. Ultimately, the study seeks to inform policy recommendations for improving mental health service delivery and accessibility in these underserved areas.

1.3 DEFINITION OF OPERATIONAL TERMS

This section aims to provide clear definitions of the key concepts predominantly employed throughout the study. These concepts are defined to align with the context in which this systematic review is conducted. Accordingly, the following fundamental concepts will be utilised throughout the review:

1.3.1 Mental health

According to Bhugra et al. (2013), mental health refers to an individual's ability to form and maintain meaningful relationships with others. It involves engaging in social activities, which typically include managing, recognising, acknowledging, and expressing positive actions and thoughts, as well as regulating emotions such as sadness. In other perspectives, mental health can also be viewed as the ability to adapt and exercise self-control in response to everyday challenges (Wang, 2022). Meyer et al. (2020) have shown that mental health

encompasses more than the mere absence of illness or disease, as it affects both the individual and society as a whole.

A similar definition of mental health is provided by the WHO (2018), which states:

> *"Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of well-being whereby individuals recognize their abilities, can cope with the normal stresses of life, work productively and fruitfully, and contribute to their communities. Mental health is about enhancing the competencies of individuals and communities and enabling them to achieve their self-determined goals. Mental health should be a concern for all of us, rather than only for those who suffer from a mental disorder"* (WHO, 2018, p.1)

For the purposes of this review, mental health will be operationalised to refer to the state of an individual's emotional, psychological, and social well-being, which influences their thoughts, feelings, and behaviours, as well as their capacity to manage stress, engage with others, and make decisions.

1.3.2 Health care

Healthcare is fundamentally rooted in the concept of care. According to Ghosh (2022), care or care work is often understood as activities involving 'looking after' someone in various ways, encompassing the fulfilment of the physical, psychological, and emotional needs of dependent adults and children. Donev et al. (2007) defines healthcare as the collective efforts of society, whether organised or unorganised, private or public, aimed at ensuring or promoting good health.

Healthcare can also be understood as the measures, activities, and procedures implemented by health practitioners to maintain and enhance living and working environments (Donev et al., 2007). In other words, it refers to interventions designed to maintain and improve health, prevent and control diseases, injuries, and other health conditions, using scientific methods for early disease detection. For this paper, I adopt Wang's (2022) more specific definition of healthcare, which frames it as the process of providing or receiving medical treatment.

1.3.3 Mental health care

Based on the definition of healthcare provided above, the term *mental healthcare* will be used to refer to the process of addressing the mental and emotional dimensions of human life through the provision of services such as counselling, therapy, and other interventions that focus on cognitive aspects.

1.3.4 Access

According to Muhorakeye & Biracyaza (2021), healthcare access refers to people's ability to provide good healthcare services on time without impediments . In the context of this research, access shall broadly be understood as the mobilisation of health aspects or services so that they are available to patients and other stakeholders. In light of this study, access is considered as the assurance that one can utilise any health service whenever the need arises (Reoch & Thomson, 2018). Based on these definitions, it appears that there may be access barriers that may limit people from attaining health services. In this light, I wish to define the term "access barrier" as a mediating variable considered in this research.

1.3.5 Access barriers

While definitions of "access barrier" may vary among scholars, this term will predominantly be used to refer to any factor that obstructs or hinders progress or access to health services. The researcher adopts Baporika's (2013) definition of an access barrier, which views it as anything, whether temporary or permanent, that delays or prevents the delivery of a particular healthcare service. This definition necessitates further exploration of the term healthcare service, which is clarified in the following paragraph as operationalised in this report.

1.3.6 Healthcare services

For Sosic and Donev (2008) and WHO (2018), a healthcare service implies any service offered to patients by healthcare providers or an entity operating under the leadership of a healthcare professional. In this study, the term healthcare service shall be operationally used to refer to the overall efforts made by health practitioners to ensure that people live healthy and safely. It can range from offering health-related information to the treatment of health problems by issuing prescriptions and appropriate medicine.

1.3.7 Disadvantaged communities

In examining the definitions of *disadvantaged communities*, it becomes evident that various scholars have developed robust yet diverse interpretations of what constitutes such communities. Some scholars focus on social and economic dimensions, while others unpack the concept in terms of politics and law. Below are some of the definitions that exist regarding what defines a disadvantaged community:

Haaland and Ortiz (2022) offer a twofold definition. First, a disadvantaged community can be one where household income is insufficient to cover even basic needs. Second, it may refer to a community that is environmentally vulnerable or challenged. Based on these definitions, a community is considered disadvantaged if it is characterised by poverty or if it is geographically at risk of not being able to meet daily needs consistently.

Singh and Bajpai (2023) define disadvantaged communities as those that lag in social, political, biological, scientific, technological, linguistic, and literary advancements. For these authors, if a community lacks access to improved education, income opportunities, skill development, and social transformation, it is disadvantaged. This definition conceptualises disadvantaged communities as being shaped by cultural and social factors but omits other aspects, such as the physical environment of a disadvantaged community.

Furthermore, Okumus (2021) expands the definition of disadvantaged communities by identifying them as communities in which people's opportunities to participate in social and economic life are significantly lower than those of individuals in other societies, where they are afforded greater chances for participation and adaptation. People may be disadvantaged due to their unique characteristics, economic, social, and physical conditions, gender, ethnic or linguistic backgrounds, or religious or political status (Okumus, 2021).

Given this context, marginalising individuals based on cultural, social, biological, or physical conditions places them in positions where they are unable to meet their desired needs and are therefore disadvantaged. This definition is broader and more explicit than those provided by Haaland and Ortiz (2022) and Singh and Bajpai (2023). In the present research, the term *disadvantaged communities* will be operationalised based on Okumus' (2021) definition.

Disadvantaged communities, particularly rural societies, frequently encounter barriers that exacerbate mental health problems, creating a cycle of hardship that is difficult to break. Social injustices, unstable economies, and limited access to healthcare contribute to heightened stress levels and mental health challenges in these populations. The following paragraphs outline some typical consequences of untreated mental health issues.

1.4 EFFECTS OF MENTAL DISTRESS

Individuals experiencing mental distress may face a range of consequences affecting their emotional, cognitive, physical, and social well-being. According to Corrigan et al. (2014), untreated mental distress can lead to physical and psychological disabilities, unemployment or retrenchment, substance abuse, homelessness, and a diminished quality of life. Additionally, Corrigan et al. (2014) highlight suicides and violent behaviours as severe outcomes of untreated mental distress.

Furthermore, individuals may struggle with mastering basic communication, assertiveness, and problem-solving skills necessary for achieving social goals. Untreated mental distress can particularly affect students, as it impairs their ability to communicate effectively, maintain alertness, and develop essential problem-solving skills required for academic success (Corrigan et al., 2014; Schlack et al., 2021). The Centre for Behavioural Health Statistics and Quality (2015) extends this by noting that untreated mental illnesses among teenagers significantly contribute to academic failure, delinquency, heavy drug dependence, and a disproportionate number of youth admissions into prisons.

Suicide and violence are among the most severe consequences of mental illness. Research indicates that approximately 4% of the general population report lifetime suicidal ideation, 1% report having a plan for suicide, and 0.5% report previous suicide attempts (WHO, 2022) Untreated mental distress among adults can also result in increased absenteeism from work. The Centre for Behavioural Health Statistics and Quality (2015) reports that employees with mental health issues tend to take more sick days than those without mental health conditions, such as depression. This absenteeism often leads to higher employee turnover and lost earnings.

Additionally, Hung et al. (2022) conducted a meta-analysis that revealed an association between mild-to-moderate traumatic brain injury, whiplash-associated disorders, spinal cord injuries, and an increased risk of psychological distress. These findings emphasise the

connection between physical injuries and long-term psychological distress, underscoring the importance of addressing both physical and mental health in tandem.

In summary, the effects mentioned above of untreated mental distress provide insight into the potential long-term consequences if mental health issues remain unaddressed. These findings call for early interventions by healthcare professionals and other relevant stakeholders to prevent mental health crises from escalating.

1.5 SIGNIFICANCE OF THE REVIEW

The preceding discussions on mental health highlight the necessity for healthcare practitioners and other stakeholders to collaborate effectively to prevent mental health crises. However, the prevention of mental illness requires that countries prioritise addressing the risk factors associated with mental health. In consequence, developing a comprehensive understanding of the impediments contributing to mental illness among South African populations is a crucial step in formulating effective interventions and strategies aimed at alleviating such mental health issues.

The relationship between mental healthcare and access factors can yield valuable insights for prioritising early interventions. While the studies referenced earlier in this chapter shed light on various issues pertaining to mental healthcare in South Africa, to my knowledge, no comprehensive systematic review has been conducted to thoroughly examine all potential access barriers to mental healthcare services, particularly in disadvantaged communities. Therefore, this systematic review was undertaken to identify and elucidate all reported barriers to mental healthcare access in disadvantaged communities in South Africa.

1.6 RESEARCH QUESTIONS

The primary aim of this systematic review is to identify barriers to mental healthcare access in disadvantaged communities in South Africa. The following questions underpinned the review:

- What are the reported barriers to seeking mental healthcare in disadvantaged communities?
- What is the role of culture in the perception of mental health distress in disadvantaged communities?
- What scopes of interventions do people in disadvantaged communities utilize when they present with symptoms of mental distress?

1.7 RESEARCH OBJECTIVES

- The main objective of this systematic review is to identify and analyse the multifaceted barriers that obstruct access to mental healthcare in disadvantaged communities across South Africa. The objectives of this systematic review were:
  - To identify and synthesize the reported barriers to seeking mental healthcare in disadvantaged communities.
  - To examine the role of culture in shaping perceptions of mental health distress in disadvantaged communities.
  - To identify the types of interventions utilised by individuals in disadvantaged communities.

1.8 OVERVIEW OF THE RESEARCH METHODS

In conducting this study on the factors that impede access to mental healthcare within disadvantaged South African communities, I employed a systematic review methodology. The systematic review method was found appropriate for this study due to its ability to gather robust data from numerous empirical studies on access to mental healthcare services within communities.

The inclusion and exclusion criteria in this study were determined based on three key factors: the population, the phenomenon of interest, and the study context or setting. This methodical approach guided the data collection process. The research was conducted in three distinct phases: data collection, data analysis, and the presentation of findings and conclusions. Within the data collection phase, three subsections were established: the search strategy, the data screening procedures, and the PRISMA chart, which visually outlines the entire selection process. Following this, the data analysis phase focused on examining the reviewed studies to identify prevailing themes. Finally, the thematic analysis technique was employed during the analysis stage to interpret the data.

1.9 OUTLINE OF THE THESIS

There are seven chapters in this thesis, each with a specific function. An outline of the study's structure can be found below.

1.9.1 Chapter One: Background and Study Overview

Chapter One of this systematic review serves as an introduction, providing the rationale and orientation for the research. It outlines the context in which the study is situated and

subsequently offers definitions of key terms that are widely used throughout the paper. The chapter further elucidates the rationale for conducting this systematic review, followed by the research objectives and research questions. Within this chapter, the goals of the study, underlying assumptions, and an overview of the research methods are presented. Additionally, the chapter sets the scene by providing an outline of the subsequent study chapters.

1.9.2 Chapter Two: Theoretical framework

The second chapter delves into the theoretical frameworks, i.e., the Ecological Systems Theory and the Social Determinant of Health Framework that guided this systematic review . This section establishes how the mentioned theories were utilised to make sense of the data generated.

1.9.3 Chapter Three: Conceptual Framework

The third chapter covers literature on the study variables. That is, it explores the factors associated with mental healthcare provision across the globe, highlighting the policies that exist on mental healthcare and subsequently provides the summary of the section.

1.9.4 Chapter Four: Methodology

Chapter Four articulates the research methodology employed for data collection and analysis. It discusses the procedures followed to select the studies included in the systematic review. The chapter further explains, in detail, the data analysis techniques utilised and the ethical considerations addressed in this research.

1.9.5 Chapter Five: Data Interpretation and Analysis

In this chapter, the current study's results are presented based on emerging themes as observed from the data on mental healthcare access within the rural disadvantaged communities in South Africa. The study conclusions and recommendations are developed based on this chapter.

1.9.6 Chapter Six: Discussion of the findings

The findings of the current study are discussed in this chapter, citing convergence and divergence of the study’s findings with the literature and theoretical underpinnings.

1.9.7 Chapter Seven: Summary, conclusions and recommendation

This final chapter summarises the study's aims, research questions, and methodology. It also presents a synthesis of the findings, followed by the conclusions and recommendations derived from those findings.

1.10 CHAPTER SUMMARY

This chapter provided the background and rationale of the study, including its objectives and significance. It also defined key terms as operationalised in the study and presented an outline of the dissertation structure. Finally, it summarised the methodological approaches employed to collect data for the study's objectives. The next chapter explores the conceptual review informing the study.

2 CHAPTER TWO-CONCEPTUAL REVIEW

2.1 INTRODUCTION

The variables underpinning this study are covered in detail in this chapter. Additionally, it elucidates the potential of the South African Mental Health Policy (SAMHP) 2023-2030 in the promotion of access to mental health services by South African people. The conceptual framework developed to conduct this policy analysis also formed the basis in which the limitations in accessing mental healthcare shall be underscored, highlighting the gaps in existing literature on this topic.

Therefore, this chapter is organised into three sections. The first section elucidates the indicators of good mental health. The second section explicates the initiatives or interventions that are done to help mentally ill persons. This is done by highlighting the interventions reported in the literature and those that are outlined by WHO (2009, 2021). The final section scrutinises the potential of the SAMHP 2023-2030 to promote improved access to mental healthcare services. Subsequently, the discussion explores the indicators of adequate mental health care, ranging from the individual level to the community level.

2.2 INDICATORS OF GOOD MENTAL HEALTH CARE

While various indicators may characterise good mental health, the literature suggests key indicators as those that reflect an individual's emotional, psychological, and social well-being. These include;

2.2.1 Emotional Resilience

Emotional resilience is, if not frequently acknowledged, undeniably critical in maintaining good mental health. Reich et al. (2021) explain that resilience aids individuals in adapting to and recovering from stressful or adverse events, which consequently leads to improved psychological outcomes. This view is further supported by Southwick et al. (2020). Many scholars advocate for fostering resilience as a preventative strategy for mental health, as Miller et al. (2022) assert that the development of resilience enhances an individual's ability to navigate life challenges. Nevertheless, other authors urge caution in overemphasizing individual resilience, arguing that such an approach can overlook systemic issues and socioeconomic factors that significantly contribute to mental health problems (Ungar, 2021). Moreover, assessing resilience presents challenges, as it often fluctuates based on specific circumstances and cultural contexts (Ong et al., 2021). In the following section, the discussion will focus on positive self-concept as a means to strengthen resilience.

2.2.2 Positive Self-Concept

A positive view of the self is highly impregnated with valuations of self-worth and self-esteem, hence serving as a strong predictor of positive mental health outcomes. It is associated with enhanced general well-being and lower vulnerability to mental health problems (Brown & Dutton, 2021). Researchers also indicate that individuals with a positive self-concept have a greater likelihood of being resilient while also being quick in solving problems (Norton & Gillett, 2020). Some even believe that such an overly optimistic self-view or inflated sense of self-importance gives birth to narcissism and holds unrealistic expectations, which are harmful to one's mental health (Zeigler-Hill et al., 2022). The concept of positive self-concept is culturally relative and thus may view variation across cultures, which would challenge the generalisability of the concept (Yamawaki & Kurokawa, 2022). Besides positive self-concept being significant in self-well-being and resilience, it can foster healthy relationships, as presented below.

2.2.3 Building Healthy Relationships

It is often acknowledged that good relationships in one's life are a major factor in maintaining good mental well-being. Good social support networks increase overall well-being and reduce feelings of isolation and loneliness, offering some level of psychological support during times of need or crises (Hefner & Eisenberg, 2022). Indeed, research tends to support the idea that supportive and significant relationships are more important than having a large pool of casual friends; relationship quality, not quantity, is key to this (Cohen & Wills, 2021).

On the other hand, there is, however, debate over the potential for issues of dependence if people rely on relationships too heavily to supply emotional resources that they should be able to manage themselves (Wright et al., 2023). In addition, interactions may be more or less important for different individuals; some people can have very little social interaction and still get along great, which questions the assumption that, extensive social networks are always superior (Liu et al., 2021). Healthy relationships are a drive towards productive functioning, which is discussed below.

2.2.4 Productive Functioning

Jansen et al. (2022) have estimated the relationship between productive functioning- which can be working out or even taking part in daily activities- and mental health since such activities give a person a sense of purpose and fulfilment. Dew et al. (2023) affirm that a good amount of work-life balance would mainly avoid burnout and conserve one's mental health. Some, on the other hand, feel that this societal pressure to be constantly productive might lead

to stress and burnout, which, in their respect, worsen mental health (Kreitzer et al., 2022) also established that an output-oriented mindset may eclipse the value of rest and play, which are similarly vital in maintaining mental health (Rogers et al., 2021). Importantly, productive functioning is a sign of cognitive well-being, and the next section provides a brief illustration.

2.2.5 Cognitive Well-being

For McKay et al. (2022), cognitive well-being is important for mental acuity and effective cognitive functioning and has great importance in overall mental health. Studies have related enhanced problem-solving and emotional control to cognitive health. Thus, mental exercises and interventions are recommended in order not to face cognitive decline but to facilitate one's cognitive health (Hogan et al., 2021). Given the variation in cognition from one individual to another, there is disagreement, therefore, on the extent to which cognitive well-being should be prioritised above other mental health indicators (Tucker et al., 2022). Also, a strong emphasis on cognitive features may mask other essential elements of mental health (Wong et al., 2023). It is highly regarded that cognitive well-being is a cornerstone of multiple bodily functions that promote emotional balance. Emotional balance is deliberated briefly in the coming section.

2.2.6 Emotional Balance

The effective management and regulation of emotions, often referred to as emotional balance, is widely regarded as a key indicator of mental health (Gross & John, 2020). It facilitates greater emotional stability and enhances the capacity to manage stress effectively (Muss et al., 2022). While there is near-universal agreement that emotional balance plays an essential role in maintaining mental well-being (Aldo et al., 2022), some scholars express concerns about the potential risks associated with its pursuit. Specifically, they warn that striving for emotional balance may inadvertently encourage emotional avoidance or suppression, which could lead to long-term negative consequences (Kumar et al., 2023). Additionally, cultural differences significantly influence how emotional balance is understood and practised, underscoring its complex role in mental health across various contexts. Although emotional balance is undeniably important in addressing mental health challenges, it is equally important to adopt a range of coping strategies. The following section will explore these coping skills in greater depth.

2.2.7 Coping Skills

Coping mechanisms are important in sustaining mental health; they are crucial to handle stress and permit redemption from challenges. Research has indicated that strong coping

mechanisms help in regulating emotions and resilience processes (Connor-Smith, 2022). Some disagree with the effectiveness of the outcomes of the coping mechanisms under different situations and environments, such as Skinner et al. (2020). Furthermore, too much attention to the personal development of coping skills may overlook the influence of extensive social and environmental factors on mental health (Tovian et al., 2021). A sound set of coping skills is a catalyst for a healthy lifestyle. A brief discussion of this aspect is presented below.

2.2.8 Healthy Lifestyle

Good mental health is closely linked to maintaining a healthy lifestyle, which encompasses regular exercise, a balanced diet, and adequate sleep (Miller et al., 2023). Ward et al. (2022) argue that such lifestyle choices not only enhance overall well-being but also play a preventative role in mitigating mental health disorders. However, the universality of these lifestyle recommendations is open to debate, as individual needs and responses vary (Lange et al., 2023). Moreover, promoting a healthy lifestyle without addressing the social and economic barriers that limit access to necessary resources cannot be fully effective (Hodge et al., 2021). Good mental health is also fundamental to developing self-awareness, a concept explored in the following section.

2.2.9 Self-Awareness

Self-awareness involves the ability to understand one's feelings, ideas, and behaviours. Hence, it is important for mental health and personal growth (Goleman, 2022). According to Kabat-Zinn (2023), this also helps in having better relations with others and putting one's emotions in the right perspective. Some authors think that too much self-awareness can make a person self-critical and engage in too much thinking, which might have a negative impact on a person's mental health (Beck et al., 2020). Besides, self-awareness is influenced by the concept of mental health in different ways concerning the cultural context (Lin et al., 2021). When one is self-aware, it is easy for them to live a meaningful life and identify their purpose. In order to understand this, the section below provides an overview.

2.2.10 Meaningful Life and Having Purpose

Generally speaking, a strong feeling of meaning and purpose in life can be viewed as an important indicator of good mental health. The work of Steger et al. (2021) reassures that it maximises life satisfaction and general well-being. A feeling of purpose is related to more motivation and persistence, thus enabling people to cope with difficulties in life (Krause et al., 2022). However, its measurement objectively is difficult due to subjectivity. Moreover, the

concept of global relevance for assessing mental health is questioned because this search for meaning and purpose varies across cultures (Sharma et al., 2021). Comprehension of the self is the principal way to guide the display of appropriate emotions. The discussion on emotions is presented below.

2.2.11 Displaying Appropriate Emotions

Appropriate emotional expressiveness is linked to mental health, as it promotes effective communication and the regulation of emotions (Gross, 2021). It helps prevent psychological distress and fosters healthier relationships (Thomson et al., 2022). However, there is no consensus on what constitutes effective emotional expression, as cultural conventions greatly influence both the expression and interpretation of emotions (Gonzalez et al., 2022). Furthermore, Simmons et al. (2022) argue that placing excessive emphasis on emotional expressiveness may lead to emotional overload or encourage unhealthy behavioural tendencies.

In conclusion, the indicators of good mental health discussed above demonstrate that mental health is dynamic and influenced by a range of physical, social, and cognitive habits. Therefore, both individuals at risk and mental health professionals must seek to expand and disseminate knowledge and services aimed at improving mental health practices. Nevertheless, it is equally important to consider the role of culture in these efforts, as cultural norms and values can either support or hinder access to mental healthcare.

2.3 THE ROLE OF CULTURE IN THE PERCEPTION OF MENTAL HEALTH DISTRESS IN DISADVANTAGED COMMUNITIES

In literature, one aspect that undermines effective mental health initiatives is culture. Causadias (2021) defines culture as a complex system encompassing knowledge, beliefs, arts, morals, customs, and any other capabilities and habits acquired by individuals as members of a specific society. The following sections outline how culture influences perceptions of mental health. Culture plays a significant role in determining how mental health distress is perceived, understood, and managed within disadvantaged populations.

Firstly, access to mental healthcare services is influenced by how individuals conceptualise mental health. Different cultures hold varying beliefs about mental health and mental illness. Some authors (Corrigan et al., 2014; Pompili et al., 2021) suggest that mental

health issues may be framed in spiritual or supernatural terms rather than medical or psychological ones (Oman & Lukoff, 2018). In consequence, this affects how individuals recognise and label their experiences and whether they seek help for mental health concerns (Augustine, 2012).

Secondly, culture influences perceptions of mental health distress through stigma and social norms. Cultural norms often play a major role in shaping the stigma associated with mental illness (Kohrt et al., 2018). For example, in some communities, mental illness carries significant stigma, making individuals reluctant to seek help or openly discuss their mental health issues. Corrigan et al. (2014) found that stigma is a key factor contributing to the underutilisation of mental health services, which exacerbates mental health problems. This stigma is often heightened in disadvantaged communities where mental health services are typically less accessible (Kohrt et al., 2018).

However, there is ongoing debate as to whether stigma is solely a cultural construct or if it intersects with other factors, such as socioeconomic status and systemic barriers. Bhui et al. (2018) argue that broader social determinants, in conjunction with cultural stigma, significantly shape help-seeking behaviours.

Thirdly, culture influences help-seeking behaviours. Cultural beliefs and norms affect how individuals approach mental health services (Okunade et al., 2023). In some cultures, individuals may prefer to rely on family, community leaders, or traditional healers instead of mental health professionals. Sue et al. (2012) acknowledge that cultural beliefs shape the interpretation of symptoms, suggesting that mental health symptoms cannot be fully understood outside their cultural context. This, in turn, impacts how effectively mental health distress is addressed.

However, there is debate surrounding the extent to which cultural factors hinder the positive effects of clinical practices. Some researchers argue that cultural beliefs do not always prevent the use of modern medical treatments. Sue et al. (2012) contends that many individuals from culturally-oriented backgrounds still value scientific methods and appreciate the universality of clinical diagnoses. Kirmayer et al. (2017) further note that some patients, despite being culturally socialised, recognise the limitations of traditional treatments and prefer professional mental health services.

Fourthly, cultural norms shape the way people express and communicate mental distress. Dean et al. (2023) observe that in some cultures, younger individuals may refrain from directly addressing mental health concerns with elders, leaving the responsibility to other elders in the community (Abramson et al., 2002). This practice discourages open expressions of personal distress, which can delay the recognition and management of mental health issues.

Cultural norms regarding emotional expression also play a role in mental health. Some cultures encourage open emotional expression, while others promote emotional restraint. For example, certain cultures view men as emotionally strong and discourage them from discussing their feelings, which influences how they report distress or seek help (Ombok et al., 2022).

Fifthly, cultural beliefs influence the willingness to use modern medical tools and treatments. Disadvantaged communities have historically relied on traditional medicine due to limited access to scientific healthcare. The Annals of Medicine and Surgery (2022) highlight that this reliance on traditional practices may hinder effective mental health interventions (Okunade et al., 2023). In more flexible cultures, individuals may use both traditional and modern healthcare simultaneously (Okunade et al., 2023). Hwang et al. (2018) and Sue et al. (2019) argue that culturally adapted therapies can enhance treatment outcomes by aligning with patients' cultural values and norms.

While some researchers support culturally sensitive treatment approaches, others, such as Castro et al. (2019), caution against overemphasising cultural adaptation, arguing that it may limit the generalisability of effective treatments. They suggest that cultural adaptation should not overshadow evidence-based practices that are universally applicable (Gonzalez & Henderson, 2010).

Okunade et al. (2023) highlight potential conflicts between cultural and scientific practices, suggesting that combining traditional and modern treatments can sometimes undermine the effectiveness of interventions. This tension may lead to distrust of modern medical approaches, causing individuals to withdraw from seeking scientific treatment for mental distress.

Cultural background also affects how mental health symptoms are interpreted. For example, in some cultures, excessive anxiety may be attributed to spiritual or supernatural causes rather than recognised as a mental health condition (Sarfo, 2015). In other cultures,

behaviours considered indicative of mental health distress in one society may be viewed as normal or even revered in another (Sarfo, 2015).

In summary, understanding these cultural elements is vital for developing effective mental health interventions and support systems that respect and cater to the unique needs of disadvantaged populations. The following section will discuss initiatives aimed at improving access to mental healthcare services.

2.4 INITIATIVES THAT IMPROVE ACCESS TO MENTAL HEALTH SERVICES

2.4.1 Interventions by People in Disadvantaged Communities to Deal with Symptoms of Mental Distress

According to Campion et al. (2020), disadvantaged communities are characterised by persons who are facing several barriers to accessing mental health services. They thus tend to make use of various forms of interventions and social support mechanisms. Amongst such interventions employed to address mental problems, community-based support plays a huge role within the community (Campion et al., 2020; Kohrt et al., 2018). The majority of the people require mental treatments and resort to local community organisations for help, support groups, and religious groupings (Duncan et al., 2021). Most of them provide counselling services, emotional support groups, and crisis intervention to those in need (Kelly & Lewis, 2014).

Communities have informal or unconsciously formulated family and social networks, meaning that close family members, friends, or neighbours may be the first line in providing help to a member of the family showing mental health illness (Duncan et al., 2021). Once they feel or suspect that a member of their family is mentally disoriented, they often provide them with emotional support and practical assistance at times in an attempt to provide informal counselling (Lewis, 2014).

Other interventions used to support those with mental health needs are encased in the cultural and traditional arenas Castillo et al. (2019). For example, most of the populations in underprivileged communities have a culture that supports them to seek mental aid and help from their traditional healers, spiritual leaders, or even community elders who both use cultural-related practices and traditional medicines with ritual performances that aim to improve or treat the mental disturbance of the patient (Buechner et al., 2023; Castillo et al., 2019; Pandey, 2024).

Among these community-based interventions, religious or spiritual resources form part of mental health support (Castillo et al., 2019). That is, people around an individual with mental health needs sometimes use religion-based resources to improve the mental stability of such an individual. According to Alqarafi et al. (2022), religious interventions could be prayer, religion-based meditation, or religious counselling. In practice, many individuals from poverty-stricken communities take comfort in religion and derive regular guidance from the pastoral team, the pope, or the priests, among other church members at large (Campion et al., 2020; Oman & Lukof, 2018).

Living in the modern world that is characterised by the intensive use of the internet in every aspect of life, online resources have presented tremendous opportunities for people to seek help and information concerning issues sported within their communities regarding mental issues (Castillo et al., 2019). Due to increased digital access, patients of mental health can request support through support forums, applications used in tracking mental health, or tele therapy services (Buechner et al., 2023). Despite the difficulty in accessing reliable internet connectivity and technological gadgets, the internet has offered unlimited services according to individual interests.

In such poor communities, their members are often organised into volunteer groups with specialisations in taking care of each other (Leavey, 2022; Duncan et al., 2021). Whereas others would handle issues related to water and food insecurities, others would be grouped so that they could give support on health-related matters. In acute situations, such people could call secondary healthcare providers, offering immediate help at once while awaiting the arrival of professional mental support in such areas (Alqarafi et al., 2022).

In summary, each of these approaches does not go without strengths and limitations. Therefore, enactment of these initiatives often depends on individual circumstances, locally available resources, and personal preferences. Hence, addressing mental health distresses in disadvantaged communities often requires a combination of informal and formal mental health interventions aimed at the needs and cultural contexts of the individuals involved.

2.4.2 Perspectives on The Strengths and Limitations of The Interventions

By providing social support and reducing stigma, Community-Based Support has been observed to provide culturally responsive care near settings easily and, thus, went on to improve mental health outcomes (WHO, 2021; Simmonds, 2022). Community-based strategies incorporate mental health services into daily living and make use of resources nearby. Despite

this, however, the aforementioned programmes still have to grapple with issues regarding dependability and calibre. The effectiveness of such services may also differ according to the pattern of funding and resources provided; hence, there could be a shortage of aid in some areas (Linton & Simmonds, 2022; McCulloch et al., 2021). Moreover, the general effectiveness of such programmes is rarely ensured since they are barely linked or integrated with official mental health systems (McCulloch et al., 2021; Simmonds, 2022).

Within such communities, the more dominant these cultural or traditional practices are, the greater the influence exerted by these forms of traditions and customs on mental health care today (Gone, 2019; Kirmayer et al., 2017). These activities improve communal relationships and can often represent culturally appropriate support. Their safety and efficacy, however, remain in dispute. Some argue that traditional practices may delay access to conventional therapies and may not necessarily be evidence-based (McCulloch et al.,2020; Gone, 2019). The fact that these practices might be used instead of, rather than in addition to, clinical interventions is what makes the integration of traditional approaches with evidence-based care problematic (Kirmayer et al., 2017; McCulloch et al., 2020).

Many religious and spiritual resources are of tremendous assistance to individuals as they provide comfort and coping mechanisms that are consistent with one's beliefs (Koenig, 2021; Pargament, 2021). When such resources are within a person's range of values and beliefs, these can be useful allies in mental health treatment. However, this could also suggest that there is a risk of over-reliance on spiritual or religious resources at the expense of professional medical help. While having such services, which can most definitely be of benefit, does not necessarily provide an adequate or standalone complement to therapies that address mental health concerns (Harris, 2019; Pargament, 2021). Individual responses to spiritual support can vary, which emphasises the necessity for a well-rounded strategy that incorporates these resources with research-proven techniques (Koenig, 2012; Harris, 2019).

Internet-based treatments have been especially popular with accessible and adaptable alternatives for mental health care, including online therapy and self-help programs (Andersson & Titov, 2016; Cuijpers et al., 2020). Various strategies have proved particularly effective in managing mild to moderate symptoms of disorders. However, concerns also exist concerning the effectiveness and level of engagement that online interventions provide, along with security and privacy issues in data handling involving personal information (Titov, 2016; Cuijpers et al., 2020). The actual effectiveness of internet-based interventions would depend on how the programs are designed and implemented (Karyotaki et al., 2021; Cuijpers et al., 2020).

Community specialisation attempts to make therapies more relevant and appropriate by considering how mental health services are tailored to individual groups or needs, and these may be based on age, ethnicity, or even socioeconomic status. According to Snowden (2019) and Saxena et al. (2022), such specialist services are better responses to specific demands than general services in their place. There are also issues of equality and the way resources are allocated in this approach. These resources may be shifted from the general provision of mental health services to specialised services and may lead to a lack of services for other populations dealing with other conditions and issues (; Saxena et al., 2022; Snowden, 2019). Additionally, there are challenges to successfully meeting the diverse needs of a community once specialist services are integrated into the larger mental health system (Saxena et al., 2022; Snowden, 2019).

2.4.3 Initiatives as per WHO (2009)

WHO (2009) recommends various initiatives to be done at individual, family, community, and national levels to improve access to mental health services. Table 1 summarises the 20 key initiatives that health professionals and governments can uphold for improved access to mental healthcare services.

Table 1 -initiatives for improved mental health service delivery

Table **Initiative components and description as envisioned by WHO (2009)**
1. 1. creating a plan and a policy to direct the development of the mental health system and services
2. Reduce health stigma and mental health discrimination: To address the specific vulnerabilities that mentally ill people face—such as stigma, discrimination, and marginalization in most countries, as well as the possibility of human rights violations—mental health legislation is crucial.
3. Reduce mental health costs: Lessen the financial burden that mental illnesses place on people, families, and health systems in order to make mental health care more affordable for all.
4. **Ensure that services are effectively promoted**: In order to broaden the knowledge about mental health issues, other aspects of society such as schools should be considered and can be used as an important context for mental health prevention and promotion.
5. Protecting human rights:

Protection of individuals against human rights violations can motivate or encourage fair service delivery to people with mental health illnesses. Therefore, access to high-quality mental health treatments depends on the protection of minority groups, particularly women, minorities, minorities, and refugees.
6. Arrange health services: The governments need to specify which services need to be provided through primary healthcare centres and those that may be provided by general hospitals.
7. Provide information for all people: Information availability, particularly knowledge of their fundamental rights can increase people's knowledge about mental health issues. Information can be offered to the public through peer informant workshops, newspapers, electronic media etc.
8. Maintain confidentiality and privacy: Mental health professionals need to treat patient's information with confidentiality and privacy. When people feel that their illness is treated with confidentiality and respect for human rights, they may not be reluctant to seek mental health services when the need arises.
9. Have humane mental health facilities: Mental health patients sometimes need special treatment, thus need to be placed in mental health facilities that treat people with humanity and care
10. Fair placement of mentally ill people: Prevent the detention of mentally ill individuals in jails when they need to be receiving mental health treatment in mental health facilities.
11. Maintaining good mental health services: Good health services encompass health services that provide people in need with efficient, secure, and high-quality care at the appropriate time and with the least amount of waste
12. Build informal community care services: The term "informal community care" refers to services that are rendered in the community but are not included in the formal health system. These services can be rendered by nongovernmental organizations, teachers, police, traditional healers, laypeople, and user and family associations. In addition, because these services are an essential part of society, they are typically accessible and acceptable. Nevertheless, countries would be ill-advised to rely solely on informal community care as the main source of mental health services.
13. Promote self-care:

Promotion of self-care should include the provision of information such as how to deal with stress, the importance of physical long-stay facilities and specialist psychiatric services. Further, this initiative should educate the public about the activities for maintaining mental health, successful techniques for handling relationships and handling conflict, and the risks associated with risky drug and alcohol use. Formal health services should support and facilitate self-care.

14. Build community mental health services:

It is socially demanding to have mental health services near or within the communities. Thus, mental health services must be provided from a societal level to achieve improved access to mental healthcare services.

15. Offer unlimited counselling for common mental disorders:

People with mental disorders experience various mental disturbances and may show signs of depression. Having counsellors at all levels of the community may minimise mental health catastrophes that may result in increased suicides.

16. Provide adequate training for primary care workers:

To serve the mental health needs of society, people with esteemed knowledge of mental aspects are needed. It is essential to produce a workforce capable of providing care in line with the objectives of the human resources policy and planning.

17. Improve accessibility:

Mental health services should be available locally so that people do not have to travel long distances to receive information and mental health treatment. On the same note, making sure that services are easily accessible should ensure that health services are affordable and acceptable

18. Offer reinforcements:

Offering positive incentives and positive feedback to health workers may motivate them to offer just services to people with mental illnesses. The governments can facilitate this by providing additional stipends or bonuses to health professionals to encourage them to work harder in improving service delivery.

19. Educate families and communities about mental health issues:

Mental health issues are normally fuelled by activities that occur at the family and societal levels. These components must be targeted to reduce the influences they have on mental health. Therefore, efforts should be made to inform the family and communities about the kinds of mental illnesses and their root causes so that such influences may be avoided.

20. Offer essential psychotropic medicine:

Psychotropic medications are those that address the most pressing mental health needs of a given population. They are chosen based on factors such as comparative cost-effectiveness, evidence of efficacy and safety, and

public health relevance. Ideally, psychotropic medications should be accessible at all times within the framework of a functional mental health system, in sufficient quantities, in the right dosage forms with guaranteed quality and sufficient information, and at a cost that both the community and the individual can afford.

In summary, each of these initiatives requires collaboration between governments, healthcare providers, non-profit organizations, and communities to create a comprehensive and effective mental healthcare system. With this in mind, the discussion takes turns to find ways in which the South African Health Policy (2023) addresses the barriers to mental healthcare access. Thus, the analysis of the mentioned policy employed the WHO's checklist to evaluate its relevance in promoting access to mental health care.

2.5 POTENTIAL FOR SOUTH AFRICA'S HEALTH POLICY TO IMPROVE ACCESS TO QUALITY MENTAL HEALTH CARE

2.5.1 CONCEPTUAL FRAMEWORK

Having established the issues concerned with access to quality health care, the paper takes turns to draw a framework which shows the interconnections of the study factors that were used to debate whether South Africa's health policy has the potential to improve quality health care. Thus, this paper employed a conceptual framework (developed from the literature) to argue for the potential of mental health policy to provide access to quality health care. Based on the literature on factors considered to evaluate quality health care, the following connection between variables was observed:

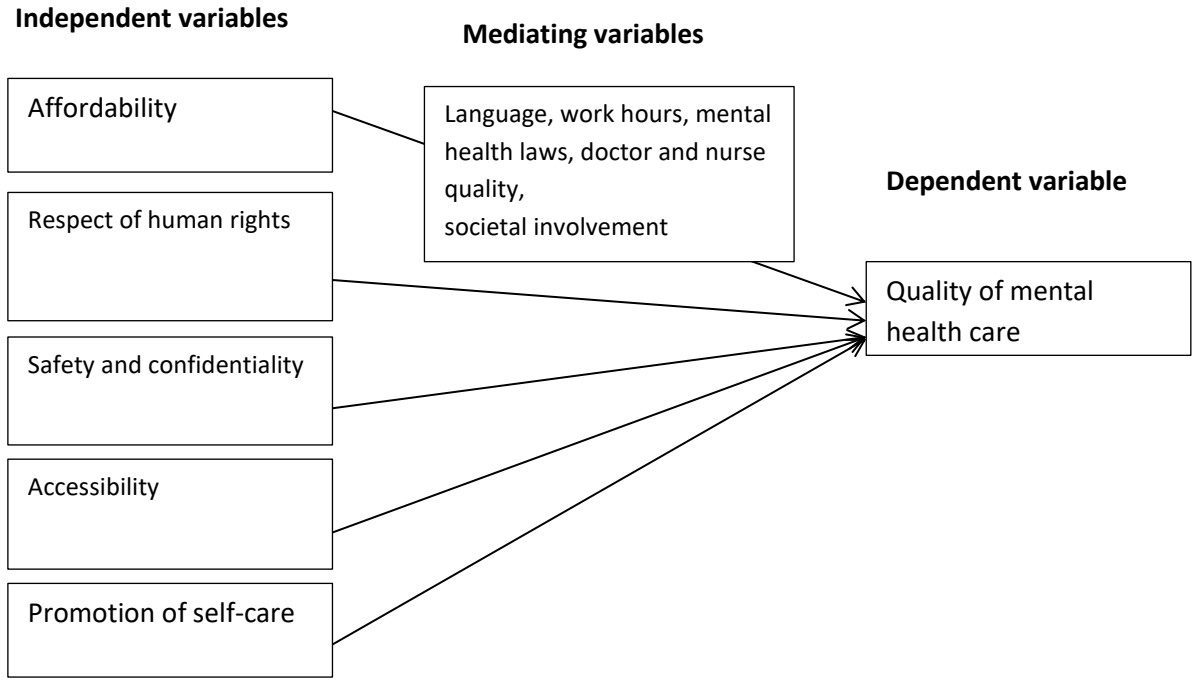

Figure 1-Factors considered for access to quality healthcare

Source: Author's own creation

Figure 1 illustrates the interconnection between the factors considered for access to quality health care. As shown in the illustration, quality healthcare directly depends on affordability, protection of human rights, confidentiality, accessibility, and promotion of self-care. Variables that can either strengthen or weaken quality healthcare include language, working hours, legislative laws, doctor and nurse quality and quantity, and societal involvement. These factors are referred to as mediating variables. These factors are taken into consideration when debating whether South Africa's Mental health policy has the potential to improve access to quality health care. Thus, these factors are contextualised in the forthcoming paragraphs.

This section discusses the potential for South Africa's 2023-2030 policy to improve access to quality health care. The main argument of this paper is that South Africa's health policy has the potential to improve access to healthcare to a greater degree. However, there are some health aspects that the policy overlooks despite their importance for quality healthcare assurance. The analysis of the South Africa Health Care Policy 2023-2030 policy noted the following strengths:

2.5.2 Accessibility

Accessibility includes the efforts that are employed to promote access to the offered services (SAMHP, 2023). The South African Mental Health Policy 2023-2030 encourages accessibility in various ways. South Africa's health policy is sound on issues that affect patients' access to mental healthcare(Republic of South Africa, 2023). Amongst others, the policy recognises that many individuals may not be able to access healthcare due to financial instabilities. As such, the policy intends to remove financial barriers by maintaining that mental health will be financially prioritised according to the principles adopted for all health financing in South Africa, and mental health patients will be protected from catastrophic financial consequences (SAMHP, 2023).

The policy further makes provisions to ensure that all mental healthcare services are offered at the same prices as other health treatments. This quote evidences this: *"In the financing of the National Health Insurance (NHI) system, mental health services will be given parity with other health conditions"* (SAMHP, 2023, p.38).

Further, the policy also emphasis on equity. Amongst its provisions, the mental health policy encourages health professionals to guarantee that mental health services are accessible to people without consideration of their demographic determinants. In emphasising this, the policy demands that equitable services should be accessible to all people, regardless of geographical location, economic status, race, gender, or social condition (SAMHP, 2023).

Moreover, the policy extends accessibility and equity by calling upon both primary and secondary healthcare centres to support people with special needs. This is evidenced by the following quote extracted from the policy principles: "The people with psychosocial, mental and intellectual disabilities should be given support to access care and services." (SAMHP, 2023, p.30).

Lastly, accessibility may be improved if the people at risk of mental disorientations are given proper medication and at efficient levels. Thus, the policy demands that: "*All psychotropic medicines, as provided on the standard treatment guidelines and essential medicines list (EML), will be available at all levels of care, including PHC clinics."* (SAMHP, 2023, p.44)

2.5.3 Protection of Human Rights

Literature on factors that impede access to mental healthcare services established that human rights violations may discourage vulnerable people from seeking medical help when

the need arises. In response to this backdrop, the SAMHP (2023) discourages unjust treatment of mental health patients. It has prioritised the protection of human rights for children and adult patients. Within the principles that the concerned stakeholders should uphold to improve access to mental health services, the policy posits that the human rights of people with mental illness should be promoted and protected.

According to SAMHP (2023), mental healthcare services should respect the following rights: non-conditional rights of mental healthcare users under the age of eighteen (18), including basic nutrition, shelter, primary healthcare services, and social services; dignity, respect, autonomy, information, and participation; rights to work; enough food, water, and energy; rights to education; and rights to social security, including social assistance for people experiencing poverty.

The human rights include the right to receive mental health education and relevant information. As evidenced by the literature, quality access to mental health services starts with knowing what services exist in mental health facilities and what illnesses are treatable and which may not. Therefore, people can prevent mental health catastrophes in the early stages only if they have enough knowledge about mental issues. To eliminate these disparities, the policy demands that people with mental illness should be better informed about the prescribed medication, the possible side effects and the personal choices they can make for treatment (SAMHP, 2023).

2.5.4 Inclusivity to Avoid Discrimination

In order to ensure that every citizen in South Africa, despite their physical and emotional status, receives equal opportunities, the policy recognises the need to provide early mental health interventions, which shall ensure that individuals with special needs also attend school, access services and pursue their interests like their counterparts. This is mirrored by the following statements extracted from SAMHP (2023):

> *"The value of the lives of people living with mental, intellectual and psychosocial disabilities should be treated equally with all other citizens…There are varying cultural expressions and interpretations of mental illness, which should be respected insofar as they protect the human rights of people living with mental health conditions and cause no harm…People living with mental health conditions have a right to practice religious rituals and adhere to spiritual beliefs in line with their culture…Mental health services*

for individuals with special needs to ensure they develop to their full potential and are included in community activities." (SAMHP, 2023, p.32).

These deliberations are evidence that quality healthcare should be prioritised for all individuals. The early mental healthcare centres shall enrol individuals with special needs and encourage them to participate in daily societal activities. Therefore, it would seem appropriate to argue that maintaining health inclusivity by South Africa's health policy brings individuals a step closer to accessing quality health care.

2.5.5 Improvements in Living Environments

The literature has emphasised that healthcare centres should ensure appropriate living environments (SAMHP, 2023). According to SAMHP (2023), living environments include areas with improved health care, feeding systems, water and sanitation, gardens and playgrounds. The effort to call for environments that are conducive to living marks the potential of South Africa's health policy to provide access to quality health care.

2.5.6 Recognition of Qualified Professionals

The policy's principles on access to healthcare also address the issue of having qualified health professionals to improve patient's access to mental health services. The policy over-emphasises that mental health services should be offered by trained temporary workers, counsellors, nurses, and doctors. To be more specific, the policy posits that all health staff working in health settings should receive basic mental health training, including anti-stigma training and ongoing routine supervision and mentoring (SAMHP, 2023). It further highlights the need to give permanent posts to registered counsellors within primary care settings to fill the gaps in the DOH staff establishment.

Literature has shown that instructors who had received inadequate in-service training on mental health or those who did not enrol in a health training programme are likely to fail to provide individuals with communication and emotional support. They may as well be impatient with the individuals, fail to offer appropriate psychological services, and fail to provide environments where patients may develop social skills and exercise critical thinking capabilities.

These gaps are recognised by the South African Healthcare Policy (2023-2030), which states that a high level of mental health support shall be offered by professionals who receive training to maintain access to quality healthcare by individuals. On the same note, South Africa's health policy recognises a need to develop full-time health professionals to sharpen

and model a generation of elite health professionals that can be employed across the nation (SAMHP, 2023).

2.5.7 Inter-Sectoral Collaboration

In alignment with WHO's (2009) initiatives to improve access to mental healthcare services, stakeholders must ensure these services are effectively promoted. To enhance public awareness of mental health issues, other societal sectors, such as schools, should be considered, as they provide a vital setting for promoting mental health and preventing related issues. In response to WHO's vision, the SAMHP (2023) advocates for the involvement of additional stakeholders in broadening access to mental healthcare by disseminating mental health knowledge within their respective institutions.

The policy further highlights that some individuals, including parents in cases involving children, may be unfamiliar with healthcare programs and early intervention opportunities. This lack of awareness often results in missed opportunities to seek appropriate care for their children. Consequently, limited knowledge of mental health treatment options presents a significant barrier to accessing quality healthcare. The policy addresses this gap by calling for the active participation of parents, teachers, employees, and NGOs in expanding mental health education and awareness.

2.5.8 Emphasis on Community Support

Moreover, the SAMHP 2023-2030 extends mental health services to both family and community levels. As noted by WHO (2009; 2021), mental health issues are often exacerbated by activities that occur within the family and society. In response, the SAMHP (2023) emphasises the need for comprehensive support for households, caregivers, and communities of individuals with mental health needs. This support aims to expand care networks, enhance wellness in the workplace, and strengthen overall community well-being. These areas must be specifically addressed in order to mitigate their impacts on mental health. As a result, efforts should focus on educating families and communities about the nature of mental illnesses and their root causes, enabling the prevention of negative influences.

The SAMHP 2023-2030 underscores this point by acknowledging ongoing challenges to accessing mental health services due to limited-service hours and the distances individuals must travel to receive care. WHO (2009) stresses the importance of localising mental health services to eliminate the need for extensive travel in order to access both information and

treatment. In line with this, SAMHP (2023) envisions a significant scaling up of mental health facilities within communities and towns to ensure unlimited access to necessary services.

Additionally, SAMHP (2023) advocates that individuals in need of mental health support should be able to access services near their homes and workplaces. Where possible, resources from the local community should be mobilised to provide immediate assistance. Once again, the policy anticipates an increase in community-based mental health services, aligning with national standards that focus on three key components: day-care services, outpatient services (which encompass general health and mental health support within primary healthcare), and community residential care (including assisted living, group homes, and halfway houses for mental health service users) (SAMHP, 2023).

Furthermore, the policy outlines the mental health interventions that should be incorporated into the core package of health services. Principally, it encourages task-sharing, wherein non-professional health workers may deliver detection-based psychosocial interventions. According to the policy, evidence-based psychosocial interventions may include:

> • *Medication monitoring and psychosocial rehabilitation within a recovery framework for severe mental illness.* (SAMHP, 2023, p36).
>
> • *Detection and a stepped approach to management and referral of depression and anxiety and other disorders as outlined in the APC manual in PHC clinics… detection and management of child and adolescent mental disorders in PHC clinics and community level (e.g., schools), and referral where appropriate* (SAMHP, 2023, p.35-36).

2.6 CONCLUSION

A thorough analysis of WHO's (2009) recommendations alongside the SAMHP 2023-2030 policy was essential in enriching the current systematic review of mental health barriers. Policies play a significant role in shaping both the accessibility and quality of mental health services; thus, understanding these frameworks allowed for a deeper contextualisation of the barriers identified throughout the review. Specifically, the examination of existing policy measures enabled a clearer determination of whether the issues arise from inadequate policies

or the ineffective implementation of existing guidelines. This contextual insight was pivotal in evaluating the extent to which current policies address the identified barriers and whether they necessitate adjustments or the introduction of new approaches.

Additionally, integrating the analysis of the SAMHP 2023-2030 into the review revealed gaps in the literature, thereby allowing for the suggestion of targeted improvements. Policies affect various dimensions of mental health care, including funding, service delivery, and stigma reduction. By scrutinising how the SAMHP 2023-2030 either aligns with or contradicts the barriers identified in this review, practical recommendations for policy adjustments or areas in need of enhanced implementation can be proposed.

In conclusion, the analysis of WHO's (2009) interventions and the SAMHP (2023) not only provided a comprehensive understanding of the systemic factors influencing mental health but also facilitated the development of appropriate recommendations to overcome the barriers identified. The forthcoming chapter will, therefore, discuss the theoretical underpinnings employed to inform the research.

3 CHAPTER THREE -THEORETICAL FRAMEWORK

3.1 INTRODUCTION

Having provided a conceptual review informing the study, this report now highlights the theoretical underpinnings of the study.

Access to mental health services is a critical concern, particularly for individuals from disadvantaged backgrounds. To comprehensively examine the complex factors influencing access to mental healthcare in this context, the research draws heavily on two foundational frameworks: The Ecological Systems Theory and the Social Determinants of Health Framework.

This chapter is, therefore, divided into two sections. The first section focuses on the theoretical concepts that guide the current investigation, while the second section explains how these theories are applied to examine the study variables. As a result, the discussion explores the theoretical foundations underpinning this investigation.

3.2 ECOLOGICAL SYSTEMS THEORY (EST)

The Ecological Systems Theory (EST) (Bronfenbrenner, 1994) posits that well-being is interconnected with the various environmental systems that surround individuals, which include the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. According to Bronfenbrenner (1994), individuals are indirectly influenced by systems present in their families, workplaces, and schools through the policies, resources, and expectations of others. Bronfenbrenner popularised the idea that changing environments significantly impact individual development and that individuals can also influence their surroundings.

Individual characteristics such as intelligence, temperament, physical appearance, and activities—including social interactions, physical activities, and maintenance tasks—can affect both the environment and its influence (Bronfenbrenner, 2004; Bronfenbrenner & Morris, 2006). However, a comprehensive understanding of human development necessitates attention to the interactions among microsystems, mesosystems, exosystems, and macrosystems (Chong et al., 2022). Within the framework of EST, the concept of 'Context' plays a crucial role in understanding human behaviour. Figure 1 illustrates the arrangement of human systems as developed by Bronfenbrenner.

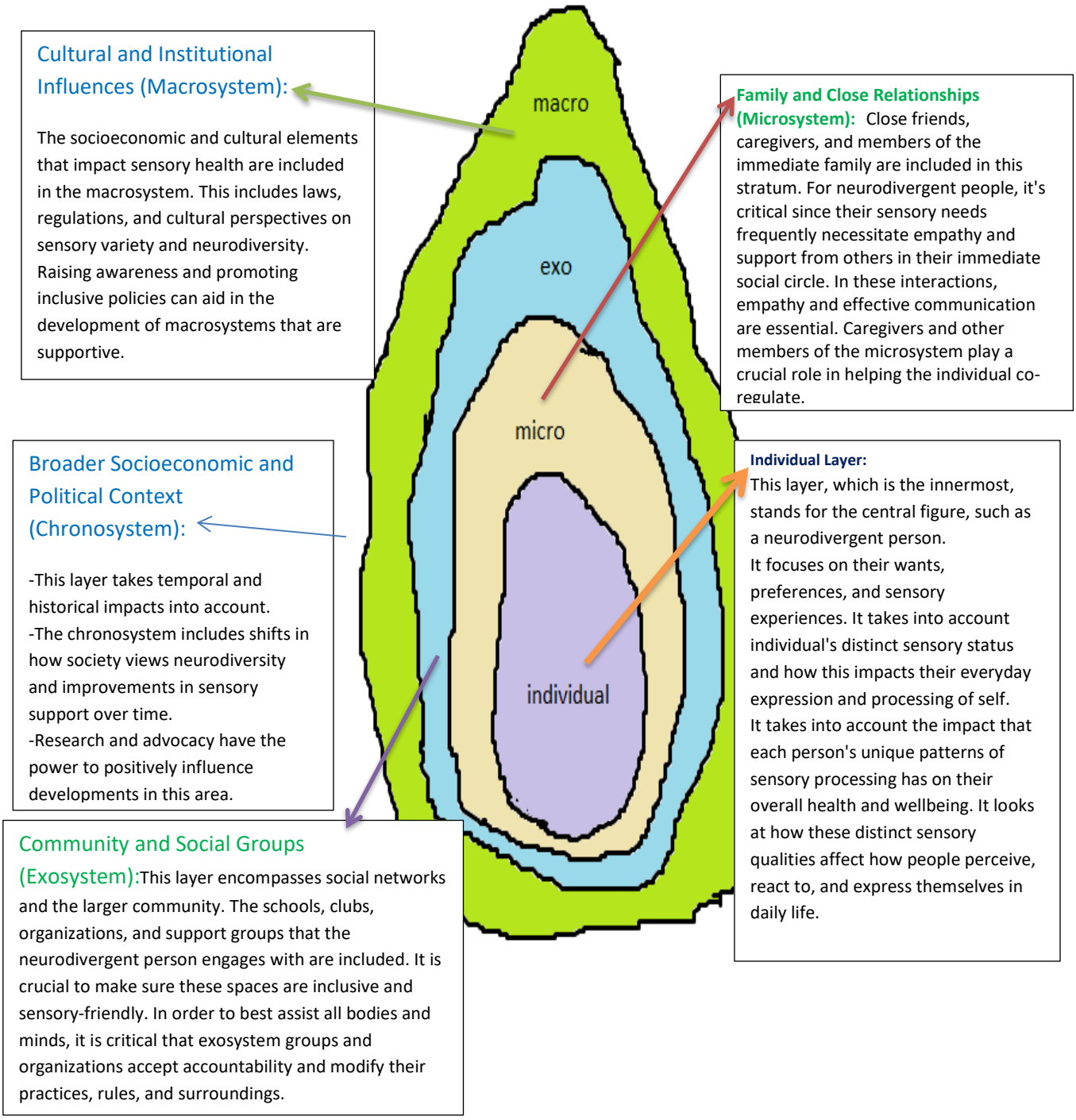

Figure 2- Ecological Systems Theory

Source: Star institute: www.sensoryhealth.org (Star Institute, 2021)

Crawford (2020) asserts that the microsystem is the level that most closely reflects a child's daily existence. According to Crawford (2020), a person's microsystem comprises all the people, institutions, and services with which they interact directly on a daily basis in their immediate environment. This includes parents, siblings, and other family members; schools

(comprising teachers, other staff, and peers); places of worship; health services; neighbourhood play programmes or initiatives; and, for some children and teenagers, places of employment.

The mesosystem focuses on the relationships and interactions among the individuals within the various microsystems that surround the child. Examples include a teacher contacting a child to inquire about their tardiness to class, the leader of the child's place of worship organising a community event, or the child's parents attending an event at the school. The interactions among these diverse microsystems in the child's environment directly impact their learning and overall well-being (Bronfenbrenner, 1994).

Furthermore, the child's wider community constitutes a component of this system. It encompasses various elements, including political systems and policies, neighbours, family friends, parents' workplaces, extended family members, the media, and health, education, and social welfare services (Chong et al., 2022). According to Bronfenbrenner (1994), even though the child may not have direct interactions with this system, the exosystem nevertheless influences them by affecting individuals in the child's immediate environments.

Crawford (2020) identifies the exosystem as potentially encompassing the parents' workplace. In this ecological system, while the child is not a participant in the workplace, they can be indirectly affected by events that directly impact the parent. Because the child is not part of the workplace environment, this setting cannot be included in their microsystem or mesosystem. For instance, the child may be influenced by the exosystem if the parent is required to work long hours, potentially missing school events or returning home stressed from work (Crawford, 2020).

The macrosystem examines events occurring at a larger social scale and how these affect the child's environment and other systems (Bronfenbrenner, 1977). It consists of the beliefs, values, attitudes, laws, and practices inherent in a specific culture. However, particular attention is given to the subcultures that exist within groups, the opportunity structures that individuals encounter as a result of their environments, and the patterns of exchange that occur both within and between groups (Antony & Antony, 2022).

As Antony (2022) posits, the pattern of social exchange is another significant component of the macrosystem. In this context, an immigrant family may communicate in a language other than the official language of the host nation if their cultural background differs from that of the majority. The adults may not speak the language of the host country, while

their children may be influenced to become bilingual due to the demands of the school and socialisation processes within the microsystem and mesosystem. Consequently, the broader community influences specific behaviours of individuals and their families to facilitate interaction within society (Antony & Antony, 2022; Crawford, 2020).

In the context of this review, the microsystem represents the immediate environment for disadvantaged communities, encompassing family, school, and peers. The mesosystem examines the interactions among these microsystems and their impact on access to mental health services. Beyond this, the exosystem includes external settings that indirectly influence access to mental healthcare, such as community resources and support networks. The macrosystem explores broader societal and cultural factors that shape perceptions of mental health and the availability of services. Lastly, the chronosystem acknowledges how changes over time, such as policy reforms, can affect access to mental health care.

In summary, the Ecological Systems Theory (EST) is a framework of human development that considers how the influences of all systems play a role in shaping behavioural attitudes and the lived experiences of individuals, regardless of how remote those influences may be (Chong et al., 2022; Crawford, 2020). Employing this theory allows the researcher to gain insights into how family dynamics, school environments, community resources, cultural norms, and policy changes intersect to affect access to mental health services in disadvantaged communities.

3.3 SOCIAL DETERMINANTS OF HEALTH (SDH)

The Social Determinants of Health (SDH) framework broadens our understanding by examining the societal conditions that influence health outcomes, moving beyond individual-level factors (Vandergrift, 2019). The social determinants of health encompass a range of elements, such as social status, educational attainment, employment conditions, wealth distribution, community resources, social support, and levels of empowerment. These determinants can either enhance or detract from an individual's or community's overall health (Vandergrift, 2019). According to Vandergrift's (2019) perspective on the factors affecting access to health services, it appears that individual choices may not solely dictate access to mental health services but is also shaped by the social and economic circumstances prevalent in disadvantaged communities.

Social determinants are defined as the conditions under which individuals are born, grow, work, live, and age, along with a broader array of factors and systems that influence daily life (WHO, 2023). These determinants include political systems, social norms, development goals, social programmes, and economic policies. Additional broader determinants that fall under this category encompass environmental, cultural, biological, commercial, and technological aspects of life (Tukuitonga et al., 2018; Zajacova & Lawrence, 2018). The Social Determinants of Health framework acknowledges several key factors that may facilitate or obstruct access to healthcare services:

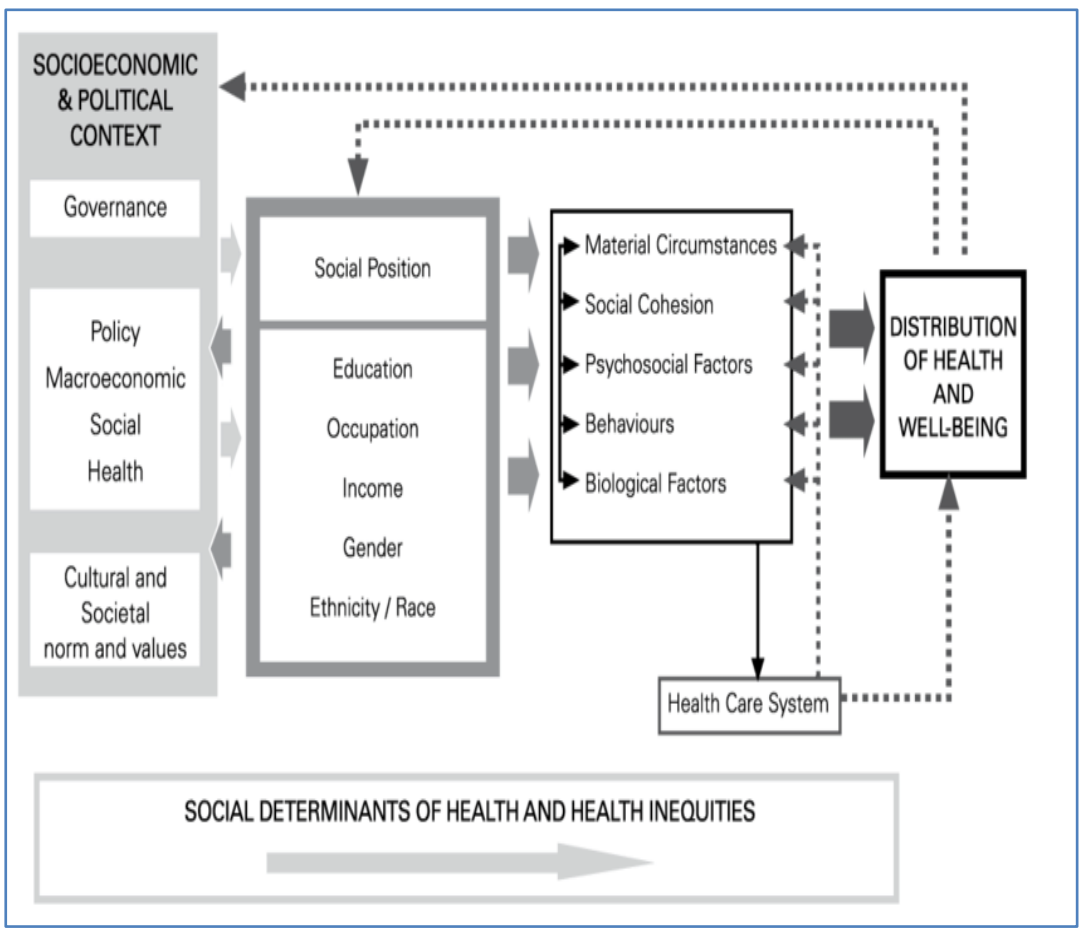

Figure 3- Framework for Social Determinants of Health

Source: Baum and Paul Laris (2010)

3.3.1 Poverty

Among the numerous social determinants of health, poverty is a critical factor in this discussion. The literature indicates that individuals in low-income countries generally have significantly less access to healthcare services compared to those in affluent countries or communities. Furthermore, within such communities, people with low incomes often

experience limited access to quality health services in comparison to their wealthier counterparts (Leskošek, 2012; Peters et al., 2008). When healthcare is required but either not provided or delayed, individuals' health can deteriorate, forcing them to rely on less effective, cheaper medications due to financial constraints (Peters et al., 2008).

Leskošek (2012) elucidates that individuals living in poverty are among the most disadvantaged in terms of accessing healthcare, adequate housing, and education, including opportunities for lifelong learning. These deficiencies can lead to further consequences, such as unemployment, reduced income, and social exclusion. Moreover, it is particularly concerning that underprivileged individuals frequently encounter barriers to meeting their basic health needs, including access to clean water, a nutritious diet, and opportunities for physical fitness (Leskošek, 2012).

3.3.2 Educational Access

According to Telfair and Shelton (2014), education enhances individuals' knowledge, skills, reasoning, effectiveness, and a wide range of other abilities that contribute to the adoption of healthy lifestyles. Well-educated adults are better equipped to utilise personal resources to safeguard their health, whereas those with less education may remain vulnerable without any concrete plans for health improvement (Zajacova & Lawrence, 2018). Resultantly, access to quality healthcare is often contingent upon the achievement of adequate basic education.

Education serves as a crucial indicator of health quality, promoting knowledge and fostering personal and social skills that empower individuals to access and utilise information to maintain and enhance their own health and that of their families (Zajacova & Lawrence, 2018). This knowledge can be classified as "health literacy," defined as an individual's capacity to access, comprehend, and apply essential health information and services necessary for making informed, independent health decisions.

Moreover, health education transcends mere reading of health messages; it also encompasses practical behaviours such as the consistent use of protection during sexual activity. Research conducted by Telfair and Shelton (2014) and Wilde (2008) indicates that the majority of teenagers and adults with lower levels of education are more likely to engage in unprotected sex and are less aware of sexually transmitted infections.

The educational level of parents can similarly impact health-related attitudes within families. Wilde (2008) posits that parental education can significantly influence child and family health behaviours. A recent review of children's vaccination rates in the USA highlighted that parents with low or no qualifications were less likely to vaccinate their children compared to those with higher educational attainment. Conversely, researchers such as Zajacova and Lawrence (2018) and Huebener (2018) argue that enhancing parental education positively influences children's health and contributes to the establishment of healthy behaviours.

For instance, parents with higher educational levels are more likely to purchase healthier food options and enrol in superior healthcare services. Additionally, education plays a vital role in communication. According to Ejike (2017), language barriers can impede access to quality healthcare, whereas employing trained interpreters can enhance access, quality, and patient satisfaction. Specifically, individuals, including children and adults, with limited proficiency in the English language often encounter difficulties in obtaining healthcare services provided by English-speaking professionals.

3.3.3 Cultural Factors

Cultural norms and attitudes in South Africa can either inhibit or encourage access to health services (Booysen et al., 2021; Mindu et al., 2023). Tukuitonga (2018) argues that social norms and expectations often conflict with efforts to promote healthy lifestyles. In many South African communities, some individuals believe that illnesses are caused by spiritual forces or ancestral displeasure, leading them to seek guidance from traditional healers before consulting Western medical practitioners (Ashforth, 2005). This cultural reliance on indigenous healing practices remains deeply embedded in South Africa's diverse society.

Traditional or spiritual healing refers to a holistic way to care or healing. According to Linda, Phetlhu & Klopper (2019) – it is designed to reach the invisible, deep human needs that are important to meet personhood needs such as good health, pursuit of meaning, hope, inner strength, and peace. The African cosmology views human beings as part of a holistic system that includes relationships with elements of nature and the supernatural, the ancestors play a significance role, the rituals are means of restoring balance and harmony, dreams are a means of communication between the living and the dead and traditional healers have a non-dualistic understanding of the mind and body coexistence (Nwoye,2015).

Additionally, South Africa's rich cultural diversity influences perceptions of pain and healthcare-seeking behaviour. In certain communities, stoicism is valued, leading individuals to endure severe pain rather than seek timely medical intervention (Campbell, 2003). Conversely, other groups openly express discomfort and are more likely to access healthcare services promptly. Dietary habits also differ across South African cultural groups, with some communities traditionally consuming only two meals a day, which can have long-term health implications.

Furthermore, gender roles in South Africa often dictate that women engage in physical activity primarily through domestic or agricultural labour, such as farming, carrying water, washing, cleaning, cooking, or caring for children. These cultural expectations can shape women's health behaviours and limit their participation in structured exercise programs (Nxumalo, Goudge, & Manderson, 2016). Recognising and addressing these cultural factors is essential to improving health outcomes in South Africa.

Ejike (2017) notes that distrust of Western medicine may drive some individuals to prefer traditional healers over physicians for their medical needs. According to Booysen et al. (2021) and Mindu et al. (2023), this mistrust may stem from the belief that physicians lack the knowledge or understanding necessary to treat culture-bound syndromes.

3.3.4 Work circumstances

As a social determinant of health, work circumstances influence access to healthcare services. In that regard, Ganu (2013) identifies several factors that restrict access to healthcare, including lack of control over work schedules or tasks, high job insecurity, limited input in major decisions, excessive work demands and stress, lack of organisational support for family responsibilities, hostile co-worker dynamics, and unsupportive supervisors. Similarly, Ronchetti et al. (2021) illustrate that changes in working hour arrangements—such as the rise of night or afternoon shifts, extended hours, part-time employment, and irregular schedules—can hinder regular medical consultations for health-related issues.

In contrast, Quinlan (2015) argues that self-employed individuals may have more flexibility to visit doctors regularly. However, the health inequalities associated with temporary employment are exacerbated by the limited access to medical treatment and compensation following an injury, as well as the challenges in filing claims for exposure to hazardous

substances (Quinlan, 2015). Furthermore, the lure of securing pension benefits may compel some individuals to remain employed, even at the expense of their health.

Building on this, Barnay (2016) highlights that governments often raise the retirement age as a strategy to keep people in the workforce longer. Additionally, the absence of comprehensive leave programs may force individuals to return to work before fully recovering from illness or injury. Consequently, many employees resume work with ongoing health issues to avoid the risk of job loss.

3.3.5 Community context

Community context is a critical factor influencing access to healthcare services. As noted by Flournoy (2004) and Kok et al. (2015), the extent to which a community ensures access to quality healthcare is shaped by several elements, including the physical characteristics of the community, such as air quality, water safety, geographical location, and climate. The availability of both healthy and unhealthy environments plays a significant role, as factors such as employment opportunities, housing conditions, affordable food options, and access to safe recreational spaces can either support or hinder community health. Furthermore, the presence of both public and private services—such as healthcare and welfare programmes, transportation, education, street lighting, and places of worship—significantly impacts the overall well-being of the community.

Moreover, social and cultural aspects of a neighbourhood, including prevailing standards and values, support networks within the community, levels of assimilation, crime rates, and perceived safety risks, also affect healthcare accessibility. Kok et al. (2015) argue that if a health centre is located in a neighbourhood with a damaged reputation, it may contribute to a lack of confidence among residents, further discouraging them from seeking medical care. Compounding these issues, complex geographies and long distances to healthcare facilities can severely limit the frequency with which individuals can visit doctors, particularly in rural or underserved areas. In such cases, access to health-related information may be minimal, often limited to what is broadcast over the radio. These communities typically have few clinics and no hospitals, which may necessitate nurses performing surgeries at the clinic level, increasing the risk of medical errors and loss of life.

Many individuals living in these challenging conditions encounter additional hurdles, such as drinking water contaminated with lead, limited access to shopping areas and pharmacies, inflated local food prices, restricted recreational spaces, inadequate transportation

options, and higher crime rates. These factors, combined with poor perceptions of neighbourhood safety and well-being, place communities in what Kok et al. (2015) describe as "chronic survival mode." Consequently, such communities may lack the resources necessary to practice preventive healthcare, acquire essential health knowledge, and secure access to high-quality medical care. As Pertes et al. (2017) and Flournoy and Yen (2004) emphasise, these barriers can perpetuate health disparities, leaving residents vulnerable to poor health outcomes due to their limited ability to engage effectively with the healthcare system.

3.3.6 Gender

The differing biology of women and men has a significant impact on health outcomes. Firstly, gender discrimination can influence the intention to seek care as desired by individuals at a given health centre. According to the PubMed Central (PMC) (2023) report, feminist health practitioners are reported to be more critical of men than women, resulting in men receiving poorer treatment than that offered to women. Regarding gender discrimination, the Inter-Agency Standing Committee (IASC, 2010) highlights that women are often marginalised, mainly through policy frameworks. Evidence presented within this brief indicates that deaths from unsafe abortions underscore the neglect of women's specific health needs in health policies.

Moreover, the IASC (2010) emphasises that deaths resulting from unsafe abortions could be prevented. Most maternal deaths could be avoided through timely medical intervention; however, investment in transportation, clinics, and skilled birth attendants is frequently overlooked. The literature indicates that women often incur higher costs when seeking healthcare compared to men, despite the health services provided to them not being more expensive than those available to men. Consequently, women may hesitate to utilise health services due to financial constraints imposed by the costs of medical treatment. In this context, Grabman et al. (2012) portray women as a liability.

Furthermore, stereotypical standards of masculinity—such as the perception that men possess uncontested power and are inherently risk-takers—tend to affect men's health. These conceptions of masculinity may deter men from engaging in health-seeking behaviours that could protect them from injury or facilitate disease treatment. Additionally, such attitudes restrict men's ability to explore and fulfil the nurturing and caring aspects of their roles, making them reluctant to be actively involved in the planning and concerns of their families (Grabman & Friedman, 2012).

3.3.7 Race

Racial factors may also encourage or deprive people of the opportunity to access health services. To validate this assertion, Yearby (2018) cites that the dominant group uses structural racism not only to obtain resources, wealth, employment and income, and healthcare but also to hinder the inferior races from these aspects. A practical example is racial discrimination in the United States of America.

Braveman et al. (2009) found that the United States is a segregated society in which, through its racial residential segregation system, blacks and Hispanics are concentrated in neighbourhoods with fewer resources and fewer opportunities for good health. Similarly, Yearby 2018 explains that in racially segregated neighbourhoods, black Americans are disproportionately likely to be admitted into low-quality hospitals with poor medicinal treatments, while white people are admitted into high-quality hospitals with advanced medical treatments.

3.3.8 Policy and Governance

Health policy and governance can significantly influence individuals' access to medical services, either facilitating or hindering their rights and opportunities to obtain such healthcare. In practice, health policies are designed to streamline health services and enhance accessibility. These policies can help to minimise the costs associated with accessing medication within public health facilities. However, as Pascall (2014) points out, if a policy restricts health practitioners from providing essential medications or treatments, patients may face delays or may not receive necessary services at all due to burdensome administrative processes.

Furthermore, Glover and Henderson (2010) argue that in certain countries, health policies may eliminate specific services, such as abortion, compelling women to resort to unsafe, illegal procedures, which can lead to severe complications, including excessive bleeding or even death.

Using this framework as a foundation, I examined how poverty, lack of educational opportunities, unsafe neighbourhoods, and cultural perceptions of mental illness contribute to disparities in access to mental healthcare services among individuals residing in disadvantaged communities. These two frameworks offer a comprehensive lens through which to analyse the complex nature of mental health service accessibility among these populations. The integration of the EST illustrates how various environmental systems are interconnected, either facilitating or obstructing access to mental health services. Concurrently, the SDH framework highlights

the social and economic factors that exacerbate disparities in mental health and create barriers to accessing appropriate interventions. The next section addresses the methodological approaches employed in the systematic review.

4 CHAPTER FOUR-METHODOLOGY

4.1 INTRODUCTION

The primary aim of this systematic review was to identify and examine the various obstacles faced by disadvantaged communities across South Africa in accessing mental health care. This section outlines the different methods employed to collect information in response to the research questions of the review. This is achieved by systematically addressing the population and sample, design, data collection tools, data generation process, data analysis techniques, and ethical considerations within the study.

4.2 RESEARCH PHILOSOPHY

According to Dawadi et al. (2021), a research philosophy, also referred to as a paradigm, encompasses the researcher's fundamental philosophical beliefs concerning reality and truth, as well as their conviction that a particular research problem requires attention. It involves the researcher's views on the ontological and epistemological dimensions of human existence.

The philosophical stance underpinning the present research is the interpretivist paradigm. As noted by Al-ababneh (2020), Al- Saadi (2014), Irene (2014), and Lawson (2014), interpretivism relates to contextual truth and knowledge, which are understood through subjective, context-specific experiences. In line with the aims of this study, the current review sought to explore how rural communities in SA access mental health services, with the goal of identifying how these communities are affected by social, economic, political, environmental, and institutional barriers to access. Thus, interpretivism is well-suited to this study, as the validity of the data will be grounded in participants' experiences, which may vary depending on the specific context and sample selected.

4.3 RESEARCH APPROACH

This systematic review aimed to consolidate studies on the subject to identify key themes, concepts, or theories offering novel or more comprehensive insights into the topic under examination. As outlined by Tawfik et al. (2019), systematic reviews are characterised by their methodical, transparent, and replicable approach. The review process is divided into three distinct phases: data collection, data analysis, and data synthesis (Crossan & Apaydin, 2010). The primary objective of a systematic review is to provide a structured framework for

compiling and synthesising research, ultimately serving as a valuable resource for decision-makers in clinical practice, consumer advocacy, and policymaking (Cumpston et al., 2020).

In order to conduct this review effectively, a thorough and systematic examination of all relevant published and unpublished literature related to the research questions was essential (Siddaway et al., 2019). Each piece of literature was rigorously assessed for its relevance to the review questions, adhering to predefined criteria governing its inclusion or exclusion.

For data analysis, the researcher employed a qualitative approach. According to Sandelowski (2000), the majority of qualitative research is exploratory in nature, allowing for the investigation of fundamental motivations, beliefs, and justifications. This method provides a deeper understanding of the issue or helps in developing concepts or theories for potential quantitative studies. Sandelowski (2000) also emphasises that qualitative research involves collecting and analysing non-numerical data to derive meaning, focusing on specific populations or settings to gain insights into social life. In contrast, quantitative research is concerned with numerical data. In this review, the qualitative approach was applied to identify and examine the complex barriers hindering access to mental healthcare in disadvantaged communities across South Africa.

4.4 RESEARCH DESIGN

The overall plan that organises the study's development to solve the research challenge is known as the research design (Asenahabi, 2019). It includes the procedures for gathering, measuring, analysing, and assessing data to draw conclusions (Ansari et al., 2022). There are several types of research designs, such as case study, causal, survey, cohort, exploratory, experimental, and longitudinal designs. According to Ranganathan and Aggarwal (2020), the aforementioned designs are utilised to generate data for primary research. For these authors, secondary data, which is normally for reviews, utilises secondary research designs.

For example, Ranganathan and Aggarwal (2020) cite systematic review as a type of secondary research design that is used to summarize the results of prior primary research studies. Systematic reviews are considered the highest level of evidence for a particular research question. The present study is primarily a systematic review and thus follows a systematic review research design.

According to Vet et al. (2005), a systematic review's design comprises several components, such as defining the research question underpinning the study, defining inclusion

and exclusion criteria, conducting a literature search, selecting the final articles for inclusion in the review, evaluating the methodological quality of each study, conducting analysis, and formulating conclusions. This design applies to reviews that summarise the findings of randomised trials as well as reviews that summarise the findings from observational studies or reviews that highlight the importance of a particular phenomenon being investigated (Vet et al., 2005). These stages undertaken to complete the present systematic review on access to mental healthcare services in disadvantaged South African communities are extensively explained in the forthcoming paragraphs.

4.5 SELECTION OF STUDIES

The primary objective of the current study was to identify and describe the factors that hinder access to mental health services in disadvantaged South African communities. For this reason, the selection encompassed all the studies done on access to healthcare services. From the pool of these studies on mental health care, only the studies that were conducted on access to mental healthcare services in disadvantaged communities, especially rural societies, formed the basis for this systematic review research.

4.6 INFORMATION SOURCES

According to Muhammad and Kabir (2018), data collection instruments are the tools used for data collection. According to Ajayi (2023), research is conducted using either primary, secondary or a combination of the two types of data. While secondary data collection sources include government publications, websites, books, journal articles, and internal records, primary data sources can include surveys, observations, experiments, questionnaires, personal interviews, and more (Ajayi, 2023). For this systematic review, internet sources (secondary data) formed an integral part of data generation.

4.6.1 Identification and Searching

During this phase, a systematic and thorough literature search is conducted. As suggested by Siddaway et al. (2019), the researcher must explore two or more electronic databases. The objective is to identify all published and unpublished works relevant to the research questions, as operationalised by the chosen search terms. Resultantly, the search results are assessed, and a selection of recent and higher-quality articles is reviewed. Evaluation is conducted to gauge the reliability and effectiveness of the inclusion and exclusion criteria in identifying potentially pertinent articles while maintaining a balance between specificity and sensitivity. The electronic databases employed for this review encompass Google Scholar,

EBSCO HOST, PsycINFO, MEDLINE, Web of Science, Cochrane Database of Systematic Reviews, and National ETD Portal.

The search strategy for this systematic review was conducted through a two-phase process, beginning with the identification of targeted keywords and followed by the selection of sources that appeared in more than one search engine or were listed more than once in a single search engine. This approach ensured the comprehensive retrieval of relevant studies. The search strategy prioritised research that contained phrases related to access to mental healthcare, mental health patients in rural areas, interventions for mental health distress, mental health problems, and barriers to mental healthcare.

In the first phase, the same set of keywords was used across multiple search engines to maximise the scope of material gathered for the review's analysis phase. Search engines such as Google Scholar allowed for the filtering of results by time period, enabling the researcher to limit the selection to studies published within the last decade, which ensured that the review remained current.

The keywords used in the search included phrases such as *"mental health access" and "mental health services" in South Africa, "mental healthcare disparities" and "disadvantaged populations" and "access to healthcare" in South Africa, and "South African mental health" combined with "mental health care," "barriers," and "cultural perspectives." Other key search terms focused on "barriers to mental health services" and the intersection of rural areas or disadvantaged communities with help-seeking behaviours in South Africa. Additionally, the terms "mental health service utilisation," "help-seeking barriers," and "mental health support"* in South Africa were incorporated into the search to refine the material identified for this review further.

The second phase of the systematic review made use of the mentioned databases to source articles that reported factors that influence access to mental healthcare in South African disadvantaged communities. The field of psychology and health frequently makes use of these databases, thus holding access to peer-reviewed studies and accredited journals. While it is a known fact that some of the studies may be published by more than one journal house, it was, therefore, necessary to identify the duplicates that may later be removed before the analysis phase (see PRISMA flow diagram in chapter five).

4.7 INCLUSION CRITERIA

The inclusion criteria for this systematic research encompass the careful selection of a sample based on specific factors that align with the study's objectives. To define these criteria, the population, phenomenon of interest, and context of care setting framework were used to guide the analysis process. As such, the inclusion criteria primarily focused on studies involving mental healthcare workers and patients as the study population. Additionally, studies that explored the training needs of mental healthcare professionals were incorporated, as these were relevant to understanding the support systems necessary for effective mental health service delivery.

One of the key considerations for inclusion was the literature published between 2014 and 2024. This time frame was selected to ensure that the research incorporated the most recent and relevant findings in the field of mental healthcare. Furthermore, the inclusion criteria emphasised studies that directly addressed access to mental healthcare services in disadvantaged South African communities, particularly rural areas. The rationale behind this was that such studies would be directly applicable to the research aim of identifying the barriers influencing access to mental healthcare in these marginalized settings.

In addition, only peer-reviewed studies written in English were considered for the review. This decision was made to maintain the academic rigour and accessibility of the sources. As a result, studies conducted and reported in languages other than English were excluded from the review. The inclusion criteria also limited the scope of the research to academic book chapters and journal articles, further refining the focus to ensure that only scholarly, evidence-based literature was included in the analysis.

In summary, the inclusion criteria were shaped to ensure that the studies selected for review were not only recent and peer-reviewed but also aligned with the research objective of examining access to mental healthcare services in disadvantaged South African communities. The criteria included studies with a focus on barriers to mental healthcare access, particularly in underprivileged areas, and those that addressed cultural, socio-economic, and systemic factors influencing mental health service utilisation. Additionally, the review included studies with diverse research designs, encompassing qualitative, quantitative, and mixed methods approaches. This broad range of research designs allowed for a comprehensive analysis of the various factors affecting access to mental healthcare from different perspectives. By

incorporating studies with varied methodologies, the review was able to capture both in-depth, context-specific insights (from qualitative studies) and generalizable data on trends and patterns (from quantitative studies), thus enhancing the richness and applicability of the findings. These criteria helped to refine the scope of the research and ensure the relevance and quality of the selected studies.

4.8 EXCLUSION CRITERIA

The exclusion criteria for this systematic review were established based on the studies excluded from the data analysis phase. All the publications that were published in other languages besides English were excluded. Again, any studies that were conducted outside of SA were excluded. Specifically, all literature, whether published or unpublished, that was older than 10 years was excluded from the review. To maintain relevance and ensure that the literature reflected current practices and challenges, only generic sources within a 10-year timeframe were considered. This approach aimed to provide a contemporary understanding of barriers and interventions related to mental healthcare-seeking behaviours.

Furthermore, non-peer-reviewed journal articles were omitted to mitigate potential bias and ensure the credibility of the findings. Additionally, academic literature that did not specifically focus on 'mental healthcare access' and 'disadvantaged communities in South Africa' was excluded, as it was essential to keep the review centred on these core research themes. This targeted exclusion helped to refine the scope of the review, ensuring that only the most relevant and high-quality studies were analysed.

4.9 DATA SYNTHESIS

According to Taherdoost (2023), data analysis is a process of organising generated data into a summarised form. It is done through various formats such as themes, percentages, median, mean, and many others. In this study, data was analysed through qualitative methods. Deductive thematic analysis was utilised to gather data for this review.

4.9.1 Thematic Analysis

According to Kiger and Varpio (2020), the process of thematic analysis involves getting acquainted with the data, creating preliminary codes, discovering themes, going over these topics, defining and labelling them, and summarizing the experiences that participants have in common. The data is organized into predetermined themes that arose from the literature, and direct quotations are provided to present the data. This is the deductive basis for thematic analysis (Bingham, 2024).

Following the methodology proposed by Braun and Clarke (2006; 2021), the analysis involves a continuous process of navigating between the entire data set, coded data extracts, and the evolving data analysis. The six steps of a thematic analysis are as follows: 1) familiarization with the data and creation of familiarization notes; 2) methodical data coding; 3) initial theme development and evaluation using coded and collected data; 4) theme development and review; 5) theme refinement, definition, and labelling; and 6) report writing.

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4.9.2 Step one: Transcription, Familiarization with the Data, and Selection of Quotations

According to Naeem et al. (2023), This is the first stage of the thematic analysis process, where data is transcribed and thoroughly reviewed. Researchers immerse themselves in the content to identify emerging themes and key sections. They then choose quotes that vividly illustrate the data, capturing different perspectives and patterns relevant to the research goals (Naeem et al., 2023). In this study, familiarisation with the data reported in the studies considered for this review was done. This was done to examine the studies' findings extensively.

4.9.3 Step two: Selection of Keywords

The researcher closely examines the data, whether from focus groups, interviews, or visual content, as part of the second phase of the thematic analysis to find recurrent themes, concepts, or visual components that can be classified as keywords. These keywords reveal participants' experiences and perceptions (Dawadi, 2020). Having familiarised myself with the data, I noted the reported findings as presented by each study and underlined the recurring patterns from the findings.

4.9.4 Step three: Coding

According to Maguire and Delahunt (2017), the third step of thematic analysis encompasses coding, which involves assigning short phrases or words, known as codes, to segments of data that capture the data's core message, significance, or theme. This step transforms the data into a theoretical form and identifies patterns related to the research questions. The keywords selected from the transcribed data in step two form the backbone of the analysis and help convert raw data into insightful, manageable segments (Maguire & Delahunt, 2017). This step was initiated by going through the captured findings from each study and assigning similar quotes with similar colours.

4.9.5 Step four: Theme Development

In order to find structured meanings that connect the study questions and data, theme creation entails grouping codes into meaningful categories. (Ibrahim, 2012). In simpler terms, this step involves a detailed analysis of codes and categories to form abstract interpretations by creating themes. In this study, the highlighted quotes that had the same colour, assuming the same meaning, were then grouped under a certain meaning that they were found to purport. These themes were determined by both the theories underpinning the study and the literature review.

4.9.6 Step five: Conceptualization through Interpretation of Keywords, Codes, and Themes

The fifth step of thematic analysis includes comprehending and defining ideas that appear in the data and aligning such concepts with their research questions. That is, themes that can be arranged under a broader theme are then grouped and placed under that broader theme. What follows, then is the utilisation of resources to comprehend the connections between various ideas, such as models or diagrams, based on their relevance and how they advance theory and practice. For this research, the subthemes were merged with the broader themes, with each broader theme separated from one another based on the meanings they purport for the research questions. In simple terms, the subthemes that emerged from the data were interpreted for meaning and then arranged into unique, broader themes.

4.9.7 Step six: Development of Conceptual representation

Finally, the creation of a conceptual model is the sixth phase in the thematic analysis process. Having interpreted the data, the researcher created a unique representation of the data, guided by existing theories. The presentation serves to answer the research questions and underscore the study's contribution to knowledge (Dawadi, 2020). In this systematic review, I carefully examined the reported findings and grouped them according to their applicability to the study's research questions.

4.10 QUALITY ASSESSMENT MEASURES

Quality assessment in research ensures that the generated data is accurate and reflects the participants' true experiences (Connelly, 2016). According to Rule and John (2011), certain measures are taken by the researchers to ensure credibility, confirmability, dependability, and transferability of findings. Since this study follows a review design, each study reviewed was assessed for quality using the Critical Appraisal Skills Programme (CASP); this was motivated by the qualitative nature of the selected studies. According to Singh (2016), CASP is a tool

used to evaluate the quality of qualitative studies. This approach to quality assessment measures encompasses a checklist comprising ten items (J. Singh, 2016).

The key considerations of CASP are as follows (Long et al., 2020): "(1) Was there a clear statement of the aims of the research? (2) Is a qualitative methodology appropriate? (3) Was the research design appropriate to address the aims of the research? (4) Was the recruitment strategy appropriate to the aims of the research? (5) Was the data collected in a way that addressed the research issue? (6) Has the relationship between the researcher and participants been adequately considered? (7) Have ethical issues been taken into consideration? (8) Was the data analysis sufficiently rigorous? (9) Is there a clear statement of findings? (10) How valuable is the research?" p.3. Applying these items to selected studies allowed for the judgement of how good or low the quality of the reviewed study was.

4.10.1 Applicability within this review

To ensure the integrity of the review, a rigorously established methodology was followed throughout the process. This methodology was applied uniformly to all selected literature, thereby reducing the risk of selection bias and enhancing the reliability of the findings. In line with these objectives, a predetermined set of criteria was consistently used to evaluate the quality of each study.

The evaluation of study quality was based on a checklist designed to ensure that each aspect of the research is scrutinised. Key questions include whether the goal or inquiry of the study is clearly and adequately stated. Furthermore, attention was given to the design of the study, assessing whether it was both clear and appropriate for addressing the research question. The checklist also considered whether the sampling methods were well-described and suitable for the study's objectives. Additionally, the characteristics of the individuals included in the research were examined to ensure that sufficient detail was provided, which is crucial for assessing the generalisability of the findings.

Another important criterion was whether the barrier measure used in the study was clearly defined, as this ensured that the key variables were appropriately operationalised. The quality of the analysis was also scrutinised, with attention paid to whether the analytical methods were suitable, justified, and thoroughly described. Furthermore, the results were assessed for their specificity, ensuring that they are presented with sufficient detail to allow for

meaningful interpretation. Lastly, the evaluation considered whether the study's findings align with its conclusions, ensuring that the research is both credible and well-supported.

After the data from the selected studies had been collected, screened, and analysed, it was organised into a chart format. Specifically, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart was used to represent the data visually. This charting method aids in illustrating the process of study selection, screening, and inclusion, offering a clear and transparent overview of the research process. By adhering to these rigorous standards, the review ensured that relevant studies contributed to the final analysis, thereby strengthening the overall conclusions drawn from the research.

4.11 ETHICAL CONSIDERATIONS

Several ethical considerations were paramount in conducting this systematic review to uphold the integrity of the research process and ensure respect for all individuals involved.

First and foremost, it is essential to recognise that this systematic review primarily relied on secondary data from previous studies. Consequently, maintaining the integrity and accuracy of these studies throughout the review process was an ethical imperative. To prevent bias or selective reporting that could distort the findings, a rigorous and transparent methodology was employed to assess the quality and relevance of the included studies.

Privacy and confidentiality were maintained at all times during the review process. Although this systematic review did not involve the collection of new participant data, it contained sensitive material from published research. As a result, careful consideration was given to data handling, ensuring that all information was anonymised and that the privacy of study participants was safeguarded to the greatest extent possible, in accordance with the confidentiality agreements of the original research.

Furthermore, ethical considerations necessitated the proper acknowledgement of the original authors' work, ensuring that they received due credit. To protect the intellectual property of the researchers whose work was synthesised and to prevent plagiarism, strict adherence to appropriate referencing and citation practices was essential. Beyond upholding academic integrity, this approach also fostered transparency and mutual respect within the scientific community.

Additionally, this systematic review adhered to a comprehensive and objective search strategy. Efforts were made to identify and include all relevant studies, regardless of their findings or publication status. This approach was crucial in ensuring that the data were presented fairly and accurately, thereby contributing to informed decision-making and advancing knowledge in the field of mental health.

In conclusion, the principal ethical considerations in this systematic review were fairness, transparency, and respect for both the original research and the individuals who contributed to it. By adhering to these ethical guidelines, the validity and reliability of the review were preserved, thereby enhancing our collective understanding. The meta-analysis of the reviewed studies is presented in the subsequent chapter.

5 CHAPTER FIVE- FINDINGS

5.1 INTRODUCTION

This chapter focuses on presenting, evaluating, and interpreting the research findings sourced from studies used for this systematic review. Thus, the findings of this study are presented based on the following research questions:

- What are the reported barriers to seeking mental healthcare in disadvantaged communities?
- What is the role of culture in the perception of mental health distress in disadvantaged communities?
- What scopes of interventions do people in disadvantaged communities utilize when they present with symptoms of mental distress?

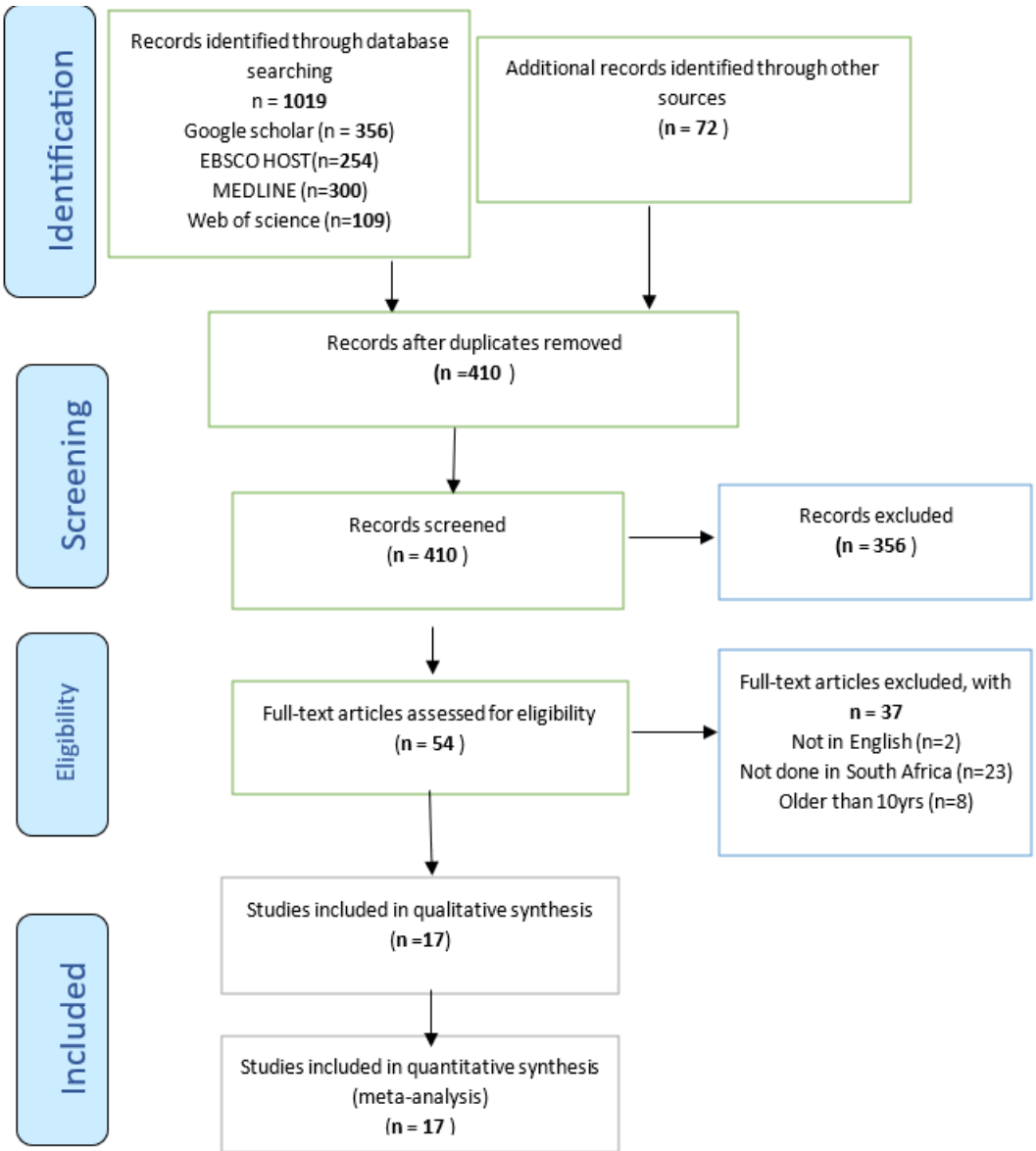

Figure 4- PRISMA Diagram

5.2 DATA EXTRACTION

After the selection of studies for synthesis, careful consideration was given during the thematic analysis phase. As a result, it was found that rural communities are affected by various impediments to mental health information-seeking behaviours. Table 2 presents a summary of the key information from the studies included in the review.

Table 2- Studies selected for the review and their characteristics

Author(s)	Design	Region	Participants	Primary aim/Phenomenon	Barriers	Interventions
Strümpher et al. (2014)	A qualitative, explorative and descriptive research design	Eastern Cape, South Africa	9 Professional nurses working in primary, secondary or tertiary healthcare services in the Port Elizabeth area minimum of two years	Views of mental health patients in the Eastern Cape Province of South Africa regarding obstacles to receiving help.	•Poverty •Lack of family support •Lack of mental health knowledge •Shortage of mental health staff •Stigma and Discrimination •Cultural influences	•Reliance on mobile clinic
Talatala (2015)	Qualitative, Interpretative Phenomenology	Rural areas in the Eastern Cape, KwaZulu Natal, Limpopo, and North-West	12 participants: mental healthcare users	Challenges that people living with mental illness face in rural areas: Testimonies of mental healthcare users from rural areas	•Poverty •Lack of human rights •Inhumane mental health treatments •Lack of mental health facilities •Shortage of mental health staff •Lack of medical resources	•Speaking with psychologists •Use of police cars
Sehoana and Laher (2015)	Experiential qualitative: phenomenology	Limpopo, South Africa	-9 psychologists (5 females, 4 males) from Pedi culture: 2 clinical psychologists in private practice, 4 clinical psychologists in government hospitals in Capricorn and Sekhukhune district, 1 educational psychologist in private practice, 1 counselling	Traditional African (Pedi community) understandings of mental illness and treatment of mental illness in the cultures	•Stigma and Discrimination •Cultural influences	•Use of traditional healers and pastors •Going to mental health facilities for help

Author(s)	Design	Region	Participants	Primary aim/Phenomenon	Barriers	Interventions
			psychologist in an educational institution -Between 1 and 15 years of practice (most participants practised more than 4 years)			
Wegner and Rhoda (2015)	Explorative qualitative design	Rural areas in KwaZulu Natal, South Africa	17 rehabilitation therapists from 5 district hospitals in a rural community: 8 physiotherapists, 7 occupational therapists, 1 dietician therapist, 1 speech therapist	The experiences of rehabilitation therapists, including occupational therapists, speech therapists, and physiotherapists, about how cultural attitudes influence the use of rehabilitation services in a rural South African community	•Poverty •Poor roads •Lack of family support •Shortage of mental health staff •Stigma and Discrimination •Cultural influences •Lack of medical resources	•Use of traditional healers and priests •Going to mental health facilities for help
De Kock and Pillay (2018)	Qualitative and review	One hundred and sixty South African PRPHC health facilities in rural areas of South Africa	chief executive officers (CEOs) and medical managers in the health facilities, Medical managers	details regarding the staff and services provided by a) clinical psychologists [22], b) mental health nurses [20], and c) medical prescribers [21] (psychiatrists and medical officers specializing in mental health counselling).	•Shortage of mental health staff •Lack of medical resources	

Author(s)	Design	Region	Participants	Primary aim/Phenomenon	Barriers	Interventions
			nursing services managers (NSM)			
Rooyen et al. (2019)	**Qualitative descriptive exploratory research**	**Emalahleni sub-district of the Chris Hani Health District in the Eastern Cape, South Africa**	**29 participants: persons living with severe and persistent mental illness (n=18) and their family members (n=11)**	**Experiences of people with severe and chronic mental illnesses, as well as those of their families, concerning mental health services offered by primary healthcare institutions in the Eastern Cape region of rural South Africa**	**•Poverty •Poor roads •Lack of family support •Lack of mental health knowledge •Shortage of mental health staff •Stigma and Discrimination •Lack of mental health resources**	**•Going to mental health facilities for help •Use of police cars •Use of public transport during emergencies**
(Sibam, 2019)**)**	**Qualitative design**	**Rural communities in Eastern Cape, South Africa**	**6 participants**	**Possible effects of mythological creature belief, particularly with regard to the tokoloshe, on mental health and general well-being in South African rural communities**	**•Self-perception •Cultural influences**	**•Use of traditional healers and priests**
(Jennings et al., 2020)**)**	**Quantitative**	**Mpumalanga province, a majority Black African area.**	**5890 people South Africans aged 40 and older**	**Access to social support among a low-income population in rural South Africa.**	**•Lack of mental health knowledge •Shortage of mental health staff**	**•Staying with family for help**

Author(s)	Design	Region	Participants	Primary aim/Phenomenon	Barriers	Interventions
Benjamin et al. (2021)	qualitative method	Rural areas of South Africa – Calvinia and Lambert's Bay	Parents and/or caregivers: These individuals were mothers or grandmothers with one or more children under the age of eighteen; stakeholders included police officers, social workers, dieticians, nurses, and community health professionals.	Participant awareness and comprehension of mental health, the accessibility of mental health resources, and the help-seeking behaviours of locals in under-resourced areas	•Poverty •Lack of family support •Language barriers •Stigma and Discrimination	•Use of traditional healers •Use of police cars
Booysen et al. (2021)	Qualitative design	Primary care clinic in a low-resource community setting in the Eastern Cape, South Africa	8 participants diagnosed with mental illness: who had been accessing treatment for at least 6 months from a primary health clinic	How people with mental illnesses experience and see mental health care in an Eastern Cape town with limited resources	•Lack of human rights •Lack of mental health knowledge •Shortage of mental health staff •Stigma and Discrimination •Cultural influences	•Use of traditional healers
Bila and Carbonatto (2022)	A collective case st udy design	Rural communities of L impopo Province, Sout h Africa	30 mental health care users (MHCUs) and 10 caregi vers of MHCUs	cultural beliefs of MHCUs and caregivers regarding help-seeking behaviour: thoughts, feelings, and experiences of th e participants as closely as possible, shari ng issues and concerns characteristic of cultural be liefs regarding mental health help-seeking behaviour	•Poverty •Lack of mental health facilities •Lack of mental health knowledge •Stigma and Discrimination •Cultural influences	•Use of traditional doctors •Going to mental health facilities for help

Author(s)	Design	Region	Participants	Primary aim/Phenomenon	Barriers	Interventions
Mbokazi et al. (2023)	Case study	urban Gugulethu, Cape Town and rural Bulungula, Eastern Cape	Participants had been diagnosed with HIV and one or more additional chronic diseases, and they were older than eighteen. 16 in Bulungula (12 women, 2 males) and 9 in Gugulethu (7 women, 7 men) spoke their native tongue, IsiXhosa.	To investigate how a patient's capacity to self-manage multimorbidity is mediated by the idea of Ubuntu and African social networks.	•Lack of mental health resources •Inhumane mental health treatments •Lack of mental health resources	•Relying on pharmacies •Building community support chains •Forming clubs for peer discussions
Mindu et al. (2023)	Mixed-methods study	Ingwavuma Community, uMkhanyakude District in KwaZulu Natal, South Africa; has several villages including Ndumo, Makhana and Bhambanana	150 participants; youths aged between 16 and 24 years	The potential benefits and obstacles of introducing a mobile phone-based mental health intervention for youth in the Ingwavuma region.	•Language barriers Lack of mental health knowledge •Cultural influences	•Use of traditional doctors/healers •Going to mental health facilities for help
Lee et al. (2023)	A cohort study	Pietermaritzburg Metropolitan Trauma Service (PMTS), Kwa-Zulu Natal province, South Africa	All patients who were aged 65 years or above ad were admitted to trauma centres from January 2013 to December 2020	The impact of rurality as compared to urban status, on the outcome of trauma in the geriatric population in Kwa-Zulu Natal province, South Africa	•Lack of mental health knowledge	

Author(s)	Design	Region	Participants	Primary aim/Phenomenon	Barriers	Interventions
Mabunda et al. (2023)	A cohort study	Giyani, Limpopo Province, South Africa	They were adult children (a son or daughter, eighteen years of age or older) of a parent who was admitted to a Giyani psychiatric hospital at the time of data collection due to a chronic mental illness. • Adult offspring were not placed in institutions. • Adult offspring had access to a landline or cell phone. • It was preferred that adult children speak English or Xitsonga.	Experiences of adult children with a parent living with a chronic mental illness	•Lack of family support •Stigma and Discrimination •Cultural influences	•Speaking with a psychologist •Using teachers for mental health support •Staying with family for help
Moonsamy and Gurayah (2024)	Qualitative descriptive design	KwaZulu Natal, South Africa	10 participants: Black South African individuals of Zulu cultural heritage Above 18 years of age	Views and experiences of black South Africans who speak isiZulu and who sought out multimodal treatment in a private mental health hospital in Kwazulu Natal using a Western-based therapy approach	•Self-perception •Lack of mental health knowledge •Stigma and Discrimination •Cultural influences	•Use of traditional healers •Going to mental health facilities for help •Forming clubs for peer discussions

Author(s)	Design	Region	Participants	Primary aim/Phenomenon	Barriers	Interventions
Sikrweqe et al. (2024)	Quantitative exploratory descriptive approach	Eastern Cape Province, South Africa	101 participants (32.6% men, 67.4% women) 70.3 % African 17.8% White/Caucasian 7.9% Coloured 4% Indian	Eastern Cape Province residents' use of culture and religion to cope with mental illness	•Cultural influences	•Use of traditional healers and priests

5.3 REPORTED BARRIERS FOR MENTAL HEALTH-SEEKING BEHAVIOURS

As highlighted in the previous chapters, the findings yielded by this review were deductively themed based on the principles of ecological systems theory and social determinants as the frameworks that underpinned this review research. Thus, the following sections provide the data synthesis based on the themes as established by the Theory of Constraints.

5.3.1 Individual Layer

5.3.1.1 Self-Perception as barrier to mental healthcare access

The reviewed studies provide evidence that some people with mental health needs do not seek professional mental health services because they think people will consider them weak (Booysen et al., 2021; Moonsamy & Gurayah, 2024). On the same note, some people with mental health needs perceive themselves to be a burden on their families (Moonsamy & Gurayah, 2024).. These internalised feelings of stigma and burden highlight the complex ways in which self-perception influences their relationship with both their community and mental healthcare access.

5.3.2 Micro and Meso-system

5.3.2.1 Lack of family support

Furthermore, the analysis of the results of the reviewed studies highlights that lack of family and community support also contributes to poor mental health help-seeking behaviours (Jennings et al., 2020; Mabunda et al., 2023; Rooyen et al., 2019; Strümpher et al., 2014). From the findings of the reviewed studies, lack of mental health support from family deprives people of sharing their mental health needs. In many cases where they want to visit mental health centres, they are discouraged by their family in health-seeking behaviours (Moonsamy & Gurayah, 2024), further reducing the likelihood of individuals accessing professional mental health services. As a result, this lack of emotional and practical support shapes mental health outcomes within communities.

5.3.3 Macro-system

5.3.3.1 Cultural beliefs

One of the issues that emerge from these findings is that cultural beliefs discriminate against people who recognise their mental health needs. More than half of the studies show that other people consider traditional healers to be more capable of treating their mental distress than Western mental health professionals (Bila & Carbonatto, 2022; Mabunda et al., 2023;

Mindu et al., 2023; Moonsamy & Gurayah, 2024; Sehoana & Laher, 2015; Sibam, 2019; Sikrweqe et al., 2024; Strümpher et al., 2014; Wegner & Rhoda, 2015).

It was also demonstrated that in some cultures, men and women are expected to display emotional resilience and are unlikely to seek help from anyone outside the family (Moonsamy & Gurayah, 2024). Additionally, harmful cultural beliefs lead to discrimination, such as taxi drivers refusing to provide transport to individuals with mental disabilities, believing they are cursed (Sibam, 2019).

5.3.3.2 Deprivation of Human Rights for individuals with mental health disorders

In this study, it was found out that the South African community system excludes or denies people with mental health disorders basic human rights such as the right to education and employment (Booysen et al., 2021; Rooyen et al., 2019). According to Rooyen et al.'s (2019) research, mentally ill individuals are not given the opportunity to speak during meetings or social events like funerals. This forces people to hide their emotional deficits because they fear it will deprive them of the chance to access other aspects of human life, such as getting a job or being admitted to school (Booysen et al., 2021).

5.3.4 Exo-system

5.3.4.1 Discrimination and Stigma

The second major finding was that social rejection and stigmatisation within the society influence people to hide their mental health situations to avoid being isolated from social interactions with the rest of the community members (Rooyen et al., 2019; Sehoana & Laher, 2015; Strümpher et al., 2014; Talatala, 2015; Wegner & Rhoda, 2015). Social stigmatization related to mental illness creates an environment where people fear isolation, making them reluctant to seek mental healthcare. Additionally, these findings highlight the broader social determinants of health that exacerbate the stigma, further marginalizing those in need of mental health services.

5.3.5 Economic barriers to mental health access

Even though there are mental health grants available to people with mental health needs, people with a chronic mental illness who receive a disability grant from the state are expected to use this money to support the needs of the family (Sehoana & Laher, 2015). Therefore, this deprives them of the chance of getting proper mental health medication and treatment (Talatala, 2015). Additionally, the overall affordability of mental health services presents a barrier, as many rural households live below the poverty line and cannot access

regular or advanced mental healthcare (Benjamin et al., 2021; Bila & Carbonatto, 2022; Rooyen et al., 2019; Strümpher et al., 2014; Wegner & Rhoda, 2015). These economic challenges hinder both access to basic carer and more advanced medical treatments.

5.3.6 Education and health literacy

5.3.6.1 Mental Health Education Knowledge

One of the major findings of this research was that participants expressed that, prior to being referred to the facility, they were unaware of the availability of these services within Western healthcare (Booysen et al., 2021). This underscores the challenge rural communities face due to a lack of knowledge about mental health issues (Mindu et al., 2023). Another significant finding was that some participants own smartphones capable of downloading mental health applications containing information on improving mental well-being (Mindu et al., 2023). However, the majority of these individuals are unaware of such applications (Mindu et al., 2023). Moreover, the results from the reviewed studies indicate that individuals without mental health needs often lack knowledge about the stages of mental health and, as a result, are unable to empathise with those experiencing mental distress (Strümpher et al., 2014).

5.3.6.2 Language

Additionally, mental health services are offered in the English language (Benjamin et al., 2021; Mindu et al., 2023; Moonsamy & Gurayah, 2022); which makes it difficult for those who cannot speak it to express their mental health needs to the professionals. Local languages are not often integrated within mental health service points (Benjamin et al., 2021; Moonsamy & Gurayah, 2024), as a result exacerbating this barrier.

5.3.7 Resources and Infrastructure

5.3.7.1 Resources

The current study found that the lack of responsive emergency transport ambulance service in the event of mental health emergencies was one of the barriers to mental health-seeking behaviours (Rooyen et al., 2019). In addition, mental health centres experience medication stock-outs, which impedes the effective delivery of mental health services (Mbokazi et al., 2023; Rooyen et al., 2019).

5.3.7.2 Transportation

Again, the results of this study show that rural communities are confronted with the difficult challenge of transporting anxious and distressed SPMI patients to therapy using public

transportation (Strümpher et al., 2014). Importantly, it was found out that public transport is unaffordable for most people. People are forced to hire a vehicle from a community member, which is quite expensive for those with poor economic backgrounds (Rooyen et al., 2019).

As reported by Wegner and Rhoda (2015), ambulance services were unwilling to respond to distressed patients in the community because of the poor roads. For this reason, such people are forced to use public transportation. However, this is associated with the high cost of transport due to the long distances, which increases the burden for people from rural areas to access healthcare (Rooyen et al., 2019; Wegner & Rhoda, 2015).

5.3.7.3 Facilities

Another important finding was that the lack of rehabilitation facilities is a challenge for rural people to access proper mental health treatment (Strümpher et al., 2014). Again, private mental health services were not easily available due to the lack of private health facilities. The review of Moonsamy and Gurayah's (2024) study revealed that due to a lack of quality primary mental healthcare facilities, a sizable proportion of the Zulu population lacks access to healthcare for conditions including anxiety and depression.

5.3.7.4 Mental Health Staff

The studies highlight shortages of experienced mental health staff as a significant challenge within the facilities (De Kock & Pillay, 2018; Strümpher et al., 2014). There is about one psychologist in 4 towns (Sikrweqe et al., 2024). This results in people having to wait for many hours before accessing treatment (Talatala, 2015). This shortage of staff not only delays care but also contributes to the overall inaccessibility of mental health services for underserved populations.

5.4 INFLUENCE OF CULTURE ON MENTAL HEALTH SERVICES SEEKING BEHAVIOURS

5.4.1 Macro-system

Furthermore, this systematic review was meant to unravel how cultural beliefs influence the perceptions of mental health distress in disadvantaged communities. Thus, it was found that culture plays a significant role in people's will to utilise mental healthcare services. Firstly, mental health patients in rural areas patients seem to rely heavily on traditional healers for almost every aspect of their health (Sehoana & Laher, 2015; Sibam, 2019; Wegner & Rhoda, 2015). When they experience mental health distress, they first seek help or confirmation

from their traditional doctors before going to modern medical facilities (Bila & Carbonatto, 2022; Booysen et al., 2021; Moonsamy & Gurayah, 2022).

It is in these traditional mental health treatment environments where patients are sometimes told that their mental distress is a result of witchcraft or ancestorial requirements (Sibam, 2019). This understanding of mental disorders discourages people with mental health needs from being diagnosed with proper mental health medication. In short, people believe that mental disorders are prompted by witchcraft or are intentionally caused by a jealous member of that community; someone casts a 'demon' on the mentally ill person (Sibam, 2019; Sikrweqe et al., 2024). Thus, the patients believe that such spells cannot be treated at hospitals, but they can be treated using traditional rituals.

Second, culture comprises individuals who are steadfast in their ancestor worship, which is seen as essential to healing and crucial to the preservation of health in traditional African societies (Strümpher et al., 2014). According to the review's findings, patients find traditional healers to be appealing from a cultural standpoint. It is possible that the patients' lack of participation in the rituals required to ensure their ancestors' protection contributed to their mental illness (Booysen et al., 2021; Mindu et al., 2023).

The results of this review reveal that cultural beliefs also shape the way people use mental health medication. Some of the patients trust that traditional medicines are more effective than Western medicinal treatment (Benjamin et al., 2021; Sibam, 2019; Sikrweqe et al., 2024). Traditional healers themselves were also found to share the same beliefs and perceptions that were reported by the people they treated (Bila & Carbonatto, 2022). Inevitably, the shared beliefs make their traditional treatment methods more appealing and trustworthy to the rural community (Mabunda et al., 2023).

Other ways in which culture influences mental health information-seeking behaviour include the belief that mental illness is regarded as a "white man's problem"(Moonsamy & Gurayah, 2024). The findings revealed that people in rural communities do not recognise anything called stress or depression. Once a person says they are stressed or depressed, people perceive such an individual as being dramatic or westernised, or colonised, and they think that such an individual perceives highly of themselves.

5.4.2 Micro-system

What is more, in traditional Zulu families, the eldest male is regarded as the family's decision-maker, leader, and provider (Moonsamy & Gurayah, 2024). As a result, the male

participants from rural areas of South Africa stated that these family roles required them to look emotionally strong and worthy of women's respect (Jennings et al., 2020). That is, a man does not disclose that he is incapable of leading the family or handling emotions during intense situations; otherwise, he loses respect. Therefore, this prevents them from being considerate about seeking mental health services from professionals.

Similarly, the results reported by Moonsamy and Gurayah (2024) reveal that women are also expected to be strong creatures. Even in times of injustice, Zulu females are expected to remain as caregivers and submissive wives (Moonsamy & Gurayah, 2024). What is more, they need to maintain the family's honour and reputation by not expressing their concerns outside of the family space. This normality influences the way mental health services are accessed when the need arises. The women know that if they seek mental health support from outside the family space, they will be victimised for such an act and may even lose their right to marriage (Moonsamy & Gurayah, 2024).

5.5 INTERVENTIONS EMPLOYED BY RURAL COMMUNITIES DURING A TIME OF MENTAL HEALTH NEED

Lastly, it was within the scope of this research to investigate the interventions employed by people in rural communities when they experience mental distress. The subsequent paragraphs describe the reported interventions by the reviewed studies on South African mental health issues.

5.5.1 Microsystem

5.5.1.1 Staying With Their Families

Even though changes exist within the majority of rural families based on support, some still receive support or care from their family members (Mbokazi et al., 2023). As long as mental health patient effectively uses their medication, they stay with their families, who support them by offering emotional support and completing specific tasks on their behalf.

5.5.1.2 Building Family and Community Support Chains

The review of the included studies revealed that some of the people in rural areas of South Africa rely heavily on support chains from family, neighbours, and community members (Mbokazi et al., 2023). These support chains are initiated to share transportation to mental healthcare centres and for security purposes in cases where patients have to walk to the health centres on foot and have to walk through unsafe forests (Mbokazi et al., 2023; Moonsamy & Gurayah, 2024).

5.5.2 Macro-system

5.5.2.1 Use of Traditional Healers and Churches

The reviewed studies revealed that people in rural areas employ various interventions when dealing with mental distress. For the treatment of mental instabilities, studies highlight that the majority of the participants normally conduct traditional or indigenous healers who perform rituals for them for treatment. (Benjamin et al., 2021; Bila & Carbonatto, 2022; Mindu et al., 2023; Sehoana & Laher, 2015; Sibam, 2019; Sikrweqe et al., 2024; Wegner & Rhoda, 2015). For example, in the Zulu rural communities, specific rituals include cleansing such as "Ukuqaphula", which involves making small incision cuts on the person's skin, then putting herbal medicines on those cuts to ensure that person is never affected again.

Apart from the use of traditional healers to deal with mental distress, people from the rural areas of South Africa apply modern religious interventions (Sikrweqe et al., 2024; Talatala, 2015). Others would pray to God, asking for God to help them get through their mental distress. The use of religious methods and traditional healers or herbalists is not always motivated by cultural beliefs but is sometimes attributed to their easy accessibility because they are often found within the same community that the patients live in (Sikrweqe et al., 2024). Also, the patients seem to resort to these interventions because they consider them cheaper than using modern medicine.

5.5.2.2 Speaking with a Psychologist or Therapist

The studies reviewed revealed that mental health patients also make attempts to speak to psychologists or therapists, who can provide perspective or understanding as well as suggest how they can improve their well-being. (Benjamin et al., 2021; Mindu et al., 2023).

5.5.2.3 Going to a Mental Health Facility

Few studies found that people with mental disorientations sometimes go to the relevant facilities to treat their distress. The facilities seem to be a healthy distraction from their challenging or sometimes toxic environments and toxic thoughts such as suicidal attempts; in such facilities, they think more rationally. The facilities are safe spaces to express their mental vulnerability, where someone listens attentively and cares about what is being expressed without being judgemental (Mbokazi et al., 2023).

5.5.3 Exo-system

5.5.3.1 Using Teachers to Disclose Their Concerns

Mental health patients, especially school children, use non-mental health experts such as teachers to talk about their struggles. In the case where there is no psychologist or, therapist or any type of counsellor, teachers are used to offer mental support (Mabunda et al., 2023).

5.5.3.2 Forming Mental Health Patients Clubs

Amongst the interventions done in rural communities to address mental distress, the formation of mental health patients' clubs seems to provide a significant contribution to minimising mental distress. In such clubs, mental health patients talk amongst themselves; they believe that maybe the mental health support teams cannot understand or relate to their mental issues (Moonsamy & Gurayah, 2024).

Other interventions employed by people within rural communities were associated with aspects of SDH. These include the utilisation of convenient resources, which are discussed below.

5.5.3.3 Use of Police Cars

The findings reported in the reviewed studies established that a lack of transportation routes and vehicles challenges rural communities. In response to this drawback, rural communities rely on police cars to take their patients to the hospitals (Benjamin et al., 2021; Rooyen et al., 2019; Talatala, 2015). However, the disadvantage of relying on police officers to take care of mentally ill persons is that police officers are not experienced in handling people with a mental health condition in the event of an emergency; this manifests in their actions when dealing with persons living with SPMI

5.5.3.4 Relying on Pharmacies for Medicine

In instances where rehabilitation is not a viable option, individuals in disadvantaged communities in South Africa utilise their prescriptions to purchase mental health medication from pharmacies as an interim measure until they can access appropriate treatment (Mbokazi et al., 2023). Furthermore, some patients obtain medication from private healthcare facilities when public health institutions experience shortages of essential medical supplies (Rooyen et al., 2019).

5.5.3.5 Reliance on Mobile Clinic

The results showed that in order to increase access to mental health care, the Eastern Cape Department of Health made an investment in outreach programs by purchasing cars and

mobile clinics (Strümpher et al., 2014). Consequently, some mental health patients rely on these mobile mental health services even though they prove to be unreliable.

5.6 CHAPTER SUMMARY

The research on mental health distress has been given in this chapter. It has also included a description of the barriers to mental health services. Additionally, the chapter has discussed how culture shapes people's perceptions of mental health issues. In addition, a comparative analysis of the research was done to determine the interventions that people in rural regions use when they show signs of mental distress. Discussions centred on the research topics presented at the beginning of this chapter will be covered in detail in the following chapter.

6 CHAPTER SIX - DISCUSSION OF FINDINGS

6.1 INTRODUCTION

The results given in the previous chapter are thoroughly discussed in this chapter. Aligning these results with the research topics and examining how they differ and overlap with previous findings are the main goals. Additionally, the goal of the debate is to either support or disconfirm the claims made by the Ecological Systems Theory, which serves as the theoretical basis for this investigation, and the Social Determinants of Health. As highlighted in the earlier chapters, the primary aim of this systematic review was to identify barriers to mental healthcare access in disadvantaged communities in South Africa. Thus, a detailed analysis of the information produced in response to each research question is presented in the following sections.

6.2 THE REPORTED BARRIERS TO SEEKING MENTAL HEALTHCARE IN DISADVANTAGED COMMUNITIES

Firstly, the impediments to mental health access include a lack of psychotropic medicine within health centres that lie within the rural communities of South Africa (Mbokazi et al., 2023). That is, the results revealed that people do not get proper access to mental healthcare due to medication stock-out. As envisioned by WHO (2009), Psychotropic medications should always be accessible within the framework of an efficient mental health system, in sufficient quantities, in the right dose forms, with guaranteed quality and sufficient information, and at a cost that both the community and the individual can pay.

The findings of this systematic review cite a lack of rehabilitation facilities within South African rural communities, which is a challenge for rural people to access proper mental health treatment. As per WHO's (2009) initiatives to better mental healthcare provision, governments need to ensure that communities consist of the appropriate facilities that can accommodate people with diverse mental distresses. As argued by WHO (2009), mental health patients sometimes need special treatment and thus need to be placed in mental health facilities that treat people with humanity and care.

In this study, it was discovered that the high cost of transport due to the long distances increases the burden for people from rural areas to access healthcare (Rooyen et al., 2019; Wegner & Rhoda, 2015). The reported results seem to agree with the results recorded by Kok et al. (2015). According to Kok et al. (2015), challenging geography and long distances to the health centre deprive people of the opportunity to see the doctor frequently.

Additionally, the findings revealed that some of the mental health patients in rural communities refuse mental health treatment because of the inhumane way in which mental health patients are treated in treatment facilities (Rooyen et al., 2019). At the microsystem level of the ecological systems theory, effective communication and empathy between the patient and caregivers is vital. In order to co-regulate the individual, caregivers and other members of the microsystem are crucial (Crawford, 2020). However, this vision is distorted by the treatment received by people with mental needs.

The current review established that social rejection and stigmatisation within society influence people to hide their mental health situations to avoid being isolated from social interactions with the rest of the community members (Bila & Carbonatto, 2022). These findings highlight the people's ignorance of mental health laws. According to WHO (2009), to address the particular vulnerabilities that people with mental disorders face, mental health legislation is crucial. In most communities, these individuals are stigmatized, subjected to discrimination, and marginalized; there is also a potential for human rights breaches. In response to this initiative proposal, SAMHP 2023-30 encouraged people to abide by the Mental Healthcare Act (2002), which removes discriminatory acts from service providers and the general public.

A lot of rural households live below the poverty level, thus cannot access mental health services regularly(Benjamin et al., 2021; Bila & Carbonatto, 2022; Strümpher et al., 2014; Talatala, 2015; Wegner & Rhoda, 2015). Once more, they lack access to more sophisticated medical care, which is a major barrier to the advancement of their mental health. These findings validate the assertions highlighted in the Social Determinants of Health framework, which highlighted that people in low-income countries/ economically disadvantaged countries tend to have minimal access to healthcare services than those in better-off countries or communities, and within such communities, people experiencing poverty tend to have less access to good health services (Leskošek, 2012; Peters et al., 2017).

Interestingly, the research revealed that the individuals involved stated that they were unaware of these services' availability under Western healthcare until being directed to the facility (Booysen et al., 2021). Thus, these results would be more appealing to Telfair and Shelton (2014), who argued that education improves individuals' knowledge, skills, reasoning, effectiveness, and a broad range of other abilities, which can be utilized to engage in healthy lifestyles. To add more, Zajacova and Lawrence (2018) posit that highly educated adults can use personal resources to protect their health while less educated people may remain vulnerable without any plan for health improvements. Therefore, it is obvious that the lack of knowledge concerning mental health treatment is consistent among some of the rural communities (Bila

& Carbonatto, 2022), thus depriving them of the chance to seek mental health support from professionals.

The results of this study also reveal data which has not previously been explicitly described in the literature. In this review, some of the people with mental health needs do not seek professional mental health services because they think people will consider them weak (Booysen et al., 2021; Moonsamy & Gurayah, 2024; Sibam, 2019). Others think they will be considered a burden to the family (Booysen et al., 2021). This self-doubt is reported in the Ecological Systems Theory, which purported that the way people process and express themselves in daily life influences their actions and decisions (Bronfenbrenner, 1994). Thus, the results of this research validated this assertion by finding that people from the rural areas decided to not seek mental healthcare services because they doubted themselves as weak people.

The findings of this research (Booysen et al., 2021; Rooyen et al., 2019; Talatala, 2015) cite that the South African system excludes or denies people with mental disorders basic human rights such as the right to education, and employment. As a result, people hide their emotional deficits because they fear it will deprive them of the chance to access other aspects of human life such as getting a job or being admitted to school. This drawback was highlighted by Barnay (2016) who found out that mentally unfit people return to work with health issues just to avoid the risk of losing their jobs. The findings of this research reveal that social and economic environments undermine the SAMHP 2023-2030 vision that "*the rights to equality, non-discrimination, dignity, respect, privacy, autonomy, information, and participation should be upheld in the provision of mental health care." p.13*

In this review, it was evident that among the factors that impede access to mental healthcare services, language played a pivotal role, especially in societies that consist of uneducated persons. This study found out that mental health services are offered in English language (Benjamin et al., 2021; Mindu et al., 2023; Moonsamy & Gurayah, 2024); which makes it difficult for those who cannot speak it to express their mental health needs to the professionals(Benjamin et al., 2021). Local languages are not often integrated within mental health service points (Mindu et al., 2023; Moonsamy & Gurayah, 2024). The emergence of these findings is quite novel. As a result, this study acknowledges the lack of literature on the positive influences of language in accessing mental healthcare services.

The reviewed studies highlight shortages of experienced mental health staff as a significant challenge within the facilities (Bila & Carbonatto, 2022; Jennings et al., 2020;

Talatala, 2015). There is about one psychologist in 4 towns. This results in people having to wait for many hours before accessing treatment. According to WHO (2009), serving the mental health needs of society requires people with esteemed knowledge of mental aspects. An important initiative is to produce a workforce that is capable of providing care in a way that aligns with the planning and human resources policy objectives. However, this remains undermined in South African rural communities.

Even though there are mental health grants available to people with mental health needs, people with a chronic mental illness who receive a disability grant from the state are expected to use this money to support the needs of the family (Sehoana & Laher, 2015). These findings are consistent with Peters et al. (2017). According to Peters et al. (2017), people who live in poverty cannot afford even basic human needs. Thus, they can divert money for their health to basic aspects such as food or clothing. Therefore, this deprives them of the chance of getting proper mental health medication and treatment.

6.3 THE ROLE OF CULTURE IN THE PERCEPTION OF MENTAL HEALTH DISTRESS IN DISADVANTAGED COMMUNITIES

The second aim of this study was to evaluate how cultural values and norms influence the perception of mental health distress within the rural communities of South Africa. Consequently, the reviewed studies highlighted that culture plays a vital role in shaping the perceptions of people on mental health issues (Bila & Carbonatto, 2022; Booysen et al., 2021; Mindu et al., 2023; Moonsamy & Gurayah, 2024; Sikrweqe et al., 2024).

For example, the results of this research revealed that other people consider traditional healers to be more capable of treating their mental distress than Western mental health professionals (Benjamin et al., 2021; Sibam, 2019; Sikrweqe et al., 2024). These findings are consistent with Ejike's (2017) findings, which revealed that mistrust in Western medicine encourages some of the traditionalists to prefer traditional healers rather than physicians to treat their sicknesses. According to Ejike (2017), they believe that the physician does not possess the knowledge or the understanding to treat the culture-bound syndromes.

Castillo et al. (2019) recorded the same findings. In their study, Castillo et al. (2019) found that interventions employed to assist individuals with mental health needs were embedded within cultural and traditional practices. Similarly, Buechner et al. (2023) and Pandey (2024) discovered that a lot of people in disadvantaged communities have a culture that encourages them to seek mental assistance and support from their traditional healers, spiritual

leaders, or community elders who use culturally related practices, traditional medicines and perform rituals that are aimed at improving the patient's mental disturbances.

When they experience mental health distress, they first seek help or confirmation from their traditional doctors before going to modern medical facilities (Sehoana & Laher, 2015). Twohe same results were recorded by Tukuitonga (2018). According to Tukuitonga (2018), some of the cultured people combined traditional methods with modern treatment methods. However, social norms and expectations may conflict with efforts aiming to achieve good health-related lifestyles (Tukuitonga, 2018).

It is in these traditional mental health treatment environments where patients are told that their mental distress is a result of witchcraft (Booysen et al., 2021; Corrigan et al., 2014; Sibam, 2019). People who require a diagnosis and appropriate medicine for mental health issues are discouraged by this perspective of mental diseases. These results are consistent with a study conducted by Rosen (2015), which found that some patients attribute their disease to fatalism, the devil, or a demon. They may even think they are unable to alter the course of events and refuse to accept a diagnosis from medical specialists. Rather, they are limited to accepting things as they are.

Lastly, other ways in which culture was found to influence mental health information-seeking behaviour include the belief that mental illness is regarded as a "white man's problem" (Moonsamy & Gurayah, 2024). The findings revealed that people in rural communities do not recognise anything called stress or depression. What is more, in traditional Zulu families, the eldest male is regarded as the family's decision-maker, leader, and provider (Moonsamy & Gurayah, 2024). Literature highlights that cultural background also influences how members of affected communities interpret mental health symptoms. For example, in certain cultures, excessive anxiety may not be seen as a mental health condition but rather as the result of spiritual issues or supernatural powers. According to Sarfo (2013), what might be socially recognized as a symptom of mental health distress, may be seen as a normal behaviour, or may be held in deep respect and devotion.

6.4 INTERVENTIONS EMPLOYED BY PEOPLE IN DISADVANTAGED COMMUNITIES WHEN THEY PRESENT WITH SYMPTOMS OF MENTAL DISTRESS

The present study intended to find the interventions employed by people in rural areas of South Africa when they present with symptoms of mental distress. Resultantly, it was found that some of the interventions are dominantly cultural. Relevant data cited in this study established that some communities, for example, Zulu rural communities, perform specific rituals which include cleansing such as “Ukuqaphula”; which involves making small incision cuts on the person’s skin, then putting herbal medicines on those cuts to ensure that person is never affected again (Moonsamy & Gurayah, 2024).

What is more, it was found that apart from the use of traditional healers to deal with mental distress, people from the rural areas of South Africa make use of modern religious interventions (Benjamin et al., 2021; Bila & Carbonatto, 2022; Booysen et al., 2021; Mindu et al., 2023; Sehoana & Laher, 2015; Sibam, 2019; Sikrweqe et al., 2024; Wegner & Rhoda, 2015). Others would pray to God, asking for God to help them get through their mental distress (Mindu et al., 2023; Moonsamy & Gurayah, 2024; Wegner & Rhoda, 2015). Duncan et al. (2021) suggest that a growing number of individuals seek mental health support from local community organizations, support groups, or religious institutions. The same sentiments were shared by Kelly and Lewis (2009) who asserted that under normal circumstances, these organizations often provide counselling, emotional support groups, and crisis intervention services to those in need.

The studies reviewed revealed that mental health patients also make attempts to speak to psychologists or therapists; who can provide perspective or understanding, as well as suggest how they can improve their well-being (Jennings et al., 2020; Mabunda et al., 2023; Moonsamy & Gurayah, 2024; Talatala, 2015).

Few studies found that people with mental disorientations sometimes go to the relevant facilities to treat their distress (Bila & Carbonatto, 2022; Mindu et al., 2023; Moonsamy & Gurayah, 2024; Rooyen et al., 2019; Sehoana & Laher, 2015; Wegner & Rhoda, 2015). The facilities appear to be a good diversion from their demanding or perhaps hazardous surroundings, and toxic thoughts such as suicidal attempts; in such facilities, they think more rationally. This provides opportunities for the South African government to expand such facilities across the nation to encourage increased enrolments so that people may be properly counselled.

It was also found out that in cases where there is no chance of being rehabilitated; people in South African disadvantaged communities use their prescriptions to buy some mental

health medication from the chemist until they can access proper treatment. In addition, some patients purchase medication from a private healthcare facility when the medical supplies in public health facilities get depleted (Mbokazi et al., 2023). While this may be an important invention to fill in the gaps of stock-runouts, it may exacerbate the economic situation within families that are not privileged.

The results reported by Mabunda et al. (2023) highlighted that mental health patients, especially school children, use non-mental health experts such as teachers to talk about their struggles. In the case where there is no psychologist or therapist or any type of counsellor, teachers are used to offer mental support. WHO (2009) highlights the importance of using informal caregivers such as traditional healers, teachers, police, and the services provided by nongovernmental organisations, user and family associations, and lay people. The fact that informal services are an essential component of society means that they are typically accepted and accessible.

The reported results established that rural communities, challenged by a lack of transportation routes and vehicles, rely on police cars to take their patients to the hospitals (Benjamin et al., 2021; Rooyen et al., 2019; Talatala, 2015). The consequence of relying on police officers to take care of mentally ill persons is that police officers are not experienced in handling mental patients in the event of an emergency. WHO (2009) warned that informal community care should not form the core of mental health service provision because countries would be ill-advised if they depended solely on these services.

The results showed that in order to increase access to mental health care, the Eastern Cape Department of Health made an investment in outreach programs by purchasing cars and mobile clinics (Strümpher et al., 2014). Whereof some mental health patients rely on these mobile mental health services even though they prove to be unreliable. For Filla et al. (2022), mobile health units are an important innovation within rural communities because they can provide home services, thus prove useful in taking care of elderly patients.

The review of the included studies (see Mbokazi et al., 2023; Moonsamy & Gurayah, 2024) revealed that some of the people in rural areas of South Africa rely heavily on support chains from family, neighbours, and community members. These support chains are initiated to share transportation to mental healthcare centres, and for security purposes in cases where patients have to walk to the health centres on foot and have to walk through unsafe roads(Mbokazi et al., 2023).

Quite a number of authors (including Al-Tamimi & Leavey, 2022; Duncan et al., 2021) highlight that people from disadvantaged communities are often organised into groups with volunteer specialisations to take care of each other. While others deal with water-related issues, and others deal with food insecurities, others are grouped to offer support on health-related matters. In acute situations, such people may contact secondary healthcare providers while simultaneously offering immediate help while awaiting the arrival of professional mental support (Alqarafi et al., 2022).

Amongst the interventions done in rural communities to address mental distress, the formation of mental health patients clubs seems to provide a significant contribution to minimising mental distress (Mbokazi et al., 2023). In such clubs, mental health patients talk amongst themselves; they believe that maybe the mental health support teams cannot understand or relate to their mental issues. Thus, these actions correspond with the ecological system theory's exosystem. Within the exosystem layer, Communities and social networks that the neurodivergent person interacts with, such as clubs, organisations, schools, and support groups, have the power to amplify or attenuate feelings and behaviours. Therefore, it is crucial for a person's mental healing that these settings be inclusive and sensory-friendly.

6.5 CHAPTER SUMMARY

In this chapter, the study findings were thoroughly discussed and matched with the research questions. The study's findings were discussed in terms of both convergence and divergence. Additionally, a comparative analysis with earlier studies on mental health treatment was conducted. To support or contradict the study's main claims, the gaps between the results and theoretical viewpoints—namely, Ecological Systems Theory, Social Determinants of Health, and the SAMHP 2023–2030—were analysed. The following chapter offers a thorough overview of the entire investigation, culminating with empirical discoveries and recommendations from the researcher. The next chapter will also examine potential avenues for future research.

7 CHAPTER SEVEN -SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

7.1 INTRODUCTION

The research findings were thoroughly discussed in the previous chapter, which also connected them to pertinent literature on mental healthcare access. The discussion also made connections between these results and the principles of the Social Determinants of Health and the Ecological Systems Theory. This section, which is the study's last chapter, summarizes the research in five different ways: it outlines the goals and purpose of the study, provides a summary of the findings, draws conclusions from the findings, offers recommendations based on the study, and suggests areas for future research.

7.2 AIM AND PURPOSE OF THE STUDY

The primary aim of this study was to identify barriers to mental healthcare access in disadvantaged communities in South Africa, specifically the rural communities, while simultaneously exploring the influence of cultural beliefs on mental health help-seeking behaviours. The study intended to uncover interventions employed by people in rural areas when they present with symptoms of mental distress.

Focusing on studies that were conducted on mental health access in rural-based South African communities, this study aimed to identify barriers to mental healthcare in disadvantaged South African rural communities and explore how cultural beliefs shape help-seeking behaviours. The research examined the scope of interventions employed by individuals in these communities when they experience mental distress.

7.3 SUMMARY OF THE STUDY FINDINGS

Certain obstacles to obtaining mental health information from mental health providers and facilities were identified by the quantitative analysis of the studies on mental health. The analysis of the research exposed cultural practices that prevent people from receiving suitable and proper mental healthcare, as well as the strategies people use to cope with mental illness. Thus, among the study's key findings, the following results were recorded:

7.3.1 Barriers to Seeking Mental Healthcare in Disadvantaged Communities

The data from the reviewed studies on mental healthcare highlighted the following barriers to mental health care access:

Figure 5 - Summary of reported barriers

Source: Author's own creation

7.3.2 Influence of culture on the perception of mental health distress in disadvantaged communities

The results of the reviewed studies illuminated several cultural factors that shape people's perceptions of mental distress. The majority of the participants, as reported by the reviewed studies, seem to think that the mental distress is a result of witchcraft or is influenced by angry ancestors. Thus, instead of going to professional facilities, people conduct traditional rituals with the help of traditional healers and community elders. Other ways in which culture shapes the perceptions of people include the finding that women and women in some South African cultures are expected to show emotional control; seeking mental health support is viewed as unnecessary.

7.3.3 Interventions employed by people in disadvantaged communities when they present with symptoms of mental distress

The studies also disclosed that people in South African rural communities seize several opportunities when they present with symptoms of mental distress. The reported interventions employed by mental health patients in rural communities include: (a) Use of traditional healers and churches (b) Speaking with a psychologist or therapist, (c) Going to a mental health facility (d) Use of police cars when there are emergencies (e) Relying on pharmacies for medicine (f) Staying with their families while properly using medicine (g) Using teachers to disclose their concerns (h) Reliance on mobile clinic (i) Building family and community support chains (j) Forming mental health patients clubs or support groups

7.4 CONCLUSIONS DRAWN FROM THE FINDINGS

Studies conducted in South African rural communities have revealed that individuals facing mental distress tend to seize several opportunities for intervention and support. These interventions are shaped by the unique socio-cultural and healthcare dynamics of rural areas, which blend traditional and modern approaches to mental health care.

One common intervention is the use of traditional healers and churches, which play a significant role in the lives of many rural inhabitants. Due to the cultural significance of these institutions, they are often the first point of contact for individuals experiencing mental health issues. In addition, speaking with a psychologist or therapist is another option that some individuals turn to, reflecting an awareness of modern mental health practices. However,

accessing professional psychological services may be more challenging in rural areas due to limited availability, so other forms of care often complement this approach.

Furthermore, going to a mental health facility is another strategy employed by some. While such facilities may not be as widespread in rural areas as in urban settings, they still provide critical care for those who manage to access them. In emergencies, many individuals rely on police cars to transport them to these health facilities, particularly when other means of transportation are unavailable.

For ongoing care, many rural residents turn to local pharmacies to obtain medication for their mental health conditions. These pharmacies become vital healthcare hubs where individuals can access both prescribed medications and advice. Additionally, some patients prefer to stay with their families while using medication, which not only helps them adhere to their treatment plans but also fosters a supportive environment crucial for their mental well-being.

Teachers also play a significant role in mental health interventions in rural communities. In some cases, individuals disclose their mental health concerns to teachers, who may then direct them to appropriate support services. Beyond this, mobile clinics provide a critical link to healthcare, especially in remote areas. These clinics bring services closer to the people, reducing the challenges associated with traveling long distances for medical care.

Moreover, individuals in rural communities actively work to build family and community support chains. These networks offer emotional, social, and sometimes financial assistance, which are invaluable in coping with mental health challenges. In addition to this, mental health patients' clubs or support groups have been formed in some areas. These groups serve as platforms for individuals to share their experiences, support one another, and collectively navigate the challenges posed by mental health issues.

7.4.1 What are the reported barriers to seeking mental healthcare in disadvantaged communities?

After a comprehensive analysis, it was concluded that certain aspects of the rural community hinder the quality of provision and access to mental healthcare services. Accordingly, it was concluded that the major impediments to seeking quality mental healthcare services in South African rural communities are low-income family finances, lack of mental health facilities (primary and secondary), stigmatisation and inhumane mental treatments with

health facilities, long distances to health facilities, language barriers, cultural beliefs, lack of human rights, and lack of knowledge about mental health issues.

7.4.2 What is the role of culture in the perception of mental health distress in disadvantaged communities?

The study confirmed that the majority of mental health patients are deeply cultured and do not always visit professional mental health facilities. Based on these findings, it was concluded that despite the influence of the reported barriers to seeking mental health care, cultural beliefs play a central role and shape how people perceive and access mental health services. That is, culture influences people's perception of mental health to a great extent.

7.4.3 What scopes of interventions do people in disadvantaged communities utilize when they present with symptoms of mental distress?

Based on the findings of this research, it was concluded that the variety of ways to help with mental health shows a full and all-inclusive method for dealing with mental health issues. By mixing traditional and Western ways, like seeing a therapist, getting instant help, community help, and taking medication, people can get different help that fits what they need. This strategy shows the need to use both usual and different ways to help people feel good and take care of their whole health.

7.5 RECOMMENDATIONS

Drawing from the findings of this systematic review, several recommendations emerge for improving mental health care in South Africa, particularly within rural communities. These recommendations address the need for a comprehensive approach to mental health that bridges gaps in access and integrates traditional and modern practices.

7.5.1 Call for community level interventions

Firstly, it is crucial for the Ministry of Health in South Africa to conduct a thorough needs analysis within communities, especially those in rural areas. This analysis will help identify the specific mental health disparities that exist within these regions. By understanding these barriers more clearly, the difficulties that individuals face can be more effectively addressed. Such an assessment will provide valuable insights into the unique challenges and needs of these communities, allowing for more targeted and effective interventions.

In addition, maintaining strategic collaboration between mental health facilities and community support organisations is essential. Community outreach programs can significantly

enhance access to healthcare and improve the treatment of mental health disorders. By working together, mental health facilities and community organisations can streamline resources, share knowledge, and ensure that individuals receive comprehensive care that is both accessible and culturally appropriate.

7.5.2 Collaboration between mental health experts and non-professional health staff

Moreover, it is recommended that mental health practitioners, parents, and churches prioritise collaboration with traditional healers. Integrating mental health experiences with traditional beliefs can be highly beneficial, given that many individuals in rural communities hold traditional practices in high regard. By acknowledging and incorporating traditional beliefs, mental health initiatives can gain greater acceptance and effectiveness within these communities. This approach respects cultural values and aligns mental health care with established cultural practices, thereby enhancing community engagement and support.

Finally, mental health professionals should organize workshops for teachers to boost their understanding of mental health issues and improve their counselling skills. Teachers are often the first point of contact for students experiencing mental distress, making their role crucial in early identification and support. By equipping teachers with enhanced knowledge and skills, they can provide more effective support to students, fostering a more supportive and informed school environment.

In summary, these recommendations highlight the importance of addressing mental health disparities through targeted needs assessments, collaborative efforts, integration of traditional and modern practices, and the enhancement of teacher capabilities. Implementing these strategies will contribute to a more inclusive and effective mental health care system in South Africa, ultimately benefiting individuals across both rural and urban communities.

7.5.3 LIMITATIONS AND AREAS FOR FURTHER RESEARCH

The results of this research revealed that the majority of mental health patients rely heavily on traditional healers or herbalists for mental support. Thus, qualitative research on the efficacy of traditional healing practices and how police officers or community leaders perceive their roles in supporting mental health is deemed necessary. This could enrich the discourse on how to integrate informal mental healthcare providers into the formal system.

What is more, this review experienced specific methodological limitations, such as the limited availability of studies in the majority of the South African rural areas. This might limit perspectives concerning mental health access behaviours within a broader context of disadvantaged South African communities.

Finally, the results of one region (rural areas) were the basis for this research's execution. The results of this research cannot be applied to other contexts; hence, the author suggests that other researchers conduct similar studies in a different context—such as metropolitan communities—to make comparisons to strengthen our understanding of the dynamics of mental health-seeking behaviours across South Africa.

7.5.4 CHAPTER SUMMARY

The complete study on mental health access in rural areas was summarized in this chapter. It provided recommendations for different stakeholders, indicated directions for further research, and summarized empirical data. The study's conclusions and insights add to our knowledge of how South Africans in rural areas seek mental health services. This review highlighted a number of barriers that need to be addressed as early as possible in order to provide improved mental health services and avoid mental health catastrophes in the near future.

As evidenced by the results of this review, the community and cultural influences seemed to play a pivotal role in shaping access abilities for improved mental health. This barrier influenced people to rely more on traditional mental health treatments than modern and/or professional treatments. The association between mental healthcare and access factors can provide useful information for prioritising early interventions.

As a result, there is a desperate need for integration of the traditional and modern mental healthcare practices in South African disadvantaged communities. This integration will contribute to better mental health outcomes as people are more likely to seek professional treatment once they feel their cultural practices are respected. To conclude this review, the chapter establishes the context for the following list of references that support the claims and arguments made in the research.

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Appendix A: Results of the data base search

Key words / Database	Mental health access barriers in South Africa	Mental health services in rural areas South Africa	Access to mental health care and help seeking behaviour in South Africa	Disadvantaged populations help seeking behaviour South Africa	Mental health help seeking behaviour in South Africa
Google scholar	18300/10	31000/			
Pubmed	138/12	42/10	15/4	0/0	34/`
Ebco-Host	973/19	1/1	494/		17/5
Web of science	218/13	31/4	12/3	0/0	0/0
Scopus	69/?	41/14	7/2	0/0	38/10
PRO Quest	1754/				

1. “Mental health access” and “mental health services” in South Africa

Google scholar	747/18				
Pubmed	434/23				
Ebco-Host	39/15				

Web of science	259/17				
Scopus	641/15				

2. “Mental health care disparities” and “ disadvantaged populations” and “ access to healthcare” in South Africa

Google scholar	18600/9				
Pubmed	0/0				
Ebco-Host	233/9				
Web of science	1/0				
Scopus	0/0				

3. “South African” AND “menta health” AND “mental health care” AND “barriers” AND “cultural perspectives” AND South Africa

Google scholar	261/				
Pubmed	0/0				
Ebco-Host	944/13				

Web of science	84/6				
Scopus	41/14				

4. “Barriers to mental health services” and “(rural areas OR disadvantaged communities)” and “help seeking behaviours” in South Africa

Google scholar	8120/4				
Pubmed	32/5				
Ebco-Host	235/				
Web of science	20/6				
Scopus	10/5				

5. “Mental health service utilization” and “help-seeking barriers” and “mental health support” in South Africa

Google .scholar	4850/7				
Pubmed	8/ 6				
Ebco-Host	61/0				
Web of science	2/0				
Scopus	2/1				
