

Factors that influence access to mental health care service: The perspective of service users and the community in western 2 health region of the Gambia

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Abstract

Access to mental health care service remains a major problem globally, but more obvious in developing countries including the Gambia. In general, mental illnesses even though are acknowledged as great contributors to the global burden of disease, they receive little attention at global, regional and local levels compared to other illnesses such as communicable diseases.

Access to mental health care in the Gambia deserves urgent attention. Whereas no recent study is done to examine the prevalent rate and treatment gap, the available data shows that 90% of mentally ill patients who require treatment do not receive it.

The aim of this study was to contribute to the improvement of access to mental health care service by exploring factors that influence access to mental health care service in the Gambia using a qualitative research design. In-depth interviews with 15 mentally ill patients using the community mental health services and 5 focus group discussions with the general population in the same health region were conducted.

The findings of this study highlight many factors that could influence access to mental health care service among people with mental illness in the Gambia. The most important of these factors that shed light on access to mental health care service include; perception of and believed causes of mental illness; In addition mental health service (biomedical) is scarce for most of the population resulting in patients and their families using what is available and also travel long distance to access services. The lack of satisfaction from these services also leads to syncretic use of different treatment systems, coupled with high cost of treatment (traditional system) and antipsychotic medicine. The findings further show that the patient's family shoulder the responsibility of providing the required financial resources for treatment and medication, but also decide where treatment is sort from.

Efforts to improve access to mental health services should be approached holistically, as it is influenced by social, family and health system factors. This study however provides a base for action to address access to mental health care service. Collaboration with traditional healers, provision of mental health services through the community mental health team and long term plan to address poverty can improve access to mental health service in Gambia.

Dedication

This work is dedicated to my Mum and Dad for the support you gave me and the struggle you took to lay a strong foundation for my life.

To my Mum, for your struggle to see me through primary to University. I am indebted to you.

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List of acronyms

APA: American Psychiatry Association

CHN: Community Health Nurse

CIOMS: Council for international organization of medical sciences

CMHT: Community Mental Health Team

DALYs: Disability-adjusted life years

DSM: Diagnostic and statistical manual

FGD: Focus group discussion

GBOS: Gambia Bureau of statistics

GDP: Growth National Product

ICD: International classification of diseases

IFAD: International fund for agricultural development

mhLAP: Mental health leadership and advocacy program

MDG: Millennium Development goals

MGMH: Movement for global mental health

MOHSW: Ministry of health and social welfare

MRC: Medical research council

NGO: Non-governmental organization

NSD: Norwegian social science data service

PTSD: Posttraumatic stress and depressive symptoms

RHMT: Regional health management team

REK: Regional committee for medical and health research ethics

SDG: Sustainable development goals

WHO: World health organization

Structure of the thesis

This thesis comprise of six different chapters. In the first chapter, back ground information on the burden of mental illness is presented. Back ground information of the Gambia where the study was conducted including mental health situation is also included in this chapter. The rationale for the conduct of this study, the study objectives and the research questions that were pursued also form part of the first chapter. In the second chapter, a literature review on the subject is presented. In the third chapter, the research design and the methodology employed are present. My reflections, data analysis and ethical considerations are also discussed in this chapter. In the fourth chapter, the study findings are presented, followed by the discussion of the findings in the fifth chapter. In the last chapter, the conclusion, limitations, and implications of the study are presented. The ethical clearance for the conduct of this study, interview guides used in the data collection and consent forms as well as the information sheet are presented at the appendices.

Chapter 1: Introduction

1.1: Introduction

Globally, the treatment gap for mental illnesses, that is, the number of people who required treatment but do not access treatment, is very wide especially in low income and middle income countries. This wide treatment gap, has been recognized by the global community as an important public health problem (Bass et al., 2012; WHO, 2013). These illnesses are identified as major contributors to the global disease burden (Whiteford et al., 2013) accounting for 13% in 2004 (WHO, 2013).

Globally, the number of people affected by mental illness is enormous as indicated by recent data from the 2010 global burden of disease study. It is estimated that over 450 million people have mental illness (Mathers & Loncar, 2006) and about 80% of these people are said to live in low income and middle-income countries (Prince et al., 2007).

According to WHO estimate, globally, 59 million people suffer from bipolar disorder, while 24 million suffer from schizophrenia (WHO, 2014). Similarly, WHO estimates indicate that one in four people will experience a mental health condition in their lifetime and that approximately 600 million people worldwide are disabled as a consequence (WHO, 2003).

However, despite the recognition of the immense contribution to the global burden of disease and their effects on people who are suffering from these illnesses, majority of people who require treatment for mental illnesses do not have access to treatment.

The concept of access according to Puentes and others (Puentes-Markides, 1992), is difficult to define exactly in operational terms but is frequently related to the risk that people who actually need service are unable to obtain it. For Aday and Andersen however, access is considered in term of whether those who need service get into the system or not (Aday & Andersen, 1975). Access, for the purpose of this study, refers to the opportunity of being able to use mental health service by people who need such service.

WHO estimate indicates that between 76% and 85% of individuals with mental illnesses receive no treatment for their condition in low income and middle-income countries. While in high-income countries, an estimated 35% to 50% of affected people do not receive treatment (WHO, 2013). Similarly in Europe for example, it is estimated that 38.2% of the population has a mental illness but less than one-third receive any treatment (Wittchen et al., 2011).

People affected by these illnesses are faced with higher rates of disability and mortality. For instance, individuals with schizophrenia and major depression have a 40% to 60% increased chances of dying prematurely than the general population. These premature deaths are often the result of other physical health illness such as cardiovascular diseases, cancers, diabetes, HIV infections and suicide (Whiteford et al., 2013).

The Movement for Global Mental Health (MGMH), (Eaton, Kakuma, Wright, & Minas, 2014) argument that, because mental illnesses impact equally or more on life expectancy as thus smoking, diabetes, and obesity. Therefore it should also be included in the post 2015 development agenda. Another area of profound concern is that people with mental illnesses are also challenged with human right violation such as chaining and are subject to treatment without their consent. They are also discriminated against and being denied to take part in political activities and exclusion from social, family life and education (Eaton et al., 2014).

A survey done in the Gambia in 2007 (MOHSW, 2007) indicates the prevalence rate of mental illnesses at 120,000, of which 27,000 are said to suffer from schizophrenia, bipolar and anxiety disorders. However, about 90% of these people do not access services for their conditions.

From a search of different database, there is a paucity of published research data on mental health in the Gambia. The World health atlas country profile of 2014 indicates that there is a stand-alone policy or plan for mental health in the Gambia, but the said plan has not been implemented due to lack of funding. The atlas also indicates a scarcity of mental health professionals for the delivery of mental health service in the county.

Several studies suggest that local concepts about mental illness such as attributes of causation, treatment acceptability, and stigma impede care seeking even where the services are available (Miranda & Patel, 2005).

From other studies, we know that people seek help for other illnesses from religion, traditional as well as biomedicine. We also know from other countries that this also applies to mental health.

1.2: Background

1.2.1: Country profile



Figure 1: Map of the Gambia

The Gambia is a small country located on the bulge of the West Africa Atlantic coast and stretches about 400 kilometres inland. The country is bordered by the republic of Senegal on east, south and north and the Atlantic Ocean on the west as in figure 1. The country is divided into two by the river Gambia which flows from the Futa Jallon highland in Guinea. Gambia has a land area of about 10,689 square kilometres and a width that varies from about 50 kilometres near the mouth of the river to about 24 kilometres inland.

The Gambia was ruled by the British for over two centuries. The Gambia gained independence in 1965 and became a sovereign republic in 1970. The first republic under self-rule lasted until July 1994. The second republic came through a coup d'état and the military took over the country for two years before it returned to democratic rule as it is today.

According to the 2013 population and housing census, the Gambia has a population of 1,882,450 with an annual growth rate of 3.3 per cent. More than half of the population are female. It has a high population density of 176 persons per square kilometre, making it one of the most densely populated countries in Africa (GBOS, 2013). Nearly 44% of the population is below 15 years and 19% between the ages 15 to 24. Recent estimates indicate

an unemployment rate of 22% affecting mostly the youth population (IFAD, 2016). See figure 2 for some key indicators of the Gambia. With an annual growth rate of 3.3 per cent, the Gambia’s population is expected to double in the next 21 years (GBOS, 2013). Such increase in population will have policy implication for the health sector and also mental health.

The Gambia is divided into five administrative regions and two municipalities, Banjul city council, Kanifing municipal council, West coast region, Lower river region, Central river region, Upper river region and North bank region. However, in terms of health administration, the country is divided in to seven health regions and these are western 1 health region, western 2 health region, Mansakonko health region, Bansang health region, Basse health region, North bank east health region and North bank west health region.

The Gambia has a typical sahelian climate which is characterised by a short raining season from June to October and a long dry season from November to May. During raining season, people are engaged in agricultural production and the common types of crops grown are; groundnut, rice, maize, millet cassava and findi. Most of these crops grown are for family consumption and some for sell. Animal husbandry is also practiced along the crop production by some people especially in the rural area. Dry season vegetable production is also practiced throughout the country, but mostly by women. Most of them use this earning to support their families.

Figure 2: Indicators of the Gambia

Indicators	Number
Total population (2013)	1,849,000
Gross national income per capita (PPP int, \$, 2013)	\$1
Life expectancy at birth M/F (2013)	60/63 years
Total expenditure on health per capita(int, \$, 2013)	\$99
Total expenditure on health as % of GDP(2013)	6.0%

Source: (WHO, 2015a) Country statistics and global health estimates by WHO & UN partners (2015)

The Gambia has about nine different ethnic groups that co-exist together. One of these ethnic groups is Mandinka, which forms the largest population; the others are Wolof; Fulla; Jola; and Sarahulleh. However, these groups share so many things in common and this is what binds them together. For example, there is a lot of inter-marriage between the ethnic groups and some cultural practices are performed together such as circumcision initiation for both boys and girls and traditional marriage ceremonies. People mostly live in extended family systems especially in the rural area and as such decision making is mostly a family matter. For example, who you should marry to, where to seek and when to seek health care are influenced by family decision.

People in these different cultural groups share beliefs about illness and disease and how these are treated and by whom. Beliefs in supernatural power, witchcraft, black magic, demons, evil spirits are all very common beliefs and associated to illness and disease. The use of traditional and religious healing practices is very common among the different ethnic groups. Beliefs that some types of illness can be treated by a particular ethnic group also exist. For example, a somatoform like illness locally called 'dewdi' is commonly believed that can only be treated by an ethnic group referred to as Fulla ethnic group.

1.2.2: Religion

The Gambia is a secular state. However, 95.3% are Muslims, while 4.1% are Christians, less than 1% of the population practice other faiths or no faith.

Despite the difference in faith, people practicing these two religions do live together in one community, work together, do social practices together and live amicably each practicing their faith. While Muslims are found in every part of the country, Christians are mostly found around the urban areas.

People in this society live within the confines of religion and culture, which could have an influence on their practice and beliefs about illness and disease and how they are treated. For each of these religions in the Gambia, they have their leaders who are highly respected and followed. Most of these leaders are not only involved in religious matters but also social and cultural issues. People resort to them in times of distress and difficulty for prayers and healing.

1.2.3: Economy

The Gambia is categorised among the low in-come countries, with a per capita gross domestic product of about \$300.00. According to the most recent human development index report, the Gambia ranked 175 out of 185 countries, a drop in ranking from 172 out of 185 in the previous report. A most recent data indicate that over 60% of the Gambian population lives below poverty line (IFAD, 2016).

The main stay of the economic is agriculture production which contributes 20% to the country's GDP and also the main employer of labour. Up to 75% of the populace depend on agriculture as their source of income.

Tourism is also another importance sector that contributes to the country's GDP and serves as a source of employment and foreign exchange. However, the tourism sector operates on seasonal bases. During the off season, some of the people employed are laid off and some small scale businesses around the tourism industrial area close until the next season. This also affects employment and earning for those depending on this sector.

1.2.4: Education

The Gambia's educational system is basically divided into four different levels; lower basic, upper, senior and tertiary. The lower basic, consist of six years of education and entry into this level starts at age six. The upper basic, which is the second level, consist of 3 years of education at the end of which students sit to an examination to get entrance into the next level which is the secondary level. The senior secondary level also consists of three years of education and ends with a sub-regional examination for Anglophone West African countries of Gambia, Nigeria, Ghana and Sierra Leon. It is important to note that education at the first three levels is free for girls and free for the boys at the first two levels. This is done to encourage more girls to go to school.

There is only one public college which is the main producer of human resource for the health and other sectors like agriculture. Basically there are two schools under the college that trains public health officers and nurses at certificate and diploma levels. These graduates make up the human resource for health at the different levels of service provision.

The University of the Gambia is the only public university, established in 1999 and now train medical doctors, public health officers and nurses to first degree level. This has helped the ministry of health in its human resource development.

1.2.5: Health system

The Gambia government through the Ministry of Health is the main provider of health care services. The health delivery system is based on the primary health care strategy which was adopted since in the early 1980s.

The ministry consist of three levels of administration;

The central level - consist of central structures (program units)

The Regional level – this include the 7 regional health directorates

District – consisting of community services

The health service delivery is arranged into three level of care; primary, secondary and tertiary. The primary level consists of the village health services and community clinics; the secondary comprises of the minor and major health centres, while the tertiary is made up of general and teaching hospital.

Health care is delivered by six general hospitals and one teaching hospital at the tertiary level, while forty-seven health centres provide service at secondary level and at primary level; four hundred and ninety-two health posts provide services. About 34 private and NGO clinics also provide services.

Majority of these hospitals, health centres and clinics are located in the urban area which in essence creates an unequal distribution of health care services to the disadvantage of the rural populace.

For health care service delivery, the lowest level is the village health service where minimum health care is delivered by village health workers (VHWs) and traditional birth attendance (TBAs). These providers receive minimal training to deliver services within their community. The village health workers who are mostly male, provides treatment for illnesses such as, diarrhoea, uncomplicated malaria, fast breathing in children under five years and minor injuries. They also serve as tuberculosis treatment supervisors in their communities. They refer patients that they cannot manage to the health centre.

Health service at the village health level are complemented by monthly reproductive and child health clinics, during which nurses and public health officers deliver services such as antenatal care, immunization, weight monitoring, birth registration and the treatment of sick children.

At the health centre level which is the secondary level of care, nurses are the sole providers of services. These are mostly professionals who received nursing training for at least two to

three years. Apart from treating common illnesses, these health facilities also provide in-patients services and also laboratory services in some of the facilities. Patients who cannot be managed at this level are referred to the tertiary which is the hospitals. At the tertiary level, services are delivered by both nurses and doctors. At this level specialized care is provided.

Cases of severe mental illness are referred to the only outpatient clinic in the capital city where diagnosis and treatment starts. Those requiring hospitalization are referred to the only psychiatric hospital for admission. The main providers of mental health service at both the outpatient clinic and the hospital are nurses who had received two to three years of nursing training. Majority of them had not formal training about mental health but learned on the job.

1.2.6: National health policy

The Gambia has an existing health policy, 2012 – 2020 (MOHSW, 2010), with the adage; “A healthy population is a wealthy population”. The health policy is the machinery that seeks to make quality health care accessible to the entire population by providing services within an enabling environment and ensuring that care at all levels is delivered by adequate trained, skilled and motivated personnel; thus, making services available at the point of demand. The National health policy provided an institutional and legal framework for the implementation of the various measures it entails.

The national health policy highlighted the following challenges as affecting efficient and effective service delivery: high population growth rate; inadequate financial and logistic support; shortage of adequately and appropriately trained staff; High attrition rate; Lack of efficient and effective referral system. Frequent changes in top management of the ministry of health also hamper continuity, institutional memory and policy flow. Similarly, a study conducted in the Gambia on the role of leadership in people centred health system high light lack of human resources in the national health system (Chigudu et al., 2014)

The ministry of health is responsible for the overall policy formulation, planning, organization and coordination of the health sector at national, regional and community levels. However, to facilitate efficient and effective coordination, structures have been established at varying levels such as central and regional level.

The health policy, as the master policy for all health programs and interventions, also has a focus on mental health.

1.2.7: Mental health in the Gambia

In the Gambia, Mental health services are not integrated into the general health service as unlike other services and as proposed by the national health policy. However, its services are provided through the community mental health team (CHMT) or in specialized units at the outpatient clinic at the teaching hospital located in the capital city.

1.2.7.1: National mental health policy

A mental health policy and a strategic plan from 2007(MOHSW, 2007) that outlines plans and programs for mental health exist. The vision of this policy is the attainment of equitable, accessible and cost-effective mental health care for people living in the Gambia through the provision of quality mental health care integrated into all levels of care, by skilled and motivated personnel, with the involvement of all stakeholders.

The most recent mental health legislation was formulated in 1939, during the colonial era and amended in 1964. However, this legislation is considered obsolete and it requires urgent reform to meet the present need of people with mental illness.

Although the policy framework 2007 has one of its strategies to improve access to service and improvement of service provision, however, this vision is far from been achieved as it has never been implemented due to lack of funding.

1.2.7.2: Community mental health service

One of the means of mental health service delivery in the Gambia is the community mental health service. In this system, a group of mental health service providers goes out and meets patients in the community, mostly at health facilities. This form of mental health service delivery started in the Gambia in 1993, supported by WHO. The community mental health team was very active in delivering mental health service throughout the country until 2005 when the project ended. However, the ministry of health of the Gambia continued to use this as a model of service delivery to the entire population.

The community mental health team deliver services through schedule visits to different health facilities throughout the country, during which people with mental illness and their careers will come for consultation. They also provide schedule home visits to special cases,

outreach service to the prison, and also do advocacy, prevention and promotion interventions for mental health in schools and communities.

However, now, their activities are very limited and only concentrated around the urban area of the country, creating zero access to mental health service for most of the rural population. The low prioritization of mental health leading to allocation of limited resource could be responsible for this situation.

1.2.7.3: Outpatient service at the hospital

Apart from the community mental health team service, there is only one outpatient clinic that provide mental health service to the entire Gambian population, located at the teaching hospital in the capital city of Banjul

The clinic provides services to all the patients who are either new or comes for monthly follow-ups. This outpatient clinic is the first point of call and for referral to the only psychiatric hospital in the country. The clinic is only open from 8 in the morning to 2 in the afternoon.

Other hospitals in the country do not provide mental health service, and as a result, all the people who need such service have to travel to the capital city to access such services.

1.2.7.4: Tanka Tanka psychiatric unit

This is the only unit that provides inpatient facilities in the entire country. Administratively, it is part of the teaching hospital located in the capital city, Banjul, while it's located more than 30 kilometres away, with poor road network, making the place difficult to access especially during the rains when the road is mostly flooded with water.

According to the available annual report of 2012(MOHSW, 2012), the unit has a capacity of 100 beds and it has registered a steady increase in admission rate. A total of 798 admissions were registered in that year, of which 682 were male, while 116 were female. Two reasons were postulated for the high admission rate of males as opposed to females and these are; more male involvement in substance use and, that female are less aggressive and easily managed at home. This assertion can be understood for the fact that about half of the admissions were due to drugs induced psychosis according to the annual report.

The report also indicates that about 72% of patients that are admitted at this unit are between the age of 15 and 50 years. About 60 per cent of the admissions were readmission cases which is an indication of relapse, which the report ascribed to default treatment.

Similarly, 30 to 50 per cent of the admissions were also reported to end up absconding, of which 98% are said to be drug users who cannot stay without drugs. Notwithstanding, 15% to 20% of all admissions were reported to have improved and discharged and they continue their treatment through the outpatient unit.

Some of the constraints highlighted by the report include; inadequate budget allocations to the hospital; inadequate human resources and intermittent shortage of essential neuroleptics.

On vulnerability for people with mental illness especially the women, from 2010 to 2011, 46 cases of sexual abuse of the mentally ill which lead to 11 pregnancies by unknown people were documented. The majority of these cases are recorded in greater Banjul area and Brikama (mhLAP, 2012).

1.2.7.5: Other mental health services

In recognition of the role of traditional healers in the provision of mental health service, the Ministry of health work in close collaboration with them in the provision of service to people with mental illnesses.

In this collaboration, some selected traditional healers were provided basic psychoeducation to introduce the use of low dose of oral chlorpromazine, while follow up treatment and support to be provided by the nearest health facility. However, this program has stopped a long time ago.

1.2.7.6: Mental health leadership and advocacy program (mhLAP)

mhLAP is a WHO collaborative project that is been implemented in five Anglophone West African countries: Nigeria, Ghana, Liberia Sierra Leon and the Gambia. Its aims is to empower countries to do self-advocacy and capacity building on mental health, targeting government, non-governmental organizations and the communities.

The project started in the Gambia in 2012 and since then, they have conducted series of activities including;

- Situational analysis of mental health in the Gambia
- Advocacy for better mental health service delivery
- Advocate for a new mental health policy

- Capacity building for health and non-health staff involve in mental health

Their situational analysis report indicates that only 0.64% of the health budget is spend on mental health. On service availability, the report indicates that 95% of the people they interviewed state that mental health services are not available in their communities. The report also highlight the irregular supply of medication and practices such as chaining and beating of people with mental illness, both in the community and at traditional healing centres(mhLAP, 2012).

However, since its inception, the status quo has not changed much especially in terms of access to mental health care especially for much of the rural Gambia.

1.3: Rationale for the study

Mental illnesses constitute a significant public health problem globally, especially in low and middle income countries. Despite their public health significance, the treatment gap for these illnesses is between 76% to 85% in low and middle-income countries and 35% to 50% in high-income countries (WHO, 2013).

Despite the existence of such treatment gap, there is concern that interventions currently being implemented to improve mental health services in Africa will not be effective unless synchronized steps are taken to address peoples' care seeking behaviour (Patel, Minas, Cohen, & Prince, 2013).

Therefore, knowledge and understanding of factors that influence care seeking for mental illnesses are crucial for effective planning and implementation of any intervention that is geared towards the improvement of access to mental health service. In the same vein, due to their high prevalence rate and their early life onset, failing to address mental health can impede general health goals and risk other social and economic development (Summergrad, 2016).

Valuable understandings have been gathered from previous studies in other countries (Ae-Ngibise et al., 2010; Augsberger, Yeung, Dougher, & Hahm, 2015; Jack-Ide & Uys, 2013; Ross et al., 2015; Schierenbeck, Johansson, Andersson, & van Rooyen, 2013), on barriers and facilitators to use of mental health service. However, the living experiences, cultures, beliefs and other contextual milieus of the Gambia are different from the countries where those studies were conducted. These differences could result in possibly various factors that can influence access which permit exploration.

To the researcher's knowledge, no study has been conducted that explore the factors that influence access to mental health care service in the Gambia. Although there are no recent data on the prevalence of mental illness in the Gambia, the latest available data indicate a high rate of prevalence and a treatment gap of 90%. It is, therefore imperative to understand the factors that influence access that lead to such wide treatment gap and address it, as any further effort to meet the issues of access without understanding such factors will be futile.

This study will provide insight information that will help facilitate the design, development, and implementation of programs and strategies geared towards improving access to mental health care service in Gambia. This insight information can be particularly useful for the

Ministry of health and social welfare (MOHSW) that provides mental health care services, especially in striving to achieve the WHO mental health action plan 2013-2020 target of increasing service coverage for severe mental illnesses by 20% in 2020 (WHO, 2013).

Furthermore, the findings of this study could also lead to further exploration of access to mental health care service, by looking at other critical components such as the policy, service providers' views and other key players' in the delivery of mental health service which are not explored by this study.

Finally, with the coming of sustainable development goals (SDG), the findings of this study can provide valuable insight for the Gambia in preparation for the implementation of this new global agenda which calls for more efforts to promote mental health and well-being (WHO, 2015b).

1.4: Aim and objectives of the study

1.4.1: Aim of the study

The overall aim of the study is to contribute to the improvement of access to mental health care service in the Gambia.

1.4.2: Objectives

The specific objectives were to;

- Identify systems of treatment for mental illnesses.
- Explore local concepts about mental illness and how these influence access to mental health services.
- Find out the experiences of people in accessing mental health services.

1.4.3: Broad research questions

What factors influence access to mental health care service among the mentally ill in western 2 health region of the Gambia?

1.4.4: Research questions

- I. What are the local concepts about mental illnesses?
- II. What are the existing system(s) of treatment for mental illnesses?
- III. What determines who is consulted for what type of mental illnesses?
- IV. What are the experiences of people in accessing mental health service?

Chapter 2: Literature review

A literature review of relevant published work was done before and after the data collection as presented below. This was done to have a wider view and understanding of the subject of study especially from the standpoint of other researchers.

2.1: Definition, burden, and consequences of mental illnesses

Mental health is defined by WHO as a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2013). This definition portrays the importance of mental health and thus reflective of how integral it is to health and well-being as reflected in the WHO's definition of health; "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(WHO, 2013). The notion of mental health includes subjective well-being, perceived self-efficