PERCEPTIONS AND REFLECTIONS OF PRIMARY HEALTHCARE PROFESSIONALS ON MENTAL HEALTH SERVICES IN MAKHANDA

A mini thesis submitted in partial fulfilment of the

requirement for the degree of

MASTER'S DEGREE IN CLINICAL PSYCHOLOGY

of

RHODES UNIVERSITY

by

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October 2024

Abstract

Primary mental healthcare in South Africa is still in its early stages, despite policies that have been developed, such as the National Mental Health Framework Policy. Provinces such as the Eastern Cape are far behind development, which can be attributed to limited resources. The scarcity has been noted in the literature, but not extensively. Literature concentrated on healthcare professionals' perspectives towards primary health greatly narrow, particularly in the Makhanda area. With the integration of primary mental health services, healthcare workers' viewpoints have impacted on service delivery. This study aims to add knowledge and explore the perspectives of healthcare professionals on primary mental healthcare in Makhanda. The ecological systems theory was used as a theoretical framework for the study. Thematic analysis was used to examine the healthcare professionals' insights and to extract meaning for the participants involved in the study. Thirteen participants were used, using purposive sampling in four primary healthcare settings. Data were collected using semi-structured and one-on-one interviews. The study revealed three themes including, (i) Scarcity of Mental Health Services, (ii) Mental Health Literacy, (iii) Barriers to the Provision and Use of Physical and Mental Health Services. The findings suggest that there are limited mental health care services in primary care and that there is a gap between service provision and physical and mental healthcare. The data also revealed that mental health literacy is limited, which links to the stigma around mental illness. Furthermore, evidence points out that more mental health education, human resources and training of healthcare professionals would further improve the mental health services in the Makhanda area. In addition, there are barriers to the provision of not only primary mental health care but healthcare, as well as a lack of medical equipment, human resources, and structural space that make it difficult for healthcare professionals to perform their jobs and affect clinic functioning, at times. Another barrier is that the perception of mental health service provision is simultaneously viewed in a positive and negative light and mainly received negatively by service users. In conclusion, healthcare professionals experience a deficiency of resources and a limited provision of mental healthcare, which highlights the lack of implementation of policies that have developed nationally and globally.

Keywords: primary mental healthcare, healthcare professionals, Makhanda

Acknowledgements

To the participants in this study, your cooperation and willingness to share your insights has not gone unnoticed. Without your input, this project would have not existed. I thank you.

To Dr Duane Booysen, my supervisor, your guidance and support throughout this project are appreciated and valued.

To Zenande Mbuthuma, thank you for your constant reassurance and encouragement through this journey.

To my family, your continuous support and care has been an anchor. There are not enough words to describe how grateful I am.

DECLARATION

I, Zandisiwe Piliso, declare that 'Primary Health Professionals' Perceptions and Reflections on Mental Health Service Provision in Makhanda' is an original work of mine, and that all references used and mentioned have been cited properly, and that it has not been handed in for fulfilment toward any other degree at any other institution.

13 October 2024

Signature **Date:**

Zandisiwe Piliso

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List of Abbreviations

AFFIRM	Africa Focus on Intervention Research for Mental Health
CAP	Complementary and Alternative Care Providers
CHW	Community Health Workers
CMED	Community Mental Health Education and Detection Tool
DoH	Department of Health
EC	Eastern Cape
EMERALD	Emerging Mental Health Systems in Low- and Middle-income Countries
HIC	High-income Countries
HIV	Human Immunodeficiency Viruses
ICCCF	Innovative Care for Chronic Conditions Framework
KZN	Kwa-Zulu Natal
LMIC	Low-income and Middle-income countries
MHC	Mental Healthcare
MHCA	Mental Healthcare Act
MHCU	Mental Healthcare User
mhGAP	Mental Health Gap Action Programme
MhINT	Mental health INTegration Programme (MhINT)
MO	Medical Officers
NC	Northern Cape
NCD	Non-communicable diseases
NGO	Non-governmental organisations
NMHPF	National Mental Health Policy Framework
PACK	Practical Approach Care Kit

PHC	Primary Healthcare
PLHIV	People Living with HIV
PMHP	Perinatal Mental Health Project
PRIME	Programme for Improving Mental Healthcare
PRPHC	Public Rural Primary Healthcare
PTSD	Post-Traumatic Stress Disorder
RE-AIM	Reach, Effectiveness, Adoption, Implementation and Maintenance
RPERC	Research Proposals and Ethics Review Committee
RUESC	Rhodes University Ethical Standards Committee
SACAP	South African College of Applied Psychology
SAHRC	South African Human Rights Commission
SANMEP	South African National Mental Health Education Programme
SDG	Sustainable Development Goal
SM	Staff Member
TA	Thematic Analysis
TB	Tuberculosis
TCU-ORC	Texas Christian University Organisational Readiness for Change scale
TIDieR	Template for Intervention Description and Replication
WC	Western Cape
WHO	World Health Organisation
WP	Western Care Providers

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CHAPTER ONE

Introduction

1.1 Introduction

This study aims to explore primary health professionals' perceptions and reflections on the mental health service provision in Makhanda. This chapter summarises the background of the research problem and the rationale for the study. It also outlines the research aim, research question, and the objectives of the study. Lastly, a structural overview of the remaining five chapters will be presented.

1.2 Background to the Research Problem

Unmet mental health care needs are widespread throughout the world, but they are especially severe in low- and middle-income countries (LMICs) (Wang et al., 2007). LMICs are home to four out of every five persons with mental illnesses, including epilepsy, schizophrenia, depression, intellectual disabilities, alcohol use disorders and suicide attempts (Funk et al., 2012). The World Health Organisation (WHO) and others have calculated that treatment inequalities that have existed between affluent and poor nations are up 76-85% which have prompted WHO to establish the Mental Health Gap Action Programme (mhGAP) in 2002, in response to these claims (Shaw & Middleton, 2013).

According to Jack et al. (2014), South Africans have a higher likelihood of experiencing mental disorder in their lifetime, compared to other LMICs. The lack of mental healthcare has been considered a public health catastrophe and a violation of human rights (WHO, 2011). Furthermore, LMICs, such as South Africa, have long struggled with mental health service issues (Burns, 2011). Docrat et al. (2019) conducted a survey of mental health costs in South Africa across all provinces that indicated that only 5% of the health budget is used towards mental healthcare. Unfortunately, mental health care at the provincial and municipal level remains stagnant, plagued by long-standing difficulties, such as limited access to services, inadequate resources, and a lack of priority for mental healthcare, especially at provincial level (Lund et al., 2010; Booysen, Mahe-Poyo & Grant, 2021; SAHRC, 2019).

Moreover, professional nurses working at primary, secondary, and tertiary level healthcare facilities in the Eastern Cape (EC), reported that barriers to mental healthcare included poverty, a lack of leadership and support from stakeholders in the mental health

sector, as well as a lack of financial, human, and infrastructure resources (Strümpher et al., 2016). Healthcare professionals in the primary healthcare (PHC) setting show an understanding of the significance of attending to mental healthcare user's mental health needs; however, it is challenging to address their needs, due to the prioritisation of physical healthcare needs (Poghosyan et al., 2019). According to Poghosyan et al. (2019) this obstacle experienced by healthcare professionals has become a challenge because of insufficient time and a lack of human resources. It highlighted the importance of legislature to have extensive approaches towards the integration of mental health services in primary care settings.

Given the current status of mental health services in the Eastern Cape Province, a study conducted by Sukeri et al. (2014), indicated that after 1994, the Department of Health inherited a fractured mental healthcare system that has unequal distribution of services within the regions of EC. This was as a result of the laws that were developed in the Apartheid regime which were applied by mental health professionals in the provision of services, during that time. Human resources for the population of EC are severely lacking, with the lowest numbers for psychiatrists and child psychiatrists, stipulated by Docrat et al. (2019). The study also highlighted the severe lack of resources in the country and the significant pressure on the health budget (Docrat et al., 2019). In addition, it has been stipulated that urban areas in LMICs have concentrated mental health services, compared to non-affluent areas of the country (Mkhize & Molelekoa, 2008).

Saeidi and Wall (2018) made a case for mental health support at the primary care level, stipulating the benefits of providing a mental health service at a primary care level. Evidence showed that individuals with severe mental illness are mostly treated at the primary care level, which emphasises the importance of integrated mental health services at the primary care level (Saeidi & Wall, 2018). It further bridges the gap of service provision between health and mental health, by providing skills to health professionals to manage individuals with severe mental illness (Saeidi & Wall, 2018). This correlates with the task shifting approach proposed within the mental health framework, which also bridges the gap between health and mental health service provision. Within other LMICs, corroboration supports that task shifting as a successful strategy for mental health service provision (Petersen et al., 2011).

South Africa has issued the National Mental Health Policy Framework (NMHPF) for 2023 to 2030, descending from the NMHPF of 2013 to 2020. Both frameworks aim to provide

accessible mental health provision to the public at large, through PHC and collaboration with the community (NMHPF, 2023-2030; NMHPF, 2013-2020). The expenditure on mental health and the status of mental health services were provided by both plans. However, the new framework pointed out that the expense of not receiving mental health services is more than that of receiving them, thus highlighting the impact mental health illness has on the economy of the country (NMHPF, 2023). The two policies incorporate a holistic approach and encourage collaboration between sectors, as it is a fundamental part of the integration of mental health services in LMICs (NMHPF, 2023; NMHPF, 2013). Nevertheless, the recent policy calls for more funding and resource implementation (NMHPF, 2023).

The previous NMHPF (2013) focused attention on the insufficiency of research on mental health care services, which prompted more research to be conducted, which is essential in the current version of NMHPF. Studies conducted have made it possible for the current policy to have statistics on the country's human resources for the provision of mental health services. Given the extreme lack of execution that has been researched (NMHPF, 2023), the same research has enabled the current policy to have more specifics, such as covering a large range of mental illnesses, including neurodevelopmental disorders, suicidality and self-harm.

The new NMHPF outlines what must be done; however, it does not specify how to do it, which can present a challenge to implementation. For example, it has indicated that training needs to be given to the district and PHC settings (NMHP, 2023), but there are no specifics of who, what and where the implementation should occur. The current NMHPF includes a section on monitoring implementation, which can assist in identifying barriers to implementation; however, is likely to overstep how the framework will be applied. According to Stein et al. (2023), provinces are responsible for implementing the National Mental Health Policy Framework 2023-2030. Stein et al. (2023) added that strong policy frameworks need adequate money and strict execution, Regretfully, there is scant proof that the NMHPF of 2013-2020 resulted in increased financing implementation, or better mental health results.

It is imperative when considering the global effort to improve mental health, especially in LMICs such as South Africa, to explore and determine the challenges, barriers, services, and opportunities in low-resource settings, to create opportunities for further development. Therefore, the proposed study aims to explore the perceptions and reflections of health professionals on mental healthcare at the primary care level in the Eastern Cape.

1.3 Rationale of the Study

The perceptions of healthcare providers can influence service provision. Triliva et al. (2020) highlighted the importance of the perspective of healthcare professionals in the effectiveness of mental health service provision in PHC settings. Healthcare professionals in primary care settings are also the closest to individuals who have mental disorders within the community, thus emphasising the crucial role they have in mental health service provision within PHC settings (Triliva et al., 2020).

There has been significant research conducted on the integration of mental health service provision at the primary healthcare level; however, this has been mostly conducted in other countries. The present study explored the perception of mental health services in the primary healthcare setting in Makhanda, Eastern Cape. There is significant gap of knowledge regarding mental health service provision within this area, together with the fact that the province has the lowest statistics of mental health service provision, which can be attributed to the gap of knowledge in the NMHPF.

1.4 Research aim

The study aimed to explore and describe the perceptions of mental health service provision by primary healthcare professionals in Makhanda.

1.5 Research questions

- How do health professionals at the primary care level perceive the utility and relevance of mental health service provision at a community-based level?
- What are the facilitators and barriers to mental health service provision at the community-based level?

1.6 Research objectives

- To investigate the perception of healthcare professionals and to perceive the utility and relevance of mental health service provision at the community-based level.
- To determine the facilitators and barriers to mental health service provision at the community-based level.

1.7 Significance of the study

This study could assist in implementing service provision within Sarah Baartman district in the Eastern Cape. It could highlight the barriers that are being experienced by healthcare

professionals within the area, by exploring what healthcare professionals' need to provide adequate service. It will hopefully illuminate the relationship health professionals have with the community, as it is the key to services being accessed.

1.8 Definition of Terms

Community Mental Health Care: For this study, it refers to care that is provided outside of healthcare facilities and nearer to the places people reside , work and study (NMHPF 2023 -2030).

Healthcare Professionals: refers to primary care healthcare professionals , specifically nurses that renders health to mental healthcare users.

Mental Healthcare User: means a person receiving care and treatment from a primary healthcare facility to maintain or improve their mental health.

Primary Level Services: the first level of contact for individuals seeking healthcare (NMHPF, 2023-2030).

Task Shifting: the delivery of mental healthcare by non-specialist healthcare providers who are trained and supervised by specialist mental healthcare providers to do so (NMHPF 2023-2030).

Traditional Healing Practice: refers to the healing practises based on the culture and beliefs for treatment and improvement of mental disorder.

Western Health Care: refers to the system of predominantly biomedical, scientifically based healing practices (Campbell et al, 2010).

1.9 Structure of the Dissertation

This study consists of 6 chapters. Chapter 1 that introduces the study, rationale and aim of the study, will be followed by chapter 2 that identifies, reviews, and discusses the relevant literature to the study. Chapter 3 comprises the research design, research methodology used in the study, and further discusses the framework analysis used in the study to analyse the findings. Chapter 4 presents the findings of the study and chapter 5 discusses the findings. Finally, chapter 6 includes a summary of the main findings, the conclusion of the study and recommendations.

1.10 Scope of research

Owing to the limitations of resources and time, as well as the demanding requirements of a Master's dissertation, this investigation was limited in its scope. Therefore, the scope of this study focused on primary health professionals' perception and reflection on mental health

service in Makhanda. There are limited studies of the perceptions of health professionals within this area in the Eastern Cape because there is scarce research conducted in the province regarding mental health, generally.

1.10.1 Chapter summary

This chapter has briefly outlined the introduction to this study and provided the importance of conducting research on primary health professionals' perceptions and reflections on mental health service provision in Makhanda. The following chapter presents a review of the existing literature focusing on this research topic.

CHAPTER TWO

Literature Review

2.1 Introduction

This chapter begins with a brief explanation of the literature search technique that was used before providing an overview of the literature search, pertinent to this research problem. A brief discussion of the theoretical framework and its use in this study is covered in this chapter. Followed by the discussion of history of mental health services in South Africa. An outline of the current state of mental health services in LMIC's including the literature regarding South Africa follows with mental policies and the inclusion of various stakeholders. The chapter then discusses the integration of mental health services in primary healthcare settings. In addition, the review discusses barriers to integration and the utilisation of mental health services, as well as community mental health services and community intervention. The chapter ends with discussing the perspectives of primary healthcare workers concerning integrated mental health services.

2.2 Literature Search Strategy

To investigate the current body of research on the perceptions of healthcare professionals of mental health service provision in primary care settings in Makhanda, a literature search was carried out through multiple relevant databases to which Rhodes University subscribes. Despite the decision to concentrate on Makhanda for this research, wider literature from South Africa and other countries was consulted. The search technique was developed with this decision in mind. For publication about the perception of healthcare professionals towards mental health service provision in primary care settings, consisted of the following keywords: (i) perceptions; (ii) mental health services; (iii) low middle-income countries; (iv) primary healthcare professionals; (v) Eastern Cape, and (vi) South Africa. Following the creation of sets of synonyms and related phrases from these keywords, a thorough search was conducted. The search engines that were used were PubMed, SA Psychiatric Journal, Google Scholar, and Emerald Insight. The international literature studies that were reviewed started in 2014 and will continue through to 2024. For the local literature papers that were examined, they started from the year 2000 through to 2024.

2.3 Ecological Systems Theoretical Framework

The theoretical framework used in this study is the ecological systems theory that is informed by Bronfenbrenner developmental theory (Crawford, 2020). Bronfenbrenner's theory focuses on child

development and the various factors that influence development (Crawford, 2020). According to Eriksson et al. (2018) Brofenbrenner initially developed four levels that that were used to explain how these systems interact with each other, however, Bronfenbrenner continued to develop this theory up until his death (Eriksson et al., 2018). The theory is now applied it different areas, including health research where it is used from an ecological perspective (Eriksson et al., 2018). This ecological perspective is tailored to consider multiple levels of factors that are constantly interacting to affect health behaviour (Beyera et al., 2022). It integrates social and psychological factors and gives attention to environmental and policy perspectives on behaviour. Another use for ecological systems theory is to highlight the underpinnings of health behaviours and influence of the environment (Beyera et al., 2022). The theory has developed into various perspectives, the five different systems that Bronfenbrenner developed that explain how multiples level of factors in the environment impact development are still significant and explained below.

2.3.1 Microsystem. The first level involves the immediate environment of systems that have significant influence on the individual. It encompasses family members, friends and school an individual interacts with on a daily basis or in consistent contact (Crawford, 2020). The system is complex because the influence that is on a personal and social level, and is also symbolic (Crawford, 2020). The microsystem is fundamental because it provides a blueprint of the for the other systems that are part of an individual settings. It interacts between the other levels within the systems whether directly or indirectly (Crawford, 2020).

2.3.2 Mesosystem. It is the second level is which according to Crawford (2020) is the ecology of the microsystem. At this level the focus is on how the different systems in the microsystem interact with each whilst the individual is at the centre. Multiples layers are then created due to the interactions of these systems for example a parent interacting with a school teacher (McLaren & Hawe, 2005). These connections are deemed vital for the wellbeing of the child (McLaren & Hawe, 2005).

2.3.3 Exosystem. Refers to the interaction of different systems, however, the concentration is not solely on the individual, even if the interactions do affect an individual (McLaren & Hawe, 2005). An example would be a stressor at work that affects the parents mood at home thus impacting the child’s environment (Crawford, 2020).

2.3.4 Macrosystem involves the cultural and societal components that an individual is part of. The culture that a family is a part of is impacted by the microsystem, mesosystem and exosystem (Crawford, 2020). At this level, a pattern of the various links and networks between the systems in a setting is created. (McLaren & Hawe, 2005).

2.3.5 Chronosystem. The last level that was developed later by Bronfenbrenner as he did not account for time is an influencing construct in child development (Crawford, 2020). The development and changes that occur during the development of a child is likely influence the multiple systems and form a link between them (Crawford, 2020). For instance, the use of social media plays a role in the child's accesses information and their social interactions

2.3.6 Rationale for use of the framework

There are various influences on specific health behaviours, including elements at the intrapersonal, interpersonal, organizational, community, and public policy levels (Beyera et al., 2020). Influences on behaviours interact across these multiple levels and the most pertinent possible influences at each level should be identified by an ecological model that is behaviour-specific; and the most successful interventions for altering behaviour should be multi-level ones (Beyera et al., 2020). This study focuses on healthcare professionals that operate within primary care level, acting as first base contact for MHCUs. The study aims to look at the perspective health professionals towards mental health care provision because it is one of the elements that play a role in the provision of mental health services. The framework has guided the study into dissecting the different systems and interactions that occur influencing service delivery and ultimately impacting the MHCU. For instance, scholars have suggested, based on the ecological model, that the social context which might include family, friends, communities, and official and informal organizations like health institutions, considers the potential elements influencing health behaviour within a population, further (Beyera et al., 2020). The ecological model's primary advantage is its uniqueness in considering the several levels of determinants influence health behaviour, which increases the number of opportunities for suitable interventions (Beyera et al., 2022) which deemed the framework suitable for this study.

2.4 History of Mental Health Services

The development of mental health care has a remarkable past. Beginning in the eighteenth century in England, when the perceptions and attitudes to people with mental illness were superstitious, morally condemnatory, ignorance, and apathy (Jones, 2023), to laws and Acts that were developed and implemented in both high- and low-income developing countries. Previous perceptions and attitudes on mental health that were noted by Jones (2023) were considered harmful, since they revealed the methods used to treat those who were diagnosed with mental disorders. The goal of the laws that have been created and amended is to safeguard the human rights of people who utilise mental health services, which has a significant impact on people's perspectives and attitude to mental health treatment (Jones, 2023).

Historically, human rights atrocities were rampant in South Africa prior to the establishment of a new democratic regime in 1994 (Mkhize & Molelekoa, 2008; Sukeri et al., 2014). Since most people were not represented in the Apartheid parliament, they were not able to express their opinions in the institutions that made decisions that affected them (Mkhize & Molelekoa, 2008). Furthermore, the medical system was extremely disjointed, and healthcare services were not only centralised and divided, based on ethnicity, but also on geography, with most black people living in the homeland states and rural areas, which lacked sufficient resources (Mkhize & Molelekoa, 2008; Sukeri et al., 2014). Using science as a basis for treating black and white mental health care users (MHCU) differently, the legislation of that era permitted discriminatory treatment between the two groups (Sukeri et al., 2014). This history was detailed in a study by Sukeri et al. (2014) on historical perspectives of mental healthcare. The study also provided an overview of the development of mental healthcare within the Eastern Cape (EC) (Sukeri et al., 2024). To overcome the damaging divisions of the past and bring South Africa's health services in line with global trends, such as the Alma Ata Declaration and World Health Organisation (WHO) reports, the country launched a massive initiative to integrate health and other services after 1994 (Jacob, 2017; Mkhize & Molelekoa, 2008).

Compared to other countries, South Africa's mental health was deemed weak or non-existent, due to factors such as a lack of funding support from outside, stigma, and a lack of understanding (Omar et al., 2010). Instead, diseases, such as HIV were given priority and the allocation of funding varied across provinces, potentially creating disparities in access to mental health service and the problem of financial uncertainty (Omar et al., 2010). Despite its poverty, South Africa made significant efforts to provide services for disadvantaged and oppressed groups (Omar et al., 2010). It was recommended by Omar et al. (2010) that MHCUs, indigenous and spiritual leaders, donors and internal departments be consulted, as these groups of individuals are essential to the provision and use of mental health services. Incorporating cultural and linguistic diversity into the development of mental health policies and secure provision is also important, as it contributes to the consumption of mental health services (Omar et al., 2010).

2.5 Current State of Mental Health Services in Low- and Middle-Income Countries

Patel (2007) reviewed mental health care within low- and middle-income countries, which was previously not focused on globally, until reports of the Global Burden Disease, World Health Report 2001 was published, putting the spotlight on mental disorders. It was prevalent that LMICs have been burdened with mental disorders comorbid with health conditions (Patel,

2007). That is significant factor because countries are struggling to cope with the weight of diseases thus resulting in constrained treatment being provided to the population. Druss & Goldman highlighted the difference between health conditions and mental disorders which resulted in different systems that provide different resources respectively for each, posing challenges, i.e. gaps in access, affecting the integration of mental health service provision in primary health care (Druss & Goldman, 2018). This reflects current issues that LMICs are facing as research has shown that the resources provided for mental health services compared to individuals who need these services are out of proportion in LMICs (Funk et al., 2012; Patel, 2007). There is a substantial treatment discrepancy for individuals diagnosed with mental disorders i.e. schizophrenia because of poor access to mental health services in LMICs, according to Funk et al. (2012).

According to Patel (2007) within LMICs, some factors pose a risk to the development of healthy persons; mental disorders such as poverty, gender differences/gender roles, and trauma incidents. This has created a vicious cycle between the two different streams of health, with South Africa being no exception to the vicious cycle. As Mkhize and Molelekoa (2008) noted, the health of people with severe mental disorders and their families is affected by the lack of access to basic human resources in South Africa, such as power and water. Mkhize and Molelekoa (2008) further mentioned that the social issues that contribute to the cycle of poverty and mental health include unemployment, homelessness, and the fact that households' only source of income are social grants.

Pillay (2019), in his paper discusses the state of mental health and illness in South Africa, including a report by the South African Human Rights Commission (SAHRC) and information from the South African College of Applied Psychology (SACAP). The paper reports the alarming condition of mental healthcare. These conditions are not unique to South Africa and globally there has been neglect towards mental illness; not only has mental health been neglected but it is also not considered a priority (Pillay, 2019). Research in South Africa has shown that structural issues, social issues, inadequate funding, and poor implementation have been associated with poor mental health. The paper also mentions the Department of Health's (DoH) development of the Mental Health Care Act (MHCA) and the National Mental Health Policy Framework and Strategic Plan of 2013-2020 (Pillay, 2019). Moreover, the study highlighted that the DoH had spent only 4.6% on mental health services and there have been issues with implementing the policy and the Act (Pillay, 2019).

A study by Jacob and Coetzee (2018) revealed how common mental health issues are in the

Western Cape (WC). Since there has not been much in-depth study done in this field, the frequency of illness across various populations and risk variables has been determined, using currently available data (Jacob & Coetzee, 2018). In adults, the prevalence of common mental health conditions was 16.5%. A few examples of mental health interventions occurring in WC are the Perinatal Mental Health Project (PMHP); the Practical Approach Care Kit (PACK); the Programme for Improving Mental Health Care (PRIME); Emerging Mental Health Systems in Low- and Middle-income Countries (EMERALD); Africa Focus on Intervention Research for Mental Health (AFFIRM) project, and project (MIND) (Jacob & Coetzee, 2018).

The Gauteng DoH decided to improve district mental health after the Life Esidimeni tragedy as a preventive measure against that catastrophe happening again (Robertson et al., 2021). The establishment of district expert teams, compliance teams, non-governmental organisations (NGOs) and clinical community psychiatrist teams was necessary (Robertson et al., 2021). These teams work with underfunded human resources and the budget gap for this strategy is even more pronounced (Roberston et al., 2021). A lack of funding and human resources is probably a barrier to improving mental health services (Robertson et al., 2021).

Without question, the COVID-19 pandemic impacted the entire world and raised concerns about how it might affect mental health and the provision of services. Stepanova et al. (2024) conducted a rapid review in High-income Countries (HIC) to demonstrate how these modifications were implemented and adapted by HIC. According to Stepanova et al. (2024), the pandemic made gaps in mental healthcare worse. It was difficult for mental health services to adjust their offerings to telehealth, but the benefits of telehealth adaptation included longer service delivery hours but in certain cases, confidentiality and privacy were compromised (Stepanova et al., 2024). In addition, this restricted access for those without the resources and instruments necessary to use telehealth were disadvantaged (Stepanova et al., 2024).

Peer support is an integral component of mental health services that is acknowledged on a global scale (Krumm et al., 2022). According to Shalaby and Agyapong (2022), peer support is defined as assistance provided by individuals with mental illness to another. In contrast to HICs, peer support resources are scarce in LMICs (Krumm et al., 2022). Even though it has been perceived to improve treatment adherence and close the treatment gap, there is still a lack of implementation (Krumm et al., 2022).

The EC is perceived as a low resource province in the country and mostly rural in character. Sukeri et al. (2015) provide details of the needed requirements for the fulfilment of MH services in the Eastern Cape. Emphasised was the shortage of staff and beds for mental health

care users, within several districts in the province. This meant that the provision of services was not adequate to reach the estimated target within the region, therefore limiting any transformation of the mental health services (Sukeri et al., 2015). In addition, the number of psychologists is fewer than the necessary requirement for the provision of mental health services. There remains outdated and unsuitable mental institutions in the EC province (Sukeri et al., 2014).

2.5.1 Mental Health Policies and Involvement of Various Stakeholders in South Africa

Following the release of the National Mental Health Policy Framework of 2023 to 2030, Shisana et al. (2024) authored a study underlining mental health care's (MHC) value about general healthcare. The Stress and Health survey yielded statistics on the prevalence of anxiety, mood, and substance use disorder, despite the paucity of national data regarding the prevalence of mental illnesses (Shisana et al., 2024). There have been reports of potential, depressive symptoms among the population of retired people; those over 65 years, widowed, divorced, separated, or residing in a metropolitan region in the provinces of the Northern Cape (NC), EC, WC, Gauteng and Mpumalanga. Furthermore, violent exposure is common is South Africa, which might lead to Post-Traumatic Stress Disorder (PTSD) (Shisana et al., 2024). Furthermore, the data on the impact of COVID-19 on South Africans are still scarce, but its impact is still of concern (Shisana et al., 2024).

The MHCA of 2002 and the NHMPF of 2023 to 2030 are two examples of mental health policies that have been designed to provide guidance and mental health services (Shisana et al., 2024). For example, the MHCA created a system for both voluntary and involuntary admissions, protected the rights of MHCUs, and implemented programmes for substance abuse (Sukeri et al., 2014; Shisana et al., 2024). The NHMPF of 2023 – 2030 acknowledges the necessity of raising funds, expanding mental health services, promoting mental health, and advocating special populations' human rights (Shisana et al., 2024). Owing to severe problems with funding, institutions that provide mental healthcare, and the appropriate human resources, are few.

A paper on improving the governance of mental health systems in six LMICs in Asia and Africa was written by Petersen et al. (2017). The discovery that inadequate governance impedes the successful integration of mental health services in LMICs served as the foundation for the present study (Petersen et al., 2017). The six countries under question were Ethiopia, India, Nepal, Nigeria, and South Africa (Petersen et al., 2017). The largest obstacle to effective

government in these nations was found to be insufficient funding (Petersen, et al., 2017). Developing practical mechanisms for inter-sectoral collaboration, as well as community and service-user engagement; improving significant elements important to health system fundamentals to promote responsiveness, efficiency; and effectiveness and developing creative approaches to improving mental health literacy and stigma reduction, were among the key strategies identified (Petersen et al., 2017). The fact that South Africa was one of the countries investigated in the study indicated that these strategies could also be implemented here, which would be very beneficial.

Janse van Rensburg et al. (2018) wrote a paper that paints a realistic picture of the dynamics of local mental health service governance, and in a South African setting, which makes it significant. Notably, the intricacies and various dimensions of the power dynamics supporting efforts at integrated mental health care are highlighted (Janse van Rensburg et al., 2018).

Stakeholder participation in the global implementation of mental health policies is severely lacking. Murphy et al. (2021) conducted research which examined the obstacles to stakeholder participation, including those brought about by underfunded, weak health systems where competing agendas exist. One of the obstacles was that the partnerships lacked a common vision (Murphy et al., 2021). Engagement, adoption, and empowerment are hindered, with stigma also associated with mental health as a barrier (Murphy et al., 2021).

Freeman (2022) outlined the case for mental health investments in LMICs. Investment advantages, mental health knowledge and the subject matter of the social determinants of health should all be considered. Having a well-defined allocation vision is crucial for offering compelling justification for investments in mental health (Freeman, 2022).

Consultation with service users is given low priority in the development and implementation of mental health policies (Marias et al., 2020). According to a study conducted by Abayneh et al. (2017) in a rural African setting in Ethiopia, service user involvement is crucial to the improvement of mental health systems. It empowers people by increasing their understanding of mental illness and the suitability and quality of treatments.

2.5.2 Western Mental Healthcare Practice and Traditional, Religious Healing Practice

Collaboration between western mental healthcare practice and traditional healing practice has been called on particularly in LMICs. This is a result of individuals consulting traditional healers when experiencing symptoms of mental illness. This consultation often has a positive

effect of social support and explaining their illness in a traditional model of the reason behind it, e.g. witchcraft or not performing a ceremony (Campbell-Hall et al., 2010). Though this collaboration has been requested, there has not been clear instruction of how to conduct this collaboration (Campbell-Hall et al., 2010). Research within South Africa, particularly KZN on ways to conduct this collaboration, which highlighted that traditional healers are open to working with western practitioners, compared to western practitioners, who indicate that traditional healers should be trained to adopt a biomedical approach to their treatment (Campbell-Hall et al., 2010). A power dynamic between healers can be a possible barrier to collaboration (Campbell-Hall et al., 2010). In addition, there are more traditional healers than mental health care professionals which indicates the possibility of collaboration bridging the mental health treatment lacuna (Campbell-Hall et al., 2010).

A case study in Uganda by Shaw and Middleton (2013) highlighted the contrast between the traditional and biomedical approach in the treatment of mental disorders, which affects the provision and access to services. Traditional/religious beliefs play an important role in LMICs. Most importantly, it should be noted how international conventions and projects towards mental health service provision in LMICs are mostly based on Western culture and based on the assumption that their approach can be adapted to LMICs that mostly, do not operate from a Western perspective (Mugisha et al., 2017). Many academics have argued that a bid to effectively treat South African's mental health collaborations between Western care providers (WPs), such as psychologists and psychiatrists, and complementary and alternative care providers (CAPs), should be implemented (Zelda, 2023). Traditional healers, such as herbalists, diviners, plus faith healers (*umthandazeli*) within the Xhosa culture, along with additional spiritual healers, for instance Muslim and/or Christian practitioners of healing, are included in CAPs (Zelda, 2023).

Within the Cacadu District in the Eastern Cape, researchers (Tilolo et al., 2015) asserted that though Western medicine is accepted as a treatment for mental illness, the native people of the area see mental illness as having a spiritual foundation. A world mental health survey indicated the important role religious leaders play in mental healthcare (Kovess-Masfety et al., 2017).

The primary issue resulting from mental illness, according to relatives in mental health units, is the financial strain (Tilolo et al., 2015). Furthermore, the families are unsure about the process used for admissions, not realising that the mentally ill individual, can land in a psychiatric facility when they call in law enforcement (Tilolo et al., 2015). Traditional healers

and mental healthcare personnel should work together for them to be more helpful than critical (Tilolo et al., 2015). When providing comprehensive health services at the primary healthcare level, the Eastern Cape government memo from 1999 specified that a holistic approach be used. This was stipulated in the Department of Health's memorandum (Nontobeko & Tshotsho, 2015).

2.6 Integration of Mental Health Services in Primary Health Care

The initial point of contact between a person and the health system occurs in a PHC Setting (Wakida et al., 2019). It is intended that PHC systems provide care at the district level and mental healthcare users should have access to an integrated healthcare system at the level closest to them, for all their requirements (Mkhize & Molelekoa, 2008). It was recommended that the mental health service be delivered in all-inclusive, universal, egalitarian, and reasonably priced healthcare, which may lessen the stigma, particularly considering that the strategy included community and family involvement as essential components (Mkhize & Molelekoa, 2008). An increase in care accessibility, lessens the prevalence of chronic mental illness, and enhances social integration (Wakida et al., 2018)

According to Petersen et al. (2019) a global movement is underway to increase the availability of mental healthcare services by expanding integrated mental health into PHC systems in LMICs. However, it is more difficult to scale up integrated mental healthcare in PHC in LMICs, than it is to train general healthcare practitioners (Petersen et al., 2019). It is crucial to fortify the foundational elements of the healthcare system and make use of current procedures that complement chronic care services, to create a more conducive environment for integration (Petersen et al., 2019).

According to the WHO model of optimal mental health integration, countries should develop or redesign their mental health services to encourage self-care; create community mental health services; create unofficial community care services; expand mental health services in general hospitals and reduce dependency on psychiatric hospitals (Wakida et al., 2019). Although in several countries the recommendation by WHO to integrate mental into primary care has been adopted, in the majority of countries that have the least resources, it has not been recognised (Wakida et al., 2019). One of the main reasons that has made integration of mental healthcare in primary care unsuccessful in LMICs is the systematic destitution status of primary care (Jacob, 2017).

2.6.1 Integration of Primary Health Care in South Africa

Research regarding the implementation of integrated mental health services has been widely conducted, this research is mostly in HIC, thus limiting its adaptability to LMICs. Notably in SA, the implementation of integration was biomedically orientated, which means that PHC settings mostly depended on psychiatry health personnel, such as a psychiatric nurse for the management of MHCUs with severe mental disorders, such as schizophrenia (Mkhize & Molelekoa, 2008). Therefore, PHC health care personnel would focus on physical screening, which cannot detect mental disorders, such as anxiety or depression (Mkhize & Molelekoa, 2008). This led to the proposition of training the staff to increase their competence in screening mental health disorders and therefore, be able to manage common mental disorders at community level (Mkhize & Molelekoa, 2008). In addition, these changes within the health system can result in resistance from health professionals and be perceived as threatening (Brooke-Summer et al., 2018; Schneider et al., 2016). This begs the question whether a facility is ready to implement change, such as the Texas Christian University Organisational Readiness for Change (TCU- ORC) scale that was explored by Brooke- Summer et al. (2018).

Cornick et al. (2018) developed PACK guideline over an 18-year period which can be used to guide and train primary care workers in LMICs. The guideline is for primary care workers, as well as MHCUs as it is also used for children, adolescents and adults, thus widening its accessibility for use. For instance, Maconick et al. (2018) used the PACK for a training programme in the Eden district in the WC. The purpose of the PACK guideline is to enable primary care workers to provide quality, effective, efficient health services, including mental health (Cornick et al., 2018). Through the manual, the primary care worker is guided on how to approach a healthcare user, thus improving services and the confidence of primary care workers (Cornick et al., 2018) . The guideline is updated annually, therefore suggesting it is an ongoing process, until it reaches its full development of integration across different populations, ages, primary care levels and various diseases (Cornick et al., 2018).

Research on training programmes is limited; however, there are a few that have been conducted. A study by Maconick et al. (2018) conducted in-service training for primary care workers in the rural area of the Eden district, in the WC Province. This research site had a mental health care nurse and psychiatrist who were providing training to the 15 primary care workers who were participants (Maconick et al., 2018). At the beginning of the training, the primary care workers filled in a questionnaire, which indicated that they had little confidence in working with MHCUs (Maconick et al., 2018). This perception in primary care workers is common, as previously in South Africa, mental healthcare and healthcare were separated. After the primary care workers had completed training, their confidence levels increased (Maconick

et al., 2018). Prior to these interventions, screening was rarely performed before referrals to the mental health care nurse, but this changed after the training (Maconick et al., 2018). The training increased the number of referrals and screening prior to referral. The limitations of this study are that there was no control group; there was a limited number of participants; there was no feedback from MHCUs, and the assessment was short term (Maconick et al., 2018). This suggests that more trainings should be initiated to improve the integration and provision of mental health care services. Moreover, mental health education was provided to staff members, such as nursing assistants, receptionists, and general assistants to reduce the stigma towards mental illness. Although it was not part of the aim of the research, it served as an essential aspect of the integration of mental health services (Maconick et al., 2018).

Integrating mental health services is the current goal of effective service provision. Marais and Peterson (2015) indicated that strengthening the current health system is also important. Their study focused on the North West province, the Dr Kenneth Kaunda district and included national and provincial participants (Marais & Petersen, 2015). The participants were also essential stakeholders in the Department of Health and Department of Social Development (Marais & Petersen, 2015). The study not only provided strategies for improving integrated mental health care but provided information on a particular district within the country lacking such services (Marais & Petersen, 2015). This lack of information was a barrier to implementation as those responsible for implementation had no direction on how to go about integrating mental healthcare in primary care services (Marais & Petersen, 2015).

In the Kwa-Zulu Natal (KZN) province there have been studies conducted regarding the integration of mental health services. For instance, a study was conducted on the practice framework of assisting in the implementation of integrated mental healthcare, as well as another study on the challenges experienced on implementing the policy of integrated mental healthcare (Hlongwa & Sibiya, 2019a; Hlongwa & Sibiya, 2019b). Both these studies were important in providing information on the path to integration South Africa is pursuing. This said, considering the few studies conducted regarding mental healthcare integration into the PHC, shows its slow progression.

Rall and Swartz (2023) investigated the integration of mental health in primary healthcare in the EC and their findings were contrary to a positive outcome that had been advocated for the integration of mental health in PHC. Both the provision of treatment and the people receiving it are challenged by the inclusion of mental health services into standard primary healthcare, due to a lack of resources, such as staff and time (Rall & Swartz, 2023).

Hanlon et al. (2014) indicated that though there are challenges experienced in LMICs, there are opportunities for improved mental healthcare, by highlighting the integration of mental health disorders and non-communicable diseases (NCDs). This shows that the implementation of the integration of mental healthcare is not seen as a project that will be developed entirely on its own but rather, shows using existing resources in scarce resource contexts (Hanlon et al., 2014). Unfortunately, LMICS experience significant barriers against implementation, thus hindering the process of closing the mental health treatment gap (Hanlon et al., 2014).

A case study by Petersen et al. (2011), focusing on integrating mental health in primary healthcare, stipulated how a common framework can assist with integration. This framework included the reorientation of district management towards the integrated primary, mental healthcare establishment of community collaborative multi-sectoral forums, task shifting which entails establishing an expert consultancy liaison mental health team, and the training of general PHC staff and community health workers. The equivalent would be in identification, management and referral of mental disorders, and the promotion of self-help groups at community level (Petersen et al., 2011).

A valid and trustworthy database on the frequency of prevalent mental diseases in the community is necessary for the successful integration of mental health care into the PHC system (Mkhize & Molelekoa, 2008). Planning for mental health interventions is challenging, because there is a dearth of solid and trustworthy epidemiological data on a variety of mental diseases in many African nations, including South Africa (Mkhize & Molelekoa, 2008). Researchers generally agree that there is a general dearth of sufficient data on service provision, including statistics on the diagnosis and other characteristics of MHCUs (Mkhize & Molelekoa, 2008). Furthermore, there is a deficiency of epidemiological information on populations and issues. Thus, to determine their cost and effectiveness, evidence-based intervention models tailored to specific populations should be created and tested (Mkhize & Molelekoa, 2008).

Information systems regarding mental health services are useful, but they also come with many disadvantages. These consist of insufficient data gathering; subpar data quality; delayed reporting and critiques, and a limited use of information (Lora et al., 2017). Corrective action is needed to improve the quantity and quality of the data collected at outpatient clinics, establishing clear policies and procedures, securing adequate information on technology equipment, and training medical staff in data gathering (Lora et al., 2017). Information is essential for shifting the focus from collective administrative data to analysing, disseminating, and utilising information by relevant stakeholders, to further erode the culture of intuitive and

basic tradition (Lora et al., 2017).

2.6.2 Integration of Mental Healthcare and Non-Communicable Diseases

Evidence of mental health disorders occurring at the same time with NCD has been reported by Stein et al. (2019). For example, eating disorders, such as bulimia nervosa and anorexia nervosa are associated with the onset of diabetes, or anxiety disorders being linked to cancer (Stein et al., 2019). Both physical and health conditions have similar risk factors: lack of exercise, substance abuse, and an unhealthy diet (Stein et al., 2019). The burden of chronic physical illness and mental illness has an effect on social and economic development, especially in LMICs (Thornicroft et al., 2019). Though mental health conditions impair general functioning in a far greater way, they are less treated globally, compared to physical ailments (Stein et al., 2019). This burden is one the reasons why the integration of both the physical and mental conditions is deemed as essential (Thornicroft et al., 2019). A model provided by WHO is the Innovative Care for Chronic Conditions Framework (ICCCF), which has 8 steps aimed to assist health systems in integrating mental care (Thornicroft et al., 2019). This model has been implemented in HIC and the lessons learnt from HIC cannot be easily translated into LMIC, given that there is a question of preparedness from the health professionals and community mental health (Thornicroft et al., 2019).

The most researched field is the integration of mental healthcare with the Human Immunodeficiency Virus (HIV) or Tuberculosis (TB). A study by Conteh et al. (2023) which reviewed integrating mental healthcare with HIV, had positive findings. The findings suggested that when people living with HIV (PLHIV) were provided with cognitive behavioural treatment in settings that implemented integrated care, there was a decrease in sadness; alcohol use; greater social functioning; a decrease in self-reported stigma; decreased mental symptoms, and improved mood (Conteh et al., 2023). Healthcare professionals reported feeling more at ease discussing mental illness, while offering integrated mental health services to those living with HIV. Since HIV and mental healthcare are now linked, mental health professionals have observed a reduced stigma and an increase in referral for PLHIV for mental health services (Conteh et al., 2023). A systematic review was done by Chuah et al. (2017) on various interventions for the integration of mental health services with HIV and concluded that there is limited research on the collaboration between HIV and mental health services.

Sweetland et al. (2019) research examined the readiness of the national programme directors of TB to incorporate mental health services with TB treatment. The investigation covered 26 countries of varying income levels and there was a high degree of receptivity to integration

(Sweetland et al., 2019). Nevertheless, no country has included mental health services in its TB guidelines. Integration may be hampered by several factors, including a lack of resources, TB's societal stigma, and the perception that mental health issues are unrelated to physical health issues (Sweetland et al., 2019).

When mental health is prioritised, it can enable service provision that is adequate and affective, which is the case in Brazil, from a study conducted by Jenkins and Goldraich (2017)**.** The transformation of a rural clinic and the lessons of integration in Brazil, can possibly be transferred and utilised in the South African context because according to Jenkins and Goldraich (2017), both countries have similar backgrounds.

2.6.3 Barriers to Integration of Mental Health Provision

A thorough assessment of the barriers and facilitators of mental health programmes in primary care in LMICS was carried out by Esponda et al. (2020). This review included works published between 2017 and 1990 that employed a qualitative methodology; however, only 24 publications were found to fit the study's inclusion criteria (Esponda et al., 2020). Since the publications covered nine programmes across eleven countries, this suggested that there was little proof of mental health programmes being implemented in LMICs (Esponda et al., 2020). South Africa was one of the countries that had these programmes which can be considered as progression; however, the progression can be described as limited, due to scarce research done on the implementation programmes regarding mental health education (Esponda et al., 2020).

Sarikhani et al. (2021) conducted a study that reviewed papers that researched barriers in the provision of mental health services, namely resource administrative barriers, policy, and legislation barriers, as well as utilisation barriers, such as attitudinal barriers, structural barriers, and knowledge barriers. This analysis demonstrated that a significant issue facing health systems in many LMICs, is a lack of resources for mental health treatment (Sarikhani et al., 2021). Poor stewardship, low priority for mental health, and the state of the economy, all contribute to resource limitations in mental health (Sarikhani et al., 2021). In addition, inadequate funding, a shortage of professionals, especially at primary level, a lack of medications and a lack of service delivery facilities are some examples of the insufficiency of resources for providing mental health services (Sarikhani et al., 2021). The essential element in the delivery of mental health treatments is human resources and a shortage of human resources can occur at both primary and specialised levels (Sarikhani et al., 2021). The primary focus of mental healthcare delivery is non-specialist staff at PHC level (Sarikhani et al., 2021).

The biggest obstacle to providing equitable mental healthcare in many LMICs, according to the Sarikhani et al. (2021) review, is the concentration of mental healthcare facilities in metropolitan areas and the absence of integrated mental health services. Added to these is the lack of proper infrastructure, a shortage of mental health professionals, and a lack of relevant initiatives. These are the primary obstacles to integrating mental health services into primary care (Sarikhani et al., 2021).

According to the research conducted by Sarikhani et al. (2021), the fear of social stigma remains the primary barrier to the use of mental health care in LMICs, as it does in many other nations. Another significant mental healthcare utilisation obstacle is self-stigma, which is associated with unfavourable internalised views and attitudes about one's mental health state (Sarikhani et al., 2021). Shame may arise from this emotion, which lowers one's willingness to seek mental health assistance (Sarikhani et al., 2021). Since patients' negative personal attitudes about mental health are the primary source of this issue, education can help (Sarikhani et al., 2021).

One of the reasons mental healthcare services are not used, is the lack of mental health literacy. According to Atilola (2016), there is an urgent need to raise public understanding of mainstream psychiatry's viewpoints on mental health care in sub-Saharan Africa. Any attempt to achieve this, though, must take a thoroughly researched approach, considering both the biological and culturally complex explanatory models (Atilola, 2016). Other inclusive strategies include working with prospective partners, particularly the media and young people, and attempting to eliminate any further structural obstacles that prevent people in the area from learning about and using conventional mental health services (Atilola, 2016).

An additional barrier to the usage of mental health treatments in LMICs is mental health-care users' concern about the value and calibre of care; therefore, unfavourable treatment experiences may cause mental health care users to question the efficacy of the services they get (Sarikhani et al., 2021). Furthermore, mental health care users' tendency towards alternate methods of treatment, may persuade them to become negative about the specialist services (Sarikhani et al., 2021). The usage of mental health treatments in developing countries is MHCU's concerns about the value and calibre of care.

The use of mental health services in LMICs is the apprehension about the adverse perception and practices of mental health providers, which is another obstacle identified by Sarikhani et al. (2021). MHCU's motivation to use services that are offered, may be significantly impacted by a negative experience they had experienced with healthcare practitioners (Sarikhani et al.,

2021). Among the most significant reasons for professionals' negative perception and behaviour towards mental healthcare users is inadequate training, a failure to match scientific knowledge with cultural customs, and a fear of dealing with mental healthcare user's disorders (Sarikhani et al., 2021).

The most common structural barrier to the use of accessible services in LMICs is the high cost of mental health services (Sarikhani et al., 2019). The costs associated with treatment services and pharmaceuticals are the greatest. The location of mental healthcare facilities and transportation problems rank among the most common structural obstacles to treatment utilisation in developing nations (Sarikhani et al., 2021). Equal access to mental healthcare in low- and middle-income countries is significantly harmed by geographic distance from mental health facilities, particularly in rural areas (Jacob, 2017). Restricted access to mental health services is linked, not only to the restricted capacity for transportation, but also to the expense of transportation as a supplementary expense of care (Sarikhani et al., 2021). Lowering these obstacles in LMICs may involve building more community-based facilities and integrating mental health treatments into primary healthcare.

One of the primary structural obstacles to mental health service access is time related. Some patients may decide to discontinue their treatments, due to lengthy waiting periods at hospitals and outpatient clinics (Jack-Ide & Uys, 2013). Problems with employees and housekeepers taking time from work or attending to their personal obligations are another difficulty (Sarikhani et al. (2021) The length of time it can take to get transportation in time to travel to the clinic is yet another tome-related barrier that prevents people from using mental health services. A major barrier to the use of mental health treatments in many LMICs is patients' and their families' inadequate knowledge of mental health issues (Sarikhani et al., 2021). Understanding the issue is a necessary first step toward requesting assistance and, subsequently, making use of mental health services (Sarikhani et al., 2021).

2.6.4 Community Mental Health Services

According to Mkhize and Molelekoa (2008), an essential component of the Alma Ata Declaration is community engagement, which is supported by the WHO report of 2001. Collaboration at community level refers to educating and involving community members, including laypeople, to support mental health promotion, screening, and self-help group facilitation within a PHC environment (Zelda, 2023). This kind of cooperation is frequently referred to as task-sharing or task-shifting, in which non-specialists deliver MHC to increase access in areas with limited resources. This lessens the workload of PHC workers, facilitates

community empowerment, and promotes culturally congruent care by attempting to overcome racial, class and language barriers (Zelda, 2023). As per the White Paper, there are several ways to encourage community involvement. These include organising mental health forums in the community; creating targeted programmes to address violence against women and children; disseminating information on substance use and creating education and supportive programmes for mental health care users and psychogeriatrics to enhance their quality of life (Mkhize & Molelekoa, 2008).

Lund and Flisher (2006) conducted a study with a model that can be used in community mental health service. The findings indicated that utilising this model can assist within the scarce resource context. However, research by Robertson and Szabo (2017) in the Gauteng province indicated the challenges that are associated with community mental health services. The study posited that it is unacceptable for community mental health services to position specialised community mental healthcare in primary care and not to adhere to the suggested mental health policy service organisation in the Gauteng province. Community mental health service experts accounted for 80% of clinic visits, with only 2.23% being connected to mental health (Robertson & Szabo, 2017). The facilities and staffing levels did not meet the stated minimum cover condition (Robertson & Szabo, 2017). Literature by Carmona-Huerta et al. (2021) supports the difficulty experienced by middle-income countries such as Mexico in implementing community mental health services is because of a lack of human resources, high prices, and long travel times (Carmona-Huerta et al., 2021).

The idea of meta-community mental health care, which is distinct from community mental health care, has been covered in a study by Bouras et al. (2018). It is advisable to adopt the meta-community concept, even though it may appear unrealistic in LMICs that still struggle to provide community mental health treatment (Bouras et al., 2018). The meta-community focuses on the psychological, biological, and social aspects of community mental health treatment continuously, to resolve any issues (Bouras et al., 2018). Given that disease may arise from any disruption in any of these elements, the meta-community deals with those deficiencies or dysfunctions (Bouras et al., 2018).

Petersen et al. (2012) wrote a paper on the advantages and challenges of the participation of community members in developing community mental health services. The study was conducted within a KZN sub-district. The paper aimed at providing insights into community engagement, which is one of the research projects that is lacking, regarding the integration of mental health in PHC.

2.6.5 Community Interventions

According to Kohrt et al. (2018), LMICs value community intervention more than high income countries. This is likely because HIC have a fair picture of mental health services compared to LMICs. Kohrt et al. (2018) mentioned the key importance of communities being part of the integration beside accessible mental health services. Reaching out to communities is deemed essential because individuals with serious mental illness may be forced into isolation (Kohrt et al., 2018). Abused sexually and subjected to other sorts of exploitation in communal settings, such as prayer camps, homes, traditional health centres and places of worship, community outreach thus serves as a defence of human rights (Kohrt et al., 2018). Furthermore, negative social determinants of mental health are not frequently addressed by standard facility-based psychiatric services, and the stigma surrounding receiving or being associated with someone with mental illness is a barrier to obtaining specialist care (Kohrt et al., 2018). In the meta-review conducted by Kohrt et al. (2018), they indicated the essential components of community involvement, such as increasing awareness of mental health issues through psychoeducation; skills development; psychosocial rehabilitation efforts; case management, and psychological services. These aspects can be achieved through working with nurses, lay counsellors, and community health workers (Kohrt et al., 2018). The providers will likely provide services through training and supervision, consulting with service users; assisting with integrating with other platforms, and monitoring implementation barriers (Kohrt et al., 2018). Based on the above study, community interventions are important because of the multiple factors that are targeted to assist with service provision. Unfortunately, these interventions are scarce due to financial barriers and lack of implementation of policies. Healthcare professionals within primary care manage the mental health issues in primary care with little resources, impacting the process service provision.

PHC providers can identify mental health illnesses more accurately thanks to screening technologies (Grant et al., 2022). However, due to stigma and a lack of mental health literacy, individuals do not seek help, which led to Grant et al. (2022) investigating the use of the Community Mental Health Education and Detection (CMED) Tool. This screening tool developed by Grant et al. (2021), was found to be a culturally appropriate and pertinent tool for the community package of services developed after extensive collaboration with the KZN DoH, community health teams, and the expert mental health panel. In their investigation, community healthcare workers distributed this tool in households, which had good results (Grant et al., 2022).

A study by Gigaba et al. 2024 focused on strengthening the health systems for the integration

of mental healthcare, using the mental health integration programme (MhINT). This study was conducted in the KZN province, and a learning system approach was used which enabled continuous strategies to promote interventions for integration (Gigaba et al., 2024). Key mental health service indicators were incorporated into weekly meetings intended to review the effectiveness of clinical programmes for human immunodeficiency viruses and non-communicable illnesses (Gigaba et al., 2024). This allowed for integrated planning and monitoring. The validation of a mental health screening tool and the assessment of its viability for use in centralised screening stations were spurred by the absence of standards in the field of mental health screening (Gigaba et al., 2024). The continuous learning sessions fostered a collaborative problem-solving culture which improved the rate and use of services. This suggests that the approach has the potential to make integrated mental healthcare more accessible, particularly in LMICs (Gigaba et al., 2024). Promoting the adoption of evidence-based innovations through collaboration is a key tactic for academics and stakeholders in the health system. Integrated mental health treatment at PHC is threatened by the absence of measures to address the mental health of healthcare professionals (Gigaba et al., 2024).

From the meta-review, Kohrt et al. (2018) made seven recommendations from the identified gaps of community outreach interventions that could be implemented. These included first the creation of guidelines for the uniform reporting of community components for mental healthcare (Kohrt et al., 2018). The second recommendation was the utilisation of scientific methods for assessing community-based mental health services (Kohrt et al., 2018). The third recommendation was the examination of strategies to improve the involvement of families and service users in creating and delivering mental health services in the community (Kohrt et al., 2018). The fourth recommendation was to create instruments for researching and promoting community mental healthcare competencies and use them to enhance the quality of care (Kohrt et al., 2018). The rest of the recommendations included the utilisation of technology to increase the reach and efficacy of community components; integrate and assess tools for service providers and users, to improve the quality and reach of community health services; and more effectively, to integrate community platforms into other care systems (Kohrt et al., 2018).

A study by Giebel et al. (2024) examined community-based mental health interventions in LMICs, with an emphasis on older persons (60 years of age and over). The study offered suggestions on improving community-based mental health and well-being programmes in low- and middle-income countries (LMICs) and how to supplement broad guidelines for developing complex interventions (Giebel et al., 2024). The study was constrained because it included only interviews with clinical research professionals who developed and implemented community-

based psychosocial treatment programmes for older individuals (Giebel et al., 2024).

Considering the comorbidity of physical conditions and mental illness, Petersen et al. (2022) investigated a collaborative care package for depression, comorbid with physical conditions using The Template for Intervention Description and Replication (TIDieR) framework. This was implemented on two sites; however, the second site received less system-level support due to the lack of a collaborative design approach modified for it (Petersen et al., 2022). Therefore, to grasp the changes needed to fit different in-country health system contexts, it is emphasised that in-country, co-designed, collaborative care models and implementation research are essential (Petersen et al., 2022). A study by Kathree et al. (2023) validated the feasibility of co-located counselling in task-shared, collaborative care for the treatment of depression in underprivileged PHC settings.

To strengthen services for collaborative care for depression at the PHC level, Petersen et al. (2023) conducted a study using the Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) framework to evaluate the results of the implementation of this collaborative care package. The findings in this study suggested that a major factor in promoting nurse-level diagnosis rates was training in and the use of a proven, government-mandated mental health screening instrument, which included on-site education programmes and technical assistance visits (Petersen et al., 2023). In addition, nurses who thought favourably of the integrated care approach, were more likely to identify service users (Petersen et al., 2023). A higher chance of referral was linked to a clinic counsellor's constant availability (Petersen et al., 2023). Furthermore, Petersen et al. (2023) emphasised how crucial implementation research is to fortifying implementation tactics for the inclusion of depression treatment into standard PHC services.

Monnapula-Mazabane and Petersen (2023) stated that there is a high prevalence of stigma that service users and their caregivers experience within their communities that relates to low levels of mental health literacy. Another study by Monnapula-Mazabane and Petersen (2022), investigated the feasibility of anti-stigma intervention with caregivers in community mental health services in South Africa. The findings suggested that after the intervention service, users reported better family relationships and knowledge of mental illness amongst family members (Monnapula-Mazabane & Petersen, 2022). Caregivers saw the intervention as beneficial and acceptable, since it improved knowledge and helped them build stronger bonds with service users (Monnapula-Mazabane & Petersen, 2022).

2.7 Healthcare Professionals in Primary Mental Healthcare

Upadhaya et al. (2020) undertook a study on the perspectives of primary healthcare workers regarding integrated mental health in Nepal. The results implied that with health system level barriers removed and enabling variable enhancements, the provision of mental health services by PHC providers in settings with limited resources is feasible (Upadhaya et al., 2020). The health workers offered several strategies to address these obstacles, such as ensuring that the health facility had a dedicated staff; providing a private, dedicated space for counselling; enhancing the incentives and benefits that motivate the current health personnel; creating policy-level representation for mental health; enhancing the administration of a medicine supply chain, and fortifying the process for supervision, referral, and mental health management (Upadhaya et al., 2020).

Moloi et al. (2023), conducted a systematic review that focused on the perceptions of healthcare workers towards integrated mental healthcare, drawing information from various countries. The results of the study indicated that it is vital to take into consideration the complexity and dynamic between integration interventions and the environment, as well as the way healthcare professionals shape the outcomes of integration.

Zelda (2023) stipulated that to integrate mental healthcare services at a PHC level, primary health care (PHC) personnel at a facility should cooperate with specialists in the field. Mental health specialists, such as psychologists or psychiatrists, can provide PHC workers with training and supervision on how to recognise common mental disorders in patients with chronic health conditions who may be at risk of mental illness, manage these conditions and make appropriate referrals (Zelda, 2023). Collaborative care in particular, cooperation between paradigms for healing within areas in the KwaZulu Natal, Northern Cape, Gauteng and North West Province is happening; however, it was noted that in provinces, such as the EC it is minimal and inadequate for the entire province (Zelda, 2023). Though there are efforts for collaborative care in some regions of the country, there is still a treatment gap and a call for collaboration (Zelda, 2023). Inadequate infrastructure; a lack of resources; impressions of a lack of confidence and assistance; inadequate instruction and preparation; mental illness being stigmatised and given little priority; dynamics of power; and issues with defining roles, are challenges to the growth of collaborative care (Zelda, 2023).

According to Zelda (2023) mental health professionals by themselves will probably not be able to close the mental healthcare treatment gap in the country, given that the population ration is approximately 1.4:100,000. The ratio given by Zelda (2023), highlights the importance of integrating services and work with non-specialist healthcare workers. Gronholm

et al. (2023), conducted a systematic review that examined various factors associated with the delivery and utilisation of mental healthcare services by non-specialist health workers in LMICs. These factors that were described as barriers of utilisation of healthcare, included health worker competency; resource availability; recipient and provider characteristics; accessibility of services; sociocultural acceptance, and vulnerable groups, for whom care barriers may be more severe (Gronholm et al., 2023).

2.7.1 Nurses and Their Experiences at PHC

Mendenhall et al. (2018) highlighted the significant role that nurses may have in expanding mental health services within the healthcare system and in changing the stigma and marginalisation of individuals with mental illness in the healthcare system. The research conducted by Mendenhall et al. (2018), investigated how primary care nurses in Kenya perceived mental health services. Numerous nurses thought that incorporating mental health services into primary care would be acceptable and do-able, but there would be obstacles due to a lack of specialists and low levels of knowledge among healthcare professionals, particularly in rural regions (Mendenhall et al., 2018). These findings highlight the necessity of task-sharing mental health services within Kenya's current primary healthcare system (Mendenhall et al., 2018).

Stigma has been identified as one of the barriers to the integration of mental health services, from the community and patients, as well as healthcare professionals. Kigozi-Male et al. (2023) conducted a study using a cross-sectional survey on mental health knowledge and attitudes of nurses towards mental health care and MHCUs in South African metropolitan municipalities. This study used the integration of mental health services with PHC programmes, such as TB and the findings suggested that nurses had limited knowledge of assistant-seeking behaviour, mental health issues and employment (Kigozi-Male et al., 2023). The findings also suggested the likelihood of a negative attitude towards mental healthcare and MHCUs. Moreover, the age, in-service training, and job category, significantly contribute to the prediction of nurses' attitudes (Kigozi-Male et al., 2023). Mental health literacy among PHC workers in Zambia and South Africa is moderate, and it differs depending on their level of education (Korhonen et al., 2022). The key findings of the study were the importance of screening criteria and education for mental health issues, to increase mental health literacy amongst PHC workers (Korhonen et al., 2022).

A study conducted in South Africa by Nontobeko and Tshotsho (2015) investigated nurses' perception of integrated mental healthcare in PHC settings. The study indicated that the lack of

integration of primary healthcare is due to services being rendered in the same consulting room, result in a lack of confidentiality for mental healthcare users (Nontobeko & Tshotsho, 2015). These challenges can pose a question of the quality of service being provided which Rall and Swartz (2023) stipulated was a concern for healthcare professionals in the EC Province. Though there has been research conducted in LMICs regarding the perception of healthcare workers, it is limited in South Africa, more especially in the EC province. According to (Rall & Swartz, 2023), both the provision of treatment and the people receiving mental healthcare are challenged by the inclusion of mental health services into standard primary healthcare. Furthermore, re-segregating mental health services is recommended by the above-mentioned study as a potential means of facilitating treatment and service delivery to clients (Rall & Swartz, 2023).

A study in KZN found that healthcare workers in primary care have trouble integrating mental health services into PHC (Madlala et al., 2020). According to the nurses, they need managerial assistance and training to acquire the information and abilities (Madlala et al., 2020). Mpheng et al. (2022) conducted a study on the view's healthcare practitioners have towards comprehensive care being integrated into Mahikeng, North West Province. The findings suggested that community-based healthcare professionals promote the need for all-encompassing mental healthcare (Mpheng et al., 2022). These professionals believe that better mental care and a decrease in the recurrence in MHCUs can be achieved by increased coordination of psychiatric services, as well as involvement from stakeholders, along with other psychiatric programmes, is necessary for integrated psychiatry to continue (Mpheng et al., 2022).

A study conducted by Dube and Uys (2016) in Kwa-Zulu Natal, exploring perceptions of healthcare professionals towards the integration of mental health services at primary care level, stipulated that the nurses had mostly a positive attitude towards mental illness. However, they had negative perceptions of the management of psychiatric mental healthcare users. The reason behind the negative attitude is mainly due to a lack of knowledge, training, and the opaqueness of their role at primary care level (Dube & Uys, 2016). Moreover, Mkhize and Molelekoa (2008), pointed out that that healthcare professionals within the PHC setting are burdened with a large amount of work, therefore reducing time to provide adequate quality service will compromise their routine. Their defensive system towards these systems is to adopt a biomedical framework to treat MHCUs (Mkhize & Molelekoa, 2008) .

The general PHC nurse and the specialised mental healthcare nurse are both expected to do

tasks for which they are ill-prepared, and as a result, feel uneasy because of integration, job uncertainty, and a loss of professional identity, could be the result (Mkhize & Molelekoa, 2008) . Furthermore, even though lowering the stigma attached to mental illness was one of the objectives of incorporating mental health services into the PHC system, this admirable goal has not been accomplished (Mkhize & Molelekoa, 2008). It has been noted that non- psychiatric nurses may choose to abdicate their responsibility for the arduous duty of caring for mentally ill patients, entirely to psychiatric nurses, who feel stigmatised by other staff members because of their line of work (Mkhize & Molelekoa, 2008). A study by Kemp et al. (2021) indicated that nurses have difficulty with identifying depression and referring service users appropriately. The problems these nurses have experienced include inadequate expertise; supervision and training; emotional strain; scarce physical and human resources, and patients' perceived need for integrated services (Kemp et al., 2021).

2.7.2 Challenges Against Integration of Mental healthcare

De Kock and Pillay (2017) examined the psychiatrist's situational analysis at public rural primary healthcare (PRPHC) which indicated that only 2% of psychiatrists devote to PRPHC and only 3% of psychiatrists visit these facilities regularly, therefore making psychiatrist least accessible in rural areas. According to Janse van Rensburg et al. (2021), psychiatrists still work mostly in urban areas, with a lack of the profession in rural areas. Medical officers (MOs) are assigned to sign prescriptions to close this gap; this has proved beneficial; nevertheless, MO employment at PRPHC is declining. Thus, the burden of mental illness in rural communities is exacerbated by this disparity (De Kock & Pillay, 2017). Although MOs and psychiatrists have limited resources for basic mental healthcare, they are both expected to train task-sharing, which may place additional strain on the medical staff (De Kock & Pillay, 2017).

There is evidence from a systematic review conducted by Caulfield et al. (2019) that mental health training conducted in various settings has been effective. This enables an environment for task-sharing to address the lacuna of mental healthcare treatment. Research by (Mendenhall et al., 2014), opines that task-sharing mental health services are deemed feasible and acceptable in LMICs, provided that the essential requirements are met. These requirements are in line with what is required of the successful integration of mental health care in LMICs. More human resources and improved medication access, continuous supervision that is structured and supportive is needed, along with training together with remuneration that is sufficient for the healthcare professional (Mendenhall et al., 2014). These are the perspectives of stakeholders and healthcare professionals from four countries, including South Africa

(Mendenhall et al., 2014). In addition, constructing locally suited interventions may make it easier to deliver suitable and acceptable mental healthcare in LMICs, considering the systematic issues and sociocultural oddities as potential effects on task-sharing in the provision of mental healthcare (Mendenhall et al., 2014). Slaven et al. (2021) investigated the effectiveness of brief training intervention, such as the South African National Mental Health Education Programme (SANMEP). The findings of the study indicated that brief intervention increases the confidence of service providers and is sustainable (Slaven et al., 2021).

Selohilwe et al. (2023) indicated that task-sharing counselling intervention at PHC level in South Africa has facilitating factors, such as the availability of supervision and support for counsellors, the person-focused counselling approach, and the organisational adoption of counsellors inside facilities. However, barriers were still experienced, such as the management of mental health illnesses, including counselling not being included in mental health indicators; abundant counsellor turnover, making counsellors inaccessible constantly, and the absence of organisational backing for the counselling service, including a shortage of rooms for counselling (Selohilwe et al., 2023).

Health professionals could not provide adequate time to treat healthcare users because they had to use the same consulting space for physical ailments (Rall & Swartz, 2023). Furthermore, the waiting period for treatment for mental healthcare users is lengthy, which leads to their feeling frustrated and ignored by the healthcare professionals. They alluded to services being slow and facilities having a shortage of staff (Rall & Swartz, 2023). To improve the delivery of mental health treatments, they recommended re-segregating services within the PHC environment (Rall & Swartz, 2023).

According to De Kock and Pillay (2016), mental health nurses ought to be redistributed to PRPHC areas, due to an uneven distribution of mental health nurses in these settings. The above-mentioned authors suggested expanding the PRPHC region's human resource base to handle the workforce in mental healthcare. Furthermore, they recommended reviewing the policies about the training initiative and the present evidence-based task-shifting strategy (De Kock & Pillay, 2016). To guarantee that every South African has access to quality mental health treatment, creative strategies including expanding roles and practice areas of mental health professionals at the PHC level are required (De Kock & Pillay, 2016).

According to Le Roux et al. (2015, in order to address the demand for healthcare services, professional physicians and nurses should delegate jobs and caregiving duties to trained Community Health Workers (CHW). However, before the potential advantages of CHWs can

be realised, there are several obstacles to overcome as CHWs are frequently inadequately chosen, instructed, and overseen (Le Roux et al., 2015). In addition, CHWs frequently have strained relationships with other district health team members and are not always treated with respect by clinic and hospital personnel (Le Roux et al., 2015). According to Petersen et al. (2012) there is still work to be done to fully utilise the ability of CHWs to support mental health. This will involve considering how the healthcare system's power dynamics disempower CHWs and financial investments from those involved in policy planning and creation, to support the symbolic and financial empowerment regarding this community asset (Petersen et al., 2012). In a country, such as China, CHWs have been utilised for several years and are providing service for various NDCs and mental health conditions (Haung et al., 2018). A pilot study was conducted in South Africa focusing on the training of CHWs which resulted in the advancement of knowledge of CHWs. However, further research needs to be conducted to ascertain the impact the training has on service users (Sibeko et al., 2018). The studies that have been conducted indicate the need for CHWs to alleviate the mental health burden in primary care level for both healthcare professionals and MHCUs. Though barriers indicated by Le Roux et al. (2015) and Petersen et al. (2012) exist, the benefits from extra personnel will improve overall mental health service provision and receptiveness of these services by MHCUs.

Mkhize and Molelekoa (2008) stated that an equal connection between the people in charge of the healthcare system, the healthcare providers, and the service users is a prerequisite for providing primary mental health treatment. Nonetheless, a study on the incorporation of mental health services into KwaZulu-Natal's PHC system, has demonstrated the persistence of bureaucratic and technocratic management techniques (Mkhize & Molelekoa, 2008). The PHC guiding principles, such as integrated care that considers the MHCU's subjective experience of their distress, were not the basis for staff assessments and instead, used a biomedical approach, which can be readily quantified from a biomedical standpoint (Mkhize & Molelekoa, 2008). Employee efforts to address the integrated health care principles are violated and creativity is hindered by this bureaucratic administrative structure (Mkhize & Molelekoa, 2008).

2.8 Chapter summary

This chapter's literature review aimed to investigate and comprehend the main ideas related to primary healthcare workers' opinions and thoughts on the provision of mental health service in Makhanda. To put the results in context, this review examined both the recent and historical literature of mental health services and the integration of primary mental health- care. Though

there is much research conducted internationally on how healthcare professionals view the provision of mental health services, not much seem to be done in South Africa, where the focus is particularly on primary healthcare providers' perspectives of this topic. The current research attempts to fill this gap in the current body of literature.

CHAPTER THREE

Research Design and Methodology

3.1 Introduction

The research design and methodological considerations used by the researcher in this study are described in this chapter. This chapter contains an explanation of the theoretical foundations and guiding principles of the methodology, known as thematic analysis, that served as the basis for this investigation. There will be an explanation and justification for selecting a qualitative research design. Further information will also be provided regarding the sample of participants employed; the sampling strategy; the data collection and processing procedures, and the study's ethical considerations and trustworthiness.

3.2 Research Method

The purpose of this study was to broaden an understanding of the perspective of healthcare professionals towards primary mental healthcare in Makhanda, as previously indicated in chapter one. The aim of this study was to address the following research question: "What are the perspectives of healthcare professionals towards primary mental healthcare in Makhanda?"

The method chosen to undertake the collection of data is the qualitative research method. Understanding the experience and meaning of people's lives and their social environments is one of the main goals of qualitative research as stated by Fossey et al. (2002). Understanding a study question as a humanistic or idealistic viewpoint is the main goal of qualitative research (Pathak et al., 2013). This research method allows for a deeper understanding of the research problem and can aid in examining the data in greater detail, without the use of data that are numerical (Pathak et al., 2013). With the knowledge acquired from the data collected, understanding can be built from it, which is an essential part, as there is not much information regarding the perspectives of healthcare professionals towards primary mental healthcare (Lesley et al., 2020).

According to Lesley et al. (2020) knowledge acquired from this research study is viewed as constructive because healthcare professionals work to make sense of primary mental healthcare which is a good standpoint from which to view the data given. The

research design also allowed the researcher to look at the reason behind how the participants constructed the knowledge the way that they did (Lesley et al., 2020). This research design has assisted the researcher in answering the research question and highlighting the importance of undertaking this research.

The data collection method applied is a semi-structured, one-on-one interview with 13 healthcare professionals, to explore and gain an in-depth understanding of their perspectives on primary mental healthcare.

3.3 Participant Sampling and Sampling Technique

The study used purposive (non-probability sampling), which allowed the researcher to focus on specific characteristics of the sample i.e., the profession of the population (Neetij, 2015). The researcher specifically chose healthcare professionals within primary healthcare clinics when selecting the sample, as this allowed the representation of the population, meeting the requirements of the study (Vehovar et al., 2016). The researcher is carrying out the study while completing coursework for a Master's degree in Clinical Psychology. Therefore, purposive sampling allowed the research to be conducted efficiently with regard to cost and time (Saunders et al., 2012). The sample consisted of facility managers and health professionals who were responsible for providing primary mental health services in the four primary healthcare facilities. Fourteen participants per category were recruited; however, thirteen were part of the study. The fourteenth participant was a previous community health worker at a primary healthcare facility. However, they held a different position at the facility at the time of sampling, thus did not meet the criteria of the study sample. The facilities were chosen in the Makhanda area for this study, as it was less time- and cost- consuming than facilities within the Sarah Baartman District, which is considered a wider population but would be cost consuming. There were four facilities chosen and permission to use these facilities was via contacting the acting sub-district manager of the Makana District, Eastern Cape Department of Health. Once permission was granted, the researcher went to the four facilities and gained permission from the operational managers to conduct the study and to ascertain a schedule of when the data collection could commence.

3.4 Data Collection

The data collection method used in this study is semi-structured interviews. The nature of the study being qualitative, supports the use of semi-structured interviews to collect data. According to Mashuri et al. (2022), semi-structured interviews are more effective than other

interview formats because they enable researchers to garner comprehensive data and supporting documentation from participants, while keeping the study's objectives front and centre. Furthermore, semi-structured interviews are flexible, as they allow the interviewer to follow a sequence of less structured questions and investigate spontaneous issues suggested by the interviewee (Mashuri et al., 2022; Ryan et al., 2009), highlighting the significance of context. The face-to-face interviews complemented this study's goal, which was to conduct an in-depth investigation of the perspectives of healthcare professionals towards primary mental healthcare.

The interviews were organised with operational managers of primary health care facilities and were conducted in the same vicinity. Unfortunately, though interviews were scheduled, the primary healthcare facilities were still operating and had limited infrastructure, which led to the interviews being held in rooms that were used and thus, there were disruptions. Moreover, the majority of the participants needed to pause in between patients to participate in the interviews.

Each participant was given informed consent to participate and be audio-recorded. The forms were signed by the participants and returned to the researcher prior to the interview starting. The interview schedule was adhered to during interviews, which provided a more flexible method for conducting interviews (Frances et al., 2009). Given that the interviews are flexible, the interviewer can ask an array of fewer predetermined questions and explore any impromptu issues that come up throughout the interview (Frances et al., 2009). There were two sections on the structured schedule; the first section focused on the services provided by the primary healthcare facility, followed by prompts of specific services provided, adequate staff and resources, and the relationship the clinic had with the community. While not the primary objective of the study, it was considered important to comprehend the service the participants provided in the clinic to contextualise their perspectives. The second section focused on mental health service provision provided by the clinic. Questions included: "Based on your understanding, what is the role and objective of mental healthcare at a primary care level?" and "Does the work of your clinic involve issues related to mental health?" This section also included a question relating to community mental healthcare accessibility and resources available at the clinic. Questions included: "Would the community access mental healthcare at a clinic level if the services were readily available?" and "Are primary care clinics resourced enough (human and equipment) to provide mental healthcare?"

The interviews were conducted in rooms in the facility and lasted 10 to 40 minutes, depending on the line of patients waiting outside the room, disruptions, and openness of the participants. Audio recordings enhance a study's qualitative approach of respecting the participants' own words as sources of information and meaning (Chandler et al., 2015). Therefore, participants signed consent, and all interviews were audio-recorded. The recordings where transcribed verbatim by a hired transcriber who was familiar with the language used i.e. Xhosa and English, which is considered ideal by McMullin (2023). The data collection procedure began with the granted ethical clearance and authorisation for conducting the research. This study is part of a larger research study, and the main researcher contacted the Department of Health (DoH) in the Eastern Cape to gain approval to conduct the study in the four clinics. After permission was granted by the DoH, the researchers went to the clinics to inform the operational managers about the research and exchange contact details to organise dates to collect the data at the clinics. Fourteen participants agreed to be part of the study and signed consent forms; however, only thirteen participants were used.

3.5 Data Analysis

The qualitative data were analysed using thematic analysis (TA). Its research process finds and interprets patterns or themes in the data collected, which frequently yield fresh perspectives (Naeem et al., 2023). In this study, TA allowed the researcher to be proactive in the contribution of knowledge, as stipulated by Bryne (2021). Furthermore, TA allowed for flexibility during the coding and analysis process. It is imperative that researcher refrains from allowing their personal bias to impede the identification of significant themes (Naeem et al., 2023). TA has six steps which provide a guide for carefully processing qualitative data, thus strengthening the process's rigour and range of its conclusion (Naeem et al., 2023). This methodical, disciplined technique guarantees thoroughness and reduces the possibility of prejudice (Naeem et al., 2023). These six steps are methodically unpacked below.

3.5.1 TA and Familiarisation with the Data

With the first step, the researcher became familiar with the data with transcripts, and audio recording which is recommended by Naeem et al. (2023). This provided the researcher a starting point for analysis and means of obtaining insight to the data (Terry et al., 2017). During the data saturation phase of a theme analysis, important information pertinent to the study objectives was identified, in addition to the documentation of all information (Naeem et., 2023). These objectives gave the analysis a narrow focus; rather than prescribing a conclusion, they directed the extraction of important information from the transcripts (Naeem et al., 2023).

Relevant quotations were carefully chosen by the researcher at the first transcription stage, as quotations can give a clear representation of the topic at hand (Naeem et al., 2023). It was crucial for the researcher to prioritise relevant quotations that aligned with the interview context, enlivening the narrative, and adhering to ethical guidelines (Naeem et al., 2023). An example of a quotation chosen is

"*They are referred to the psychiatric hospital and then you find that they are discharged from that, and they go back to the community and the continuation of care is done by us at the clinic so.*" (SM13)

The researcher revisited the transcripts to improve their capacity to identify pertinent quotations (Naeem et al., 2023). Furthermore, the researcher gave the reader sufficient context to understand the quotations' meanings.

3.5.2 TA and Selection of Keywords

Naeem et al. (2023) postulated that the goal of thematic analysis is to find and highlight the datas' most recurring patterns. According to the current concept of theme analysis, quotations are chosen from the data and put together under a code to examine the interview (Naeem et al., 2023). This was done through formulating keywords which provide meaning for research as stipulated by Naeem et al. (2023). In this study keywords were selected from the provided quotation to enhance the quality and depth of the analysis. For example, the keyword selected for the above quotation is 'continuation of care'. According to Naeem et al. (2023), keywords play a significant role in qualitative research because they help create codes that adequately capture the meaning that lies behind the data (Naeem et al., 2023). For the analysis to be systematic, thorough, and anchored in the data, the keywords capture the key concepts in the data (Naeem et al., 2023). Therefore, the generated codes in this research are guaranteed to be accurate to the data by using keywords that denote the thoughts and ideas included in the data (Naeem et al., 2023).

3.5.3 TA Coding

According to Naeem et al. (2023) coding is the process of giving a word or brief sentence to the data. It represents the key, conclusive, and essence-capturing feature of the information (Naeem et al., 2023). Coding entails identifying pertinent data within each data (Terry et al., 2017) in accordance with a preset framework, which results in the data taking on a more theoretical and conceptual form. The data are divided into smaller, more manageable chunks throughout the coding process, so that it may be categorised and examined for trends and themes (Naeem et al., 2023). Continuing with the example of the above, the code that was used

"mental health provision". This assisted the researcher to gain a deeper comprehension of the underlying concepts and ideas, by using coding to assist in discovering certain data items that were pertinent to the research problem (Naeem et al., 2023). In this study, the use of ATLAS.ti 24 was used to assist with the generation of codes. The method of analysis that was used in this study is inductive coding, which Naeem et al. (2023) indicates allows patterns and themes to surface from the actual data. This exploratory methodology enabled the researcher to keep an open mind regarding novel concepts and themes that could surface from the data. Interpretive analysis and inductive coding were both combined to generate codes to represent various contexts and experiences of the participants (Naeem et al., 2023).

3.5.4 TA Theme Development

According to Braun and Clarke (2021) themes are understood as summaries or overview of common statements made by participants said in relation to specific or data collection questions. To accurately convey the data, a researcher arranged the codes together in a meaningful manner (Naeem et al., 2023). The theme serves as a crucial connection between the data and the research questions. The themes were derived from the head researcher's own insights and reasoning, during the data gathering process and observations concerning the data aided in the development of themes from the codes. For instance, the theme developed through codes selected above is "Process of Mental Healthcare". Through interpretative analysis, themes arose from the data in an inductive method, leading to a thorough understanding (Naeem et al., 2023).

3.5.5 TA and Conceptualisation through Interpretation of Keywords, Codes, and Themes

Any mental depiction of a social occurrence, including a conception, image, thought, or emotion, is referred to as a concept, according to Naeem et al., (2023). The process of creating a workable definition and a more nuanced grasp of the research's theme is known as conceptualisation (Naeem et al., 2023). The researcher was able to search for patterns or connections; the end results of the conceptualisation by analysis of the study findings was presented. Before interpreting pertinent data and defining concepts, a researcher will establish connections between various concepts, so that they can be combined into a model (Naeem et al., 2023). The definition of the variety of prospective interpretations of a concept and the identification of the types of evidence that could potentially be perceived to show the existence or absence of a concept, originated from the data (Naeem et al., 2023). The process of defining the meaning of the terms and those using concepts and words, is referred to as the interpretation

stage (Naeem et al., 2023). To explain these concepts generally at this point, the researcher should characterise these concepts in accordance with an earlier study. Naeem et al., (2023) recommended that when interpreting research findings, the theoretical underpinning of study be considered. However, Naeem et al., (2023) make the case that is common and essential for researchers, to question how a term is conceptualised in relation to their research findings.

3.6 Trustworthiness

According to Bless et al. (2013), research quality is improved through trustworthiness and reflexivity. Credibility, transferability, reliability, and confirmability are all aspects of trustworthiness (Bless et al., 2013). Adler (2022) argued that transparency is the most significant component of qualitative research, and that trustworthiness is essential to evaluating it. Transparency is essential to a qualitative study's credibility (Adler, 2022). To provide transparency, themes were described, with supporting quotations. The quotations were clear and illustrative, providing evidence for interpretation and support for themes. According to Nowell et al. (2017), a study's credibility is established when readers or researchers are faced with experiences and can identify them. The match between a respondent's opinions and how the researcher represents them is what determines credibility (Nowell et al., 2017). The study's credibility has been established by orienting it inside the thematic analysis and reformulating participants' experiences.

The extent to which research findings can be applied beyond the scope of the project is referred to as transferability (Polit & Beck, 2018). To ensure transferability, the researcher provided thorough descriptions, so that individuals who wanted to transfer the findings to their own site could assess transferability, as suggested by Nowell et al. (2017), even when the researcher is unable to predict which sites might want to do so. To assure data reliability, the quality of the transcriptions has been reviewed, by re-listening to the audiotapes. The validity of the interpretations has been ensured by providing a clear rationale.

According to Adler (2022), trustworthiness is evaluated by reflexivity. To maintain reflexivity, the researcher in this study considered their bias that might impact their analysis. The researcher has worked in a primary care facility as a mental healthcare professional in Makhanda and acknowledges that their experience can influence the interpretation of the results in this study. Therefore, the researcher continuously challenged their interpretation to be established in the data. Subsequently, the researcher by demonstrating that the results of the study were based on the data, ensured confirmability. The goal of confirmability was to show

that the researcher's conclusion and interpretation were logically drawn from the facts (Nowell et al., 2017). The analysis process was systematic and the TA steps in the research process were followed to demonstrate dependability.

3.7 Ethical Considerations

This research project took several ethical considerations into account. The Rhodes University Ethical Standards Committee (RUESC) rules were followed in the design and conduct of all the research for this study. Furthermore, the study complied with the research ethics policy of Rhodes University. Data collection for this project started only after institutional authorisation had been obtained by the registrar of Rhodes University and approval given by the Research Proposals and Ethics Review Committee (RPERC).

Informed consent was obtained from the thirteen participants prior to the start of their participation. According to Cacciattolo (2015), participants in a research project should choose to participate voluntarily and with informed consent. It is an essential part of performing ethical research; therefore, in this project, it was made it clear that participation was completely voluntary and that withdrawals were accepted at any time and without consequence. The participants were fully informed of the purpose, methods, and possible risks associated with participating in the research, before providing their consent, as suggested by Cacciattolo (2015).

The participants were also given an explanation on the form about how confidentiality and privacy would be preserved. According to Cacciattolo (2015) controlling the type of information disclosed to participants in a research project, is related to privacy. Controlling how a participant is portrayed in the public domain is necessary to protect their privacy (Cacciattolo, 2015). On the other hand, confidentiality describes how data are handled and kept (Cacciattolo, 2015). This pertains to the degree of data-sharing with parties outside the study endeavour, as well as who has access to the obtained data (Cacciattolo, 2015). The protection of the individual is therefore associated with privacy, while confidentiality safeguards the sharing of information in ways that limit the participants' exposure to possible harm or scrutiny (Cacciattolo, 2015). In addition, an informed consent form granting permission to be audio recorded during the interview had to be signed and returned by the participants. To maintain participant identity and confidentiality, the names of the participants and their signed informed consent were not appended in the transcripts. The informed consent forms utilised were developed using the RUESC template.

After the data were collected, confidentiality was preserved by limiting access to the data to

the researchers and supervisor only. To enable other researcher's part of the other project access to the data, information was stored in Dropbox. The participants' responses were pseudonymised and no information identifying them could be found in the printed transcripts. The fourteen participants granted permission for the researcher to retain the audio recordings after the study was finished, in compliance with the Rhodes University Research Ethics Policy.

3.8 Chapter Summary

The chapter discusses the research aims, design and methodology used in the study. The participant sample and sampling techniques as well as data collection and analysis procedures were also discussed. Lastly, the trustworthiness and ethical considerations that are required for the study were covered in this chapter. The study findings and discussion of the participants are presented in the next chapter.

CHAPTER FOUR

Findings

4.1 Introduction

The findings of the participant's work experience and duties are provided in this chapter to establish a context for their perspectives. The main themes that emerged from the semi-structured interviews are also presented in this chapter. Three main themes have been identified from the findings, which are as follows: (i) Primary Mental Health Service Provision, (ii) Mental Health Literacy, and (iii) Barriers to the Provision and Utilisation of Health and Mental Health Services. Each theme has been discussed in depth in this chapter, with an explanation of the researcher's perspective and verbatim quotations from participant narratives that are cited.

4.2 Description Summary of Participants

The thirteen participants in this research study were given designations, such as staff member ‘SM1’ to guarantee their anonymity. The description summary of the participants is meant to provide understanding of the participants narratives within the study. Most of the participants were professional nurses; some were acting or operational managers, and one was a staff nurse. Professional nurses' duties included providing comprehensive care for different health streams. The staff nurse's responsibilities included assisting professional nurses with their duties in the facility. Operational managers oversee the running of the clinic; administrative duties; clinic management; ordering of stock; conflict management; review performances and statistics; ensuring application of policies and guidelines; delegation of staff, and response to security and disciplinary concerns. The participants had work experience at the four primary health clinics (PHC), which ranged from 2 months to 17 years. Here follows an overview of the themes table, thereafter a discussion of each theme.

Table 1

List of themes and sub-themes

Themes	*Sub-themes*
Process of Mental Healthcare	Importance of Primary Mental Healthcare
Mental Health Literacy	Stigma Improving Mental Healthcare
Barriers to Provision and Utilisation of Health and Mental Health Services	Shortage of Resources Attitudes Towards Service Delivery Receptiveness to Service Provision

4.3 Theme 1: Process of Mental Healthcare

This theme will discuss the primary mental healthcare service provision by PHC facilities in Makhanda, from the perspective of health professionals who work in the facilities. It will include a sub-theme on the gap between health and mental health services and the importance of mental healthcare.

The staff members described limited mental health service provision that involves referring a mental healthcare user (MHCU) for a 72-hour observation. This process describes a passive role played by PHC facilities in service provision. It reflects a system that focuses on the hospitalisation of MHCUs that represents former guidelines of mental healthcare. The utilisation of this system further reflects the lack of implementation of current policies, such as the National Mental Health Framework Policy, which has been developed to integrate mental healthcare into primary care. Furthermore, though there are limited mental healthcare services, there are comprehensive services for physical healthcare, which highlights the gap between these services. An example of the referral process that the staff members engage in, is provided in the following excerpt:

"*If a person is manifesting signs of mental illness, first, in most cases they bring them here to the clinic. We conduct the mental healthcare examination; we score them, and they are up for referral at Settlers hospital where they are taken for a 72-hour assessment, where it will be determined whether they go to Fort England or what."* (SM4)

SM13 pointed out that PHC facilities provide medication for MHCUs after they have been referred from a psychiatric hospital to which SM5 pointed out that they do not start treatment but continue treatment from the psychiatric hospital.

"*They are referred to the psychiatric hospital and then you find that they are discharged from that, and they go back to the community and the continuation of care is done by us at the clinic so.*" (SM13)

"*Because at clinic level we don't initiate." (SM5)*

Provision of medication is a service provided by PHC facilities, only after a MHCU has been discharged from a psychiatric hospital. This suggests that staff members are following the protocols that were stipulated for them, which is to continue treatment. There seems to be no initiation of mental healthcare services at PHC facilities, which may be due to a lack of knowledge and implementation of new mental health policies and guidelines. This further provides evidence of using previous mental health policies, although there have been new developments. In addition, staff members may not launch mental healthcare because they do not have the confidence or training to provide mental healthcare services.

The staff members also highlighted that when they provide medication, they attend to MHCUs first because of signs of irritability and the fear of disruption they may cause at the facility. The participants acknowledged that it may be unfair to other patients waiting for their services.

"*They are sitting for sickness or whatever because it first comes serve basis, so they get impatient…….I know we shouldn't actually but not shouldn't because it's unfair to other patients, but we will do it, we will call that person first. Especially the aggressive one.*" (SM2)

Staff members within PHC facilities experience a shortage of resources and often must be creative in solving problems in the facility. This creates long waiting periods, which affects not only patients but also staff members, suggesting that staff members attend to disruptive patients first, to maintain the facility's functioning. However, this puts pressure on the limited resources that exist within the facility.

Despite the limited mental health services at the other PHC facilities, one facility had a psychologist who provided care. This indicates an effort to improve access to mental health services in the area. The following excerpt describes the provision of services by the psychologist at the facility.

"*…. cognitive assessment for the kids, referrals from the schools, and then pre-marriage counselling, post-traumatic stress, or for an assessment if you suspect… sometimes you will talk to a person and you will see, yah, something is not OK. Then we will refer to the*

psychologist". (SM2)

The staff member also pointed out that the nurses at the facilities provide counselling for MHCUs.

"And nurses are also counsellors". (SM2*)*

This facility's psychological services benefit community members within the area, thus improving health outcomes. The services provided by the psychologist seem comprehensive and attend to a variety of mental health problems. Furthermore, the service is also accessible to the community, thus reducing the impact of the cost of travelling, while improving help-seeking behaviour. For staff members in this facility, they experience less pressure, as work is divided amongst them to offer mental healthcare services and maintain their skills in counselling.

Although most of SM in these facilities described, have limited mental health services compared to those of physical health, all staff members indicated the comprehensive healthcare services provided by PHC facilities, as well as allied health professionals that visit the facilities to improve health outcomes. This suggests that there is gap between these services which is likely a result of the lack of integration in primary care, coupled with a lack of resources.

4.3.1 *Sub-theme 1: Importance of Primary Mental Healthcare*

Mental health services are considered important by some of the staff members in PHC facilities because these settings are the first point of contact for individuals. The SM explains the existing relationship between them and service users, through their daily interactions which enable them to observe changes in the wellbeing of patients.

"We get to see these things before it's too late since we work with people on a day-to-day basis." (SM7)

The relationship between staff members and patients highlights the convenience of mental healthcare in primary care settings. The SMs also indicated that they are able to identify mental illness symptoms early and are able to prevent the development of severe psychological disorders; however, there are not enough resources. Barriers, such as waiting periods when referring, or not being able to do a referral, are the challenges that staff members also face in their PHC settings. Therefore, PHC is important for the prevention and management of mental health issues.

One of the staff members further highlighted how mental health services are not prioritised

within PHC facilities.

"The role of mental healthcare at a primary healthcare level, I'd say it is important…..It is definitely not a priority; they don't prioritise at all, and it's very painful to see." (SM7)

The lack of prioritisation of mental healthcare in primary care is suggestive of a lack of resources within the facilities and a blatant disregard of mental health problems leading to the development of mental healthcare. The staff members experience frustration and unhappiness due to the low prioritisation of mental healthcare in PHC settings. They often feel as if they are not able to assist in providing care, in as much as they can, due to a lack of training and support from appropriate mental healthcare professionals. The SMs response highlights the difficulties that arise on a personal and systemic level, when mental health issues do not receive adequate consideration. These PHC facilities in EC have inherited a fragmented mental health system which is suggestive of systematic barriers within the process of the development of mental health services.

4.4 Theme 2: Mental Health Literacy

This theme discusses health professionals' perspectives on mental health literacy within the community. It highlights the traditional view of mental illness and the stigma that the staff members have observed in service users. Furthermore, it discusses staff members' viewpoints towards improving mental health literacy and ultimately, mental healthcare. This includes mental health awareness and education and the training of healthcare professionals and personnel for mental healthcare who can bridge the gap between strengthening mental health literacy and the provision of mental health services.

Mental health literacy plays a key role in service utilisation. The staff members indicated that mental health is understood through a traditional lens, which influences the approach to treatment the MHCU or their family members may take. Community members often connect mental illness to witchcraft, suggesting that alternative treatment is the first step that is taken, before seeking psychiatric assistance. Furthermore, the beliefs attached to mental illness make it difficult for staff members to educate them on mental health, when they reject the assistance offered by staff members. Eventually, when MHCUs go to PHC settings for assistance, the staff members indicate that it is already too late. Below is an excerpt of what staff members noted about community members' understanding of mental illness:

"*The community itself, I think there are things that are just... like for example, you have your elderly people that have their problems of, I don't know dementia or whatever and then*

obviously they will see that in their sense, that this is an old person having these problems and many may understand, or they may not… I don't know, have some sort of myths attached to it, such as witchcraft - there are cases like that." (SM13)

Staff members described that community members were more likely to recognise psychotic disorders than other mental disorders, which is explained in the excerpt below.

"*But as a community, I think they are aware of the more visible signs of mental health, like your delusions or whatever. They understand that but the subtle ones, like your anxiety and your depression, not so much I think.*" (SM13)

Psychotic symptoms are visible signs of mental illness because of its sudden behavioural change. Although community members notice the signs, they have limited knowledge which has led to discrimination against MHCUs. Community members are likely note signs of other psychiatric conditions; however, they are not understood. This further perpetuates discrimination against MHCUs, which staff members have tried to mitigate, by educating community members.

Furthermore, substance use disorders were noted by staff members because of their association with psychotic symptoms and family discord. It can be argued that mental disorders with symptoms of disorganised behaviour or sudden changes in behaviour, are the only recognised mental illnesses, leaving other mental health problems undetected. This is likely because of the severity and disruption the symptoms of psychiatric conditions or substance use can cause, compared to dysfunction that is severely felt by an individual. Moreover, this is another consequence of low literacy levels.

4.4.1 *Sub-theme 1: Stigma*

Staff members in this study pointed out that there is a stigma within the communities they service towards MHCUs, which often leads to discrimination and prejudice. MHCUs may fear being ostracised by the community and feel lonely, which influences their decision to seek assistance. There is a sense from staff members that the stigma towards mental illness has been present for a long time, and it is uncertain if it will be eradicated soon. This makes it difficult for staff members to educate community members about mental health, together with the entrenched cultural beliefs towards mental illness. This suggests that the stigma is a result of low mental health literacy levels, which has its negative consequences. The excerpts below provide an example of the stigma towards MHCUs.

"*Yhoo, there is a huge stigma, there is a huge stigma! I don't think it will go away anytime soon*

because even here, at the facility you'll hear them calling them amageza (crazy people), all those things." (SM4)

"*Mentally disturbed then the community uyagula (you are sick). People don't want to be associated with you… The community, they just don't want you. You're just their puppy dog in the community if you are mentally disturbed.*" (SM12)

Some participants pointed out that both the older and younger generation have self- stigmas when offered mental health services.

"*You know the older group will literally tell you, I am not crazy.*" (SM12)

"*But the younger ones they have that stigma. And I feel sometimes that's why they don't even come to the clinic and take their treatment because now they are afraid of that stigma, of that mental illness. Even if they take treatment but they're not psychotic because they are controlled still, they don't take treatment because of the stigma.*" (SM9)

The above excerpt provides an example of how a stigma has harmful consequences, such as not taking medication; not wanting to be known as having mental illness because the fear of being stigmatised affects health outcomes. Furthermore, healthcare professionals face a cycle of people not adhering to their treatment and defaulting. This unending cycle may create a sense of hopelessness in staff members, as they treat the same illness multiple times.

4.4.2 Sub-theme 2: Improving Mental Healthcare

Mental health literacy plays a part in health professionals' perspectives as it determines the treatment they provide for service users. Significantly, the staff members have described the impact of the lack of mental health literacy and the stigma that has been developed and maintained by low mental health literacy levels. Staff members have thus pointed out ways to improve knowledge towards mental health for both healthcare professionals, and service users through the enhancement of mental healthcare education within PHC facilities.

All the participants stated that mental health education is important to improve help- seeking behaviour and improve health outcomes. They gave different options of how to raise awareness.

"*I think we should start off with campaigns.* " (SM4)

"It's *education; education is the foundation to everything.*" (SM7).

Some participants indicated door-to-door campaigns and presentations at PHC facilities focusing on mental health would be essential in educating communities about mental health.

Below is an example of excerpts.

"*Yes, Yes, like some presentations in the morning, making the community aware.*" (SM3)

"*I am thinking now if you were to go door to door ……. like having posters that say this clinic offers psychological services; we don't have posters like that in the clinic.*" (SM2).

Staff members highlighted that mental health education would be good starting point for introducing mental health services. Knowledge about mental health would not only allow the community to have a better understanding of services, but it would also assist in help-seeking behaviour and early detection of mental illness symptoms. There are several ways in which staff members think education can be disseminated. This may be influenced by the health education they have done in communities, which can be applied to mental health. They further recognise that there is a limited focus on mental health, such as focusing only on mental health education during Mental Health Awareness Month, which is not sufficient for distributing information. Furthermore, the simplicity of having a poster that indicates that services are offered, can draw in people who need the service, which may have a positive outcome. In addition, daily presentations concerning mental health may consolidate mental health information received by the community.

Staff members pointed out the need for the training of healthcare professionals, which would enable staff members to provide mental health services.

"*So, if the district could also ensure that even here, each facility in Grahamstown has a psychologist is readily available or even train us as nurses, do in-service on how to properly deal with patients with depression, because even us, we are not properly trained when it comes to those things.*" (SM4)

"*We need to be trained as staff because amongst us, there are staff members who have been here for years.*" (SM7)

From the above extracts, staff members highlighted the limited set of skills they possess to manage psychiatric conditions. This has been caused by the number of years since some staff members have been trained and the quality of their training. Furthermore, staff members may not have the confidence to manage these conditions and need support from the district that can supply them with a mental health professional trainer. This would enable a task- sharing approach in the integration of mental healthcare into the primary sector.

The provision of mental health services needs human personnel to be delivered. Staff members indicated below, suggest human personnel be employed, as was previously mentioned about a shortage of human resources in PHC facilities.

"Maybe we can have, maybe a psychologist that is based in the clinic. At least maybe that comes, maybe comes monthly or weekly or whenever." (SM13)

"*If we can have psychologists employed for the primary healthcare settings."* (SM16)

From the extract above, staff members indicated the need for psychologists in these facilities to provide treatment for mental illness. They prefer that the psychologist be based in the clinic to make these services accessible and available. Mental healthcare professionals would nurture mental healthcare staff, thus playing a role in strengthening the sector.

"*So, I think a psychologist was there, maybe a whole day or even a permanent station person. First, she would not have many backlogs because she is booked up until whenever but if you have a patient now that needs more urgent help. I mean she will go over and above; I mean she will come here early because she is only here a day.*" (SM2)

The participants who have a psychologist in their facility mentioned that it would be more beneficial if the psychologist came in more than once a day, as it is evident that there is pressure on the existing mental health services, due to the limited time they spend at the facility. This suggests that there are several mental health problems that require more time from a psychologist. SM2 thinks that the psychologist should increase their working hours in the facility to reduce the pressure of mental healthcare needs.

4.5 Theme 3: Barriers to Provision and Use of Physical and Mental Health Services

This theme aims to discuss the barriers to the provision of mental health services. However, the staff members also shared the barriers in the provision of health services. Sub- themes revealed by staff members include the shortage of medical equipment, human resources, and infrastructure and services.

4.5.1 *Sub-theme 1: Shortage of Resources*

The staff members described the lack of equipment for health services that impedes the clinic's functioning. This equipment would enable staff members to treat patients and protect staff members from infection, which they were unable to do, due to the equipment shortage. It seems that staff members did not have proper communication with the relevant stakeholders, regarding the reason behind the delayed equipment delivery. This suggests that there is lack of

communication and of medical equipment that has an emotional reaction of demotivation and frustration from staff members. Below is an example of a lack of equipment experienced by staff members.

"Like not so long ago, like a month ago, I think we didn't have dressing pegs, the dressing pegs were out of stock, but we heard through a referral that in an account, something wasn't paid. " (SM2)

Similarly, SM4 has also experienced a shortage of equipment at their PHC setting.

"I'll make an example now; the clinic has been out of gloves for about 2 weeks now, and that hinders us somewhere, to provide our utmost services to the public. So, in such..., in such cases, clients complain to us." (SM4)

The shortage of medical equipment seems to affect patient and healthcare professionals' relationship as a sense of dissatisfaction with service from patients. The long waiting periods adds pressure to staff members. Some staff members have indicated a lack of human resources to provide mental health services.

"No, not mental health because we don't have the personnel so... there is so much we can do." (SM13)

"We don't have a psychologist or psychiatrist here." (SM4)

It is difficult for services to exist without human resources to provide mental health services. A lack of staff members trained in psychiatric care leaves mental health problems of MHCUs untreated, contributing to the burden of mental illness. The healthcare professionals in these PHC facilities are faced with all these mental health problems, with no skills or training.

The staff members mentioned the lack of structural space within the facility that affects the provision of mental health services. These facilities have limited rooms and no areas to expand and provide mental health services. A lack of structural space is affecting not only mental health services but also health services. The following excerpts describe how the participants are unable to do anything because of these problems in PHC facilities.

"*For this clinic in particular, the staff is all right but now the problem would be space and infrastructure on itself in the clinic."* (SM13)

"*The problem is, especially with our clinic infrastructure, which is not allowing us to have more, may I say… activities or more things that we can do." (SM5)*

The struggle with limited infrastructure also affects health services as personnel may struggle to find room to do consultations. This limited infrastructure suggests that not much can be done to provide these services, leaving staff members uncertain of the next step in providing services.

4.5.2 Sub-theme 2: Attitudes towards Service Delivery

SM in this study was not happy with the level of mental healthcare being offered at the PHC facility to the community.

"*I'm not happy at all. Like there is no there's no psyche services here.*" (SM9)

SM16 highlighted the limited mental health services that are provided for MHCUs.

"No, I'm not. In the sense that the only service or the only treatment that we give is the tablet to this person that has got a mental issue, like a depressed patient. " (SM16)

Contrary to SM9 and SM16, some staff members were satisfied with the mental health services provided by the PHC facility. These participants noted that they provide medication, and MHCUs adhere to their treatment. These different views indicate a discrepancy between participants' perspectives of mental health service provision in PHC facilities. The following excerpts stipulate the participants' satisfaction with mental health services.

"*Yes, yes, yes because if, if we don't have i-treatment of other clients, like they are moss on different treatment but i.., the, the secondary or tertiary level hospital, they do send their treatment, so that they don't travel to get their treatment. So, we don't have any problem that we, we ran out of their treatment or short whatever, so it's going well for now.*" (SM5).

SM8 further indicated that due to the provision of treatment, MHCU's psychological disorders are being treated, thus improving their functioning.

"*I am satisfied, because all the patients coming from the hospital are stable.*" (SM8)

The dissatisfaction that the staff members experience due to limited mental healthcare services within primary care reflects the frustration of knowing what could be done to enhance the functioning of MHCUs but experiencing barriers due to a lack of resources. The difference between staff members' satisfaction highlights the training level on new mental health policies. The lack of training or knowledge of new policies creates a knowledge gap between staff members, towards understanding primary mental healthcare. This may create friction between staff members, which could develop into a difficult work environment, thus impacting the functioning of the PHC facility.

4.5.3 Sub-theme 3: Receptiveness to Services Provision

Some staff members indicated that patients within the facility respond poorly to the services that they provide. The following excerpt describes how service users receive and respond to the services provided by PHC facilities, which influence the relationship that they have with nurses.

"*For those abancinci (younger ones) they can be rude. And, and, and they want things done their way, or they fight either physically or verbally they fight.*" (SM12)

SM7 elaborated on the treatment they received whilst on community outreach within the community.

"The reason why people are not receptive, they are able to identify us from a distance. You hear them remarking and say, 'There comes these nurses' so automatically they think that we are troubling them, we want to force them to go to the clinic." (SM7)

The resistance to service provision by community members may be the result of a lack of knowledge about the delivery of these services. Without knowledge, community members are left to express their opinions on the reason behind these services. In addition, healthcare professionals may be faced with rejection because community members fear the stigma attached to receiving services. Moreover, due to numerous factors, such as long waiting periods and a lack of equipment that have influenced the patient healthcare professional relationship, community members are likely to be dissatisfied with healthcare professionals and reject their assistance. Alarmingly, their form of rejection threatens violence, whether physical or verbal, causing a sense of distress to the healthcare professionals.

4.6 Chapter summary

The perspectives of healthcare professionals towards primary mental healthcare in Makhanda have been examined and discussed in this chapter. Three main themes were presented, and the results were discussed. They were as follows: (i) Primary Mental Health Service Provision; (ii) Mental Health Literacy, and (iii) Barriers to the provision and uptake of health and mental health service. The findings suggest that there is a lack of provision of services, in mental health literacy and barriers in the provision of mental health. The results will be examined and discussed in chapter five.

CHAPTER FIVE

Discussion

5.1 Introduction

The study aimed to explore healthcare professionals' perspectives on primary mental healthcare in Makhanda. Three themes were revealed as follows: (i) Primary Mental Health Service Provision; (ii) Mental Health Literacy; (iii) Barriers to the Provision and Utilisation of Health and Mental Health Services. Under each theme, a discussion of the findings of participants has been connected to the existing literature, as necessary.

5.2 Discussion

Table 1

List of themes and sub-themes

Themes	*Sub-themes*
Process of Mental Healthcare	Importance of Primary Mental Healthcare
Mental Health Literacy	Stigma Improving Mental Healthcare
Barriers to Provision and Utilisation of Health and Mental Health Services	Shortage of Resources Attitudes Towards Service Delivery Receptiveness to Service Provision

The above table provides a list of the themes that were derived from the findings of this study. The following discussion provides detailed information of the results and interpretation. The meaning taken from these results signifies the research objectives and aim of this study.

5.2.1 Process of Mental Healthcare

Primary mental healthcare was developed to make mental health services more accessible to service users. The mental healthcare service provision varies across provinces within South Africa, to which the National Mental Health Policy Framework of 2013 to 2020 was noted as unequal. The findings in this study point towards limited mental health service provision of referral to hospitals for 72 hours and providing medication. According to Rathod et al.

(2017), referrals to mental health outpatient centres, psychiatric units within regular hospitals, or specialised psychiatric facilities are made for patients who are not able to get treatment at the primary care level. This shows a limited mental health service provided within these PHC facilities. Furthermore, the services that are provided seem to be biomedically focused, which includes providing medication and referrals only, which represents a previous policy of mental health services, which Mkhize and Molelekoa (2008) stated in their study. This suggests that there is a lack of implementation of the National Mental Health Policy Framework, leading to a gap in the provision of the mental health services. The findings noted the gap as they show that health services are extensive and thorough whilst mental health services seem restricted. The development of these policies was aimed at providing promotion for mental health which is the target for the third Sustainable Development Goal (SDGs) which is Global Health and Wellbeing (Jenkins, 2019). The targets that SDGs have, are faced with obstacles, as the goals are deemed challenging (Paravano et al., 2024), which translates to the slow progress of the development of integrated mental health services, thus indicating the slow application of the NMHPF.

However, there was one facility that has more advanced mental health services, which included assessment and therapy provided by a psychologist, as well as counselling by nurses. This indicates a development of growth of the integrated health services. Rathod et al. (2017) mentioned, that most low-middle income countries (LMICs) have seen a modest pace of growth in the development of mental health services which this facility reflects. However, despite the encouraging initiatives, such as NMHPF, it is yet to apply to other facilities.

Staff members in this study pointed out the importance of mental health services within primary care because it is the initial place individuals turn to for assistance, regarding a mental health problem. This highlights the role that primary mental healthcare plays within the integration of healthcare services and the accessibility to service users. Furthermore, mental health is important for services users as well because of the impact on the daily life of a service user. Though deemed important by health professionals, it is not prioritised because there is lack of services provided or psychoeducation about mental health in the facilities. Strümpher et al. (2016) pointed to a lack of organisational support by stakeholders leading to mental health not being prioritised. This suggests that there is a systemic issue that is affecting the importance placed on mental health service within primary care. The study by Docrat et al. (2019) highlights that even psychiatric hospitals in the Eastern Cape have a

problem accessing resources. It is also likely that the neglect of mental health services has played a significant role in the low prioritisation of mental healthcare.

5.2.2 Mental Health Literacy

According to Furnham and Swami (2018), an understanding of mental illness and how to recognise, treat, and prevent mental illness, is known as mental health literacy. Individuals' limited knowledge of mental health is often linked to cultural and religious aspects of illness and belief systems, which impact help-seeking behaviour (Rathod et al., 2017). In this study, the staff members mentioned the cultural beliefs attached to mental illness that make it difficult to educate patients in the facility. Since they have less faith in the therapeutic procedures provided, many people turn first to complementary practitioners, spiritual or faith healers, for assistance (Furnham & Swami, 2018; Rathod et al., 2017). Furnham and Swami (2018) stated that people, in general, recognise the symptoms of mental health illnesses rather poorly, which staff members in this study pointed out.

In this study, not only was stigma identified as a barrier to mental health services and the uptake of these services, by de Wet and Pretorius (2020), but also a result of low mental health literacy levels. Although stigma is not exclusive to mental illness, people with psychiatric illnesses appear to be more likely to be stigmatised by the public, which is possibly a consequence of limited knowledge of mental health that, unfortunately, has harmful effects (Corrigan & Watson, 2002). These staff members indicated the prejudice and self-stigma that MHCUs have of themselves when being provided with mental health services. According to de Wet and Pretorius (2020), stigma affects the recovery of MHCUs, as they may be reluctant to receive treatment, which the participants have noted.

Mental health literacy plays a role in health professionals' perceptions of mental health. Furthermore, the level of literacy of both health professionals and service users influences the efficacy of services and their reception. Thus, the findings highlighted the importance of mental health education and the training of healthcare professionals and human personnel to improve mental healthcare. The staff members pointed out various ways to educate the community. Raising issues in a particular way regarding mental health, is likely to benefit many people and enhance how people perceive, feel about and handle mental health (Benjamin et al., 2021). This will likely reduce the stigma toward mental health and have better outcomes for these services, such as treatment adherence. According to Petersen et al.

(2017), community-based intervention has supporting evidence from high-income countries to reduce the stigma and increase literacy levels.

Despite the development of the NMHPF, Rathod et al. (2017) mentioned that primary care providers currently lack mental health training. This illustrates the dearth of organisational planning in this crucial area (Rathod et al., 2017). Some participants indicated that one way to improve mental health services is training, which has been suggested by Strümpher et al. (2016). It was noted by Strümpher et al. (2016) that the lack of human resources puts pressure on healthcare professionals in these facilities. Not only will sufficient human resources allow for the development of task-sharing, but it will also enhance the relationship between healthcare professionals and patients in this facility, reduce stigma, and enable early detection and prevention.

Substance use was noted by staff members to be a prevalent disorder in PHC facilities as stipulated in mental health literacy theme. Onaolapo et al. (2022) stated that substance abuse is a worldwide burden; a disease that has increased exponentially with the growth of African nations. Individuals in underdeveloped countries are more susceptible to mental health issues because of social factors that impact their standard of living (Alegría et al., 2018). Socioeconomic problems that affect developing nations, such as poverty, unemployment, a lack of support, and low levels of education, contribute to the prevalence of substance abuse (Uchtenhagen, 2004). Interestingly, in this study, substance use disorder, and psychiatric conditions were the only disorders noted that affected the community. This is likely the behavioural change and the impacts the symptoms have, either within the facility or in the community (Alegría et al., 2018; Uchtenhagen, 2004).

5.2.3 Barriers to the Provision and Use of Physical and Mental Health Services

Jacob (2017) averred that some health service issues in LMICs include inadequate funding; overworked systems; inadequate training for medical personnel; professional indifference, and low morale among primary healthcare, and terrible settings. Similar issues were mentioned by the participants in the study, which affected not only health services but also the provision of mental health services. The absence of medical equipment was mentioned by staff members, which Moyimane et al. (2017) highlighted in their study as a barrier to the health system's capacity to provide quality healthcare, as well as affecting the well-being of nurses. The findings in this study indicate that nurses were demotivated and

often had to choose to protect themselves from getting sick, due to a lack of equipment, affecting the patient-healthcare relationship.

Strümpher et al. (2016) have reported that the shortage of human personnel and structural conditions for mental health services are significant problems experienced by both healthcare professionals and patients in healthcare facilities in the Eastern Cape. This also applies to the PHC facilities in this study, as staff members indicated that a lack of these resources, led to an inability to access care and resulted in travelling long distances at great expense, to access the services.

The staff members in this study indicated that they were dissatisfied with the mental health services they provided. According to Resende et al. (2016), staff dissatisfaction with mental health service provision is often due to a lack of resources within their work environment. In the case of the staff members in this study, not only were resources lacking but mental health services were limited only to referring MHCUS for observation and continuing treatment. This highlights the large systemic barrier that is limiting services being provided, which may lead to the demotivation of staff members. However, some staff members were satisfied with the mental health services. This may be caused by the lack of training of current mental health policies mentioned in the paper by Rathod et al. (2017). This is likely a lack of preparation for mental health services by relevant stakeholders (Rathod et al., 2017) that resulted in this discrepancy. This further points towards systemic barriers that these facilities are facing, which impact how they view mental healthcare service delivery.

Staff members noted that patients in PHC facilities resist assistance and threaten physical or verbal violence. According to Hartley et al. (2020), a difficult environment may hinder the formation of strong nursing relationships with mental healthcare users. Owing to a lack of resources and long waiting periods, patients may be dissatisfied with services, resulting in a lack of receptiveness. This may expose personnel and service users to relationship issues, negatively affecting well-being and effectiveness (Hartley et al., 2020).

5.3 Conclusion

This chapter has explored the perspective of healthcare professionals towards mental healthcare. The three main themes were discussed which include: (i) Primary Mental Health Service Provision; (ii) Mental Health Literacy; (iii) Barriers to the provision and uptake of health and mental health services. The conclusion, recommendation and limitations of the study will be explored in chapter six.

CHAPTER SIX
Conclusion

6.1 Introduction

This chapter provides a summary of the key findings and an outline of the research that was done. Final findings are presented, along with a description of the field's limitations and suggestions for further study.

6.2 Summary of Results

The study centred on staff members' descriptions of the limited mental health services within primary healthcare facilities (PHC) in Makhanda. These services included referring the mental health care user (MHCU) for a 72-hour assessment and continuing their medication at the primary health care facility. This indicates that treatment is not initiated within PHC facilities. Furthermore, compared to the mental health services, health services were more comprehensive and inclusive of a wide range of services, including allied health professionals for service users at PHC facilities. This represents a gap between these services leading to the burden of mental illness. Furthermore, the staff members consider mental health services as important as health services. However, it is not prioritised by the relevant stakeholders.

Staff members revealed that there was a lack of mental health literacy within the community and often people understood the cause and treatment of mental illness from a cultural/traditional perspective. This has led communities to alternative forms of treatment before psychiatric assistance. In addition, the participants pointed out that communities show more knowledge of psychotic disorders than other mental disorders. Substance use disorder was the prevalent disorder that the participants saw within the PHC facility, particularly in the younger generation. The lack of mental health literacy impacts staff members' perceptions of service provision. Therefore, staff members indicated that education on mental health can improve mental health literacy. Staff members also indicated ways to improve mental health services, such as mental healthcare professionals for the provision of care within the facilities, such as psychologists. Secondly, more education/awareness for mental health is needed for people, which could occur via door-to-door campaigns and presentations at the clinic. Lastly, training for healthcare professionals would be beneficial as it would assist with the lack of human resources.

Barriers to service provision were noted not only for mental services but health services as well. This included a lack of medical equipment which prevented participants from providing health service which led to feelings of demotivation. The lack of human resources to provide mental health services was another barrier noted by the participants. Human resources, including a psychologist or psychiatrist, were absent in PHC facilities.

Limited structural space that prevented facility from developing an area where mental health services could be provided. was another barrier mentioned by the participants. Stigma from community members towards MHCUs prevented MHCUs from seeking mental health services. It also led to self-stigma which leads to MHCUs not effectively engaging in treatment adherence or seeking assistance. The last barrier that the participants revealed was that community members were not availing of services provided by PHCs.

Though the participants described the same services, some participants were satisfied with the services as they managed MHCU's mental health. Other participants thought more mental health services could be provided within PHC facilities. This discrepancy maybe as a result of a lack of resources within the facility, which impacts the services that are provided and the perceptions of staff members.

6.3 Conclusions

This study provided insights that mental health literacy is still lacking in the PHC facilities in Makhanda, which plays a role in the prevalence of a stigma towards mental health. Furthermore, barriers, such as a lack of human resource and infrastructure for the provision of mental healthcare impacts the attitude healthcare professionals have towards the provision of services. Thus, healthcare professionals face challenges of recognising mental health issues and being restricted in service provision. Furthermore, these facilities also experience an absence of medical equipment which points towards another barrier in providing health services. Mental health services are a component of health services, suggesting that the lack of resources for health services has a ripple effect on associated services. The study has shown that mental health services within these facilities is biomedically focused, indicating a slow pace in the adaption of the National Mental Health Policy Framework and ultimately not meeting the target for Sustainable Development Goals at a global level. The burden of mental illness is prevalent, according to the findings of this study and healthcare professionals are limited in their provision of care. This study has shown the need and necessity of this type of research, by exploring primary healthcare perspectives towards primary mental health in Makhanda. The study's reflexive thematic analysis and methods have shown to be effective in

providing light in this area of research. The information gathered from this study could be applied to improving knowledge of the support required and the barriers faced by healthcare workers, as well as primary mental healthcare being more pertinent and easily accessible.

6.4 Limitations of the study

Owing to the limited time and resources available, the restricted scope of the current study and the demanding technical requirements of a Master's dissertation, are some of the limitations of this study. More time and funding should be available for further research, which would be advantageous to the problems faced in the integration of primary mental healthcare Secondly, the study's limitation concerns the small sample size that was utilised. However, the limited sample size allows for in-depth knowledge of the participants' perspectives, thus making it appropriate for this study. The study focused on healthcare professionals within PHC facilities who were mostly professional nurses and operational managers. Thus, it could be worthwhile investigating the perspectives of other categories of healthcare professionals, such as doctors or dentists in PHC facilities in Makhanda.

6.5 Recommendations

6.5.1. Further research

This research is among the first to focus on the perspectives of healthcare professionals towards primary mental healthcare in Makhanda. This provides a wealth of directions for further study. Moreover, it is possible that other factors that have an impact on the perspective of healthcare professionals working in primary mental healthcare in Makhanda have not yet been discovered, due to the research's narrow focus and small sample size. Therefore, greater research in this field and a bigger sample size would be helpful in revealing more distinctive and varied viewpoints.

6.5.2 Implementation of National Mental Health Policy Framework

The integration of mental health services could assist with bridging the gap between health and mental healthcare. A catalyst in this process would be to alleviate the barriers to service provision as it would be crucial in improving mental health services. The alleviation of

barriers would enhance and improve the quality of life for MHCUs, as their access to these services is improved; this includes financial support and collaboration between various sectors. A recommendation to reduce the stigma would beneficial, as it would promote spaces where MHCUs can share their experiences without judgement and discrimination. More human resources suggests that services could be provided, allowing people to access these services. Training healthcare professionals would enable task-sharing, an important aspect in integrated services. Community outreach within the environment with which communities are familiar, would increase the chances of people understanding mental illness.

6.5.2 Promotion of Mental Health

On par with the SDG third goal, it is suggested that mental health awareness campaigns in PHC facilities and communities to promote mental healthcare should take place. Collaboration with existing cultural methods is recommended to improve the utilisation of mental health services, ensuring care for all. Furthermore, psychoeducation for healthcare professionals is proposed, to increase their knowledge of mental health, thus influencing their provision of care.

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Appendix A

INTERVIEW SCHEDULE

1. Can you briefly introduce yourself; tell me about your professional background? *(Prompt: Role as facility manager?)*

I would like to start with questions about the services at the clinic.

2. Describe the services that the clinic provides to the community? *(Prompt: specific services? staff? resources? Relationship between the clinic and community; relationship between clinic and sub-district?)*

I would like to start with questions about mental health service provision.

3. Based on your understanding, what is the role and objective of mental healthcare at a primary care level? *(Prompt: What should MH care look like at a PHC level?)*

4. How does the general community view mental illness? *(Prompt: Are there any differences between different groups, e.g. younger persons vs senior persons?)*

5. What initiatives are needed to address stigma and discrimination toward people with mental health problems? (*Prompt: e.g. anti-stigma campaigns, support for user advocacy/organisation, inclusion in government activities, etc.)*

6. How important is mental health for the clinic, compared with other health conditions? Why is that? (*Prompt: For example, HIV/AID, TB, child and maternal health)*

7. Does the work of your clinic involve issues related to mental health? What is this work? (*Prompt: For example, in education, whether they have any school/community mental health programmes, etc.)*

8. (If it does involve issues related to mental health) What groups or individuals does your clinic deal with on mental health issues? *(Prompt: specific gender, social and age groups, e.g. men, women, children, adolescents, prisoners, etc.)*

9. Are you satisfied with the services that are provided by your clinic in relation to mental health? Could they be improved?
   (Prompt: Services could include school mental health, care of victims, the elderly and children in the care of social services, care of prisoners with mental health problems, the drug addicts, etc.)

10. Would the community access mental healthcare at a clinic level if the services were readily available?
    (Prompt: If not, explore why? If yes, explore why? Barriers and facilitators?)

11. Are primary care clinics resourced enough (human and equipment) to provide mental healthcare?

    (*Prompt: access to professionals? Consultation rooms? Support from district departments and the municipality?)*

12. Are there any other comments you would like to make about the mental health services in Makana Municipality?

Thank you

Appendix B

PARTICIPANT INFORMED CONSENT DECLARATION

(To be signed by research participants)

Research Project Title: Public mental health needs, challenges, services, barriers, and opportunities in the Makana Municipality in the Eastern Cape.

Dr Duane Booysen from the Department of Psychology, Rhodes University, has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project will be to explore and describe the systemic nature of mental health service provision and its relevance in the Makana Municipality in the Eastern Cape.

2. Rhodes University has given ethical clearance to this research project 2022-5578- 7109 and I have seen/may request to see the clearance certificate by contacting the Ethics Coordinator (ethics-committee@ru.ac.za).

3. By participating in this research project, I will be contributing towards research about the systemic nature of mental health service provision and its relevance in the Makana Municipality in the Eastern Cape.

4. I will participate in the project by being interviewed about my experiences and perceptions as a health professional, working at a primary care level, about the nature and relevance of mental health service provision in Makana municipality.

5. I understand that my participation in this research will also contribute to the creation of a series of academic articles, a Master's thesis, and conference presentations.

6. My participation is entirely voluntary and should I, at any stage, wish to withdraw from participating further, I may do so without any negative consequences.

7. I will not be compensated for participating in the research.

8. The following risks are associated with my participation: The contraction of Covid-19 through in-person interviews which will be prevented through the full disclosure of my vaccination and masks will be worn throughout the interview. If at risk or not vaccinated, the interview will take place via Zoom or telephonically.

9. The researcher will maintain confidentiality and anonymity of all data collected, and my name and identity will not be revealed to anyone who has not been involved in conducting the research, *unless I indicate to the contrary/recognise that as a public figure, my identity will inevitably be/become known, in which case I agree to and accept the loss of confidentiality.*

10. In terms of the Protection of Personal Information Act (No. 4, 2013), it remains my right to request the researcher to provide me with a detailed explanation of exactly how confidentiality and anonymity will be achieved. I may request to know how my personal information will be stored securely, and for how long it will be stored.

11. If any data collected from me for this research project are to be used by the researcher for any further project, I am to be informed in writing, and my written consent requested again. I need not give consent if such further research is incompatible with the initial data presented for this study (POPIA, s15 (3)). Equally, I can simply reject the request. In such cases a formal request needs to be made by the researcher via the Ethics Coordinator (ethics-committee@ru.ac.za).

12. In terms of the Protection of Personal Information Act, I possess the right to receive feedback about this research. This will take the form of receipt of a copy of the academic articles and MA thesis work made from the research I participate in, *unless I elect not to receive feedback.*

13. Any further questions that I might have regarding the research, or my participation will be answered by Dr Duane D. Booysen who can be contacted at d.booysen@ru.ac.za or 0466038507.

14. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.

15. I **agree/disagree** with the researchers' request to voice record my comments and opinions during interviews, the purpose of which is to ensure the accurate recording of my views. The environment of my choosing where the interview will take place will also be taken into consideration in the research results for further analysis in this research project. Furthermore, I have the right to request a copy of interview transcriptions to confirm that my opinions are accurately recorded.

16. A copy of this informed consent declaration will be given to me, and the original will be kept on record by the researcher.

I, ..., have read the above information / confirm that the above information has been explained to me in a language that I understand, and I am aware of this document's contents. I have asked all the questions that I wished to ask, and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

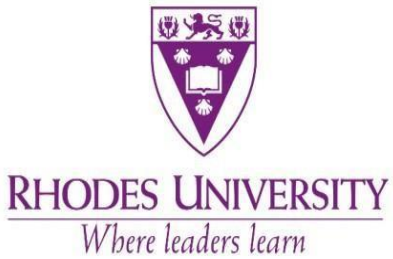
I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

……. …….

Participants signature **Date**

Appendix C

Institutional Permission and RPERC Clearance Letters



Rhodes University Human Research Ethics Committee
PO Box 94, Makhanda, 6140, South Africa
t: +27 (0) 46 603 7727
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e: ethics-committee@ru.ac.za
NHREC Registration number: RC-241114-045

https://www.ru.ac.za/researchgateway/ethics/

12 October 2022

Dr Duane Booysen

Email: D.Booysen@ru.ac.za d.booysen@ru.ac.za hainephillipa@gmail.com, siphelelezwane31@gmail.com, zpiliso92@gmail.com

Review Reference: 2022-5578-7109

Dear Dr Duane, Booysen

Title: Public mental health needs, challenges, services,

barriers, and opportunities in the Makana Municipality

in the Eastern Cape

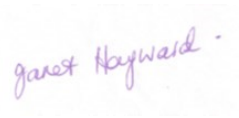
Researcher: Dr Duane Booysen

Supervisor(s): Dr Duane Booysen, Ms Phillipa Haine, Ms Siphelele Zwane, Ms Zandisiwe Piliso

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Rhodes University Human Research Ethics Committee (RU-HREC). Your Approval number is: 2022-5578-7109 Approval has been granted for 1 year. An annual progress report

will be required in order to renew approval for an additional period. You will receive an email notifying you when the annual report is due.

Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated. Sincerely,



Dr Janet Hayward

Chair: Rhodes University Human Research Ethics Committee, RU-HREC

cc: Ethics Coordinator

Appendix D

Gatekeeper Approval Letter

Province of the
EASTERN CAPE
HEALTH

Enquiries: Yvonne Sixela Tel no: 079 074 0859

Email: Yvonne.sixela@echealth.gov.za / [illegible]@gmail.com

Date: 10 October 2022

Re: Public mental health needs, challenges, services, barriers, and opportunities in the Makana Municipality in the Eastern Cape. (EC_202209_008)

Dear Dr. D. Booysen

The department would like to inform you that your application for the above mentioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Ethics Research Committee.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.

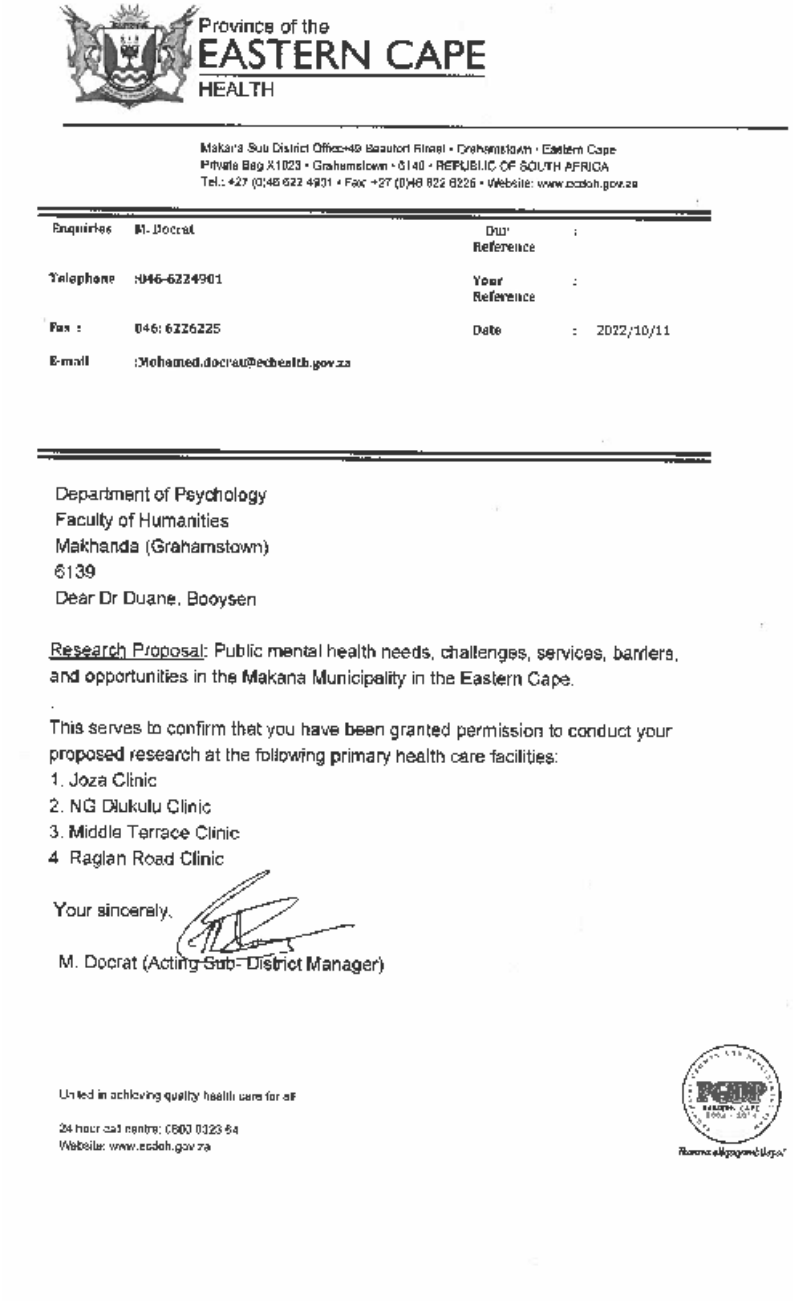
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTE

2030 NDP

TOGETHER, MOVING THE HEALTH SYSTEM FORWARD



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EASTERN CAPE
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Department of Psychology
Faculty of Humanities
Makhanda (Grahamstown)
6139
Dear Dr Duane. Booysen

Research Proposal: Public mental health needs, challenges, services, barriers, and opportunities in the Makana Municipality in the Eastern Cape.

This serves to confirm that you have been granted permission to conduct your proposed research at the following primary health care facilities:

1. Joza Clinic
2. NG Dlukulu Clinic
3. Middle Terrace Clinic
4. Raglan Road Clinic

Your sincerely,

M. Docrat (Acting Sub- District Manager)

Appendix E

Table of Super-ordinate Themes, Sub-themes and Corresponding Quotations

(i)Process of Mental Healthcare		"*If a person is manifesting signs of mental illness, first, in most cases they bring them here to the clinic, we conduct the mental healthcare examination, we score them, and they are up for referral at Settlers hospital where they are taken for a 72-hour assessment where they will be determined that whether they go to Fort England or what."* (SM4) "*They are referred to psychiatric hospital and then you find that they are discharged from that, and they go back to community and the continuation of care is done by us at the clinic so.*" (SM13) "*Because at clinic level we don't initiate." (SM5)* "*They are sitting for sickness or whatever because it first comes serve basis, so they get impatient…….I know we shouldn't actually but not shouldn't because it's unfair to other patients, but we will do it, we will call that person first. Especially the aggressive one.*" (SM2)

		"*…. cognitive assessment for the kids, referrals form the schools, and then pre-marriage counselling, post-traumatic stress, or for an assessment if you suspect… sometimes you will talk to a person and you will see, yha, "Something is not ok. Then we will refer to the psychologist."* (SM2) *"And nurses are also counsellors."* (SM2*)*
	Importance of Mental Healthcare	*"We get to see these things before it's too late, since we work with people on a day to day basis."* (SM7) *"The role of mental healthcare at a primary healthcare level, I'd say it is important…..It is definitely not a priority, they don't prioritise at all, and it's very painful to see.*" (SM7)
(ii) Mental Health Literacy		"*The community itself. I think there are things that are just... like for example, you have your elderly people that have their problems of I don't know dementia or whatever and then obviously they will see that in their sense that this is an old person having these problems and many may understand or they may, I don't know have some sort of myths attached to it such as witchcraft there are cases like that.*" (SM13) "*But as a community I think they are aware of*

		the more visible signs of mental health like your delusions or whatever. They understand that but the subtle ones like your anxiety and your depression, not so much I think." (SM13)
	Stigma	"*Yhoo, there is a huge stigma, there is a huge stigma, I don't think it will go away anytime soon because, even here at the facility you'll hear them calling them amageza (crazy people), all those things.*" (SM4) "*Mentally disturbed then the community uyagula(you are sick). People don't want to be associated with you……. The community, they just don't want you. You're just their puppy dog in the community if you are mentally disturbed.*" (SM12) "*You know the older group will literally tell you, I am not crazy.*" (SM12) "*But the younger ones they have that stigma. And I feel sometimes that's why they don't even come to the clinic and take their treatment because now they are afraid of that stigma of that mental illness. Even if they take treatment but they're not psychotic because they are controlled still, they don't take treatment because of the stigma.*" (SM9)

	Improving Mental Healthcare	"*I think we should start off with campaigns.*" (SM4) "It's *education, education is the foundation to everything.*" (SM7) "*Yes, Yes, like some presentations in the morning, making the community aware.*" (SM3) "*I am thinking now if you were to go door to door ……. like having posters that say this clinic offers psychological services, we don't have posters like that in the clinic.*" (SM2) "*So, if the district could also ensure that even here, each facility in Grahamstown has a psychologist is readily available or even train us as nurses, do in-service on how to properly deal with patients with depression, because even us, we are not properly trained when it comes to those things.*" (P4) "*We need to be trained as staff because amongst us, there are staff members who have been here for years.*" (P7)

		"Maybe we can have, maybe a psychologist that is based at the clinic. At least maybe that comes, maybe comes monthly or weekly or whenever." (P13) "*If we can have psychologists employed for the primary healthcare settings."* (P16) "*So, I think a psychologist was there, maybe a whole day or even a permanent station person. First, she would not have many backlogs because she is booked up until whenever but if you have a patient now that needs more urgent help. I mean she will go over and above; I mean she will come here early because she is only here a day*." (SM2)
(iii) Barriers to Provision and Use of Mental Healthcare Services	Shortage of Resources	*"Like not so long ago, like a month ago, I think we didn't have dressing pegs; the dressing pegs were out of stock, but we heard through a referral that in an account something wasn't paid."* (SM2) *"I'll make an example now; the clinic has been out of gloves for about 2 weeks now, and that hinders us somewhere to provide our utmost services to the public. So, in such..., in such cases, clients complain to us."* (SM4) *"No, not mental health because we don't have the personnel so... there is so much we can do."*

		(SM13) *"We don't have a psychologist or psychiatrist here."* (SM4). "*For this clinic in particular, the staff is all right but now the problem would be space and infrastructure on itself in the clinic."* (SM13) "*The problem is, especially with our clinic infrastructure, which is not allowing us to have more, may I say…, activities or more things that we can do." (SM5)*
	Attitudes Towards Service Provision	"*I'm not happy at all. Like there is no, there's no psyche services here.*" (SM9) *"No, I'm not. In the sense that the only service or the only treatment that we give is the tablet to this person that has got a mental issue, like a depressed patient. " (*SM16) "*Yes, yes, yes because if, if we don't have i-treatment of other clients, like they are moss on different treatment but i.., the, the secondary or tertiary level hospital, they do send their treatment so that they don't travel to get their treatment. So, we don't have any problem that we, we ran out of their treatment or short whatever, so it's going well for now.*" (SM5)

		"*I am satisfied, from the hospital are stable.*" (SM8)
	Receptiveness to Services	"*For those abancinci (younger ones) they can be rude. And, and, and they want things done their way, or they fight, either physically or verbally, they fight.*" (SM12) *"The reason why people are not receptive, they are able to identify us from a distance. You hear them remarking and say, "There comes these nurses" so automatically, they think that we are troubling them, we want to force them to go to the clinic.*" (SM7)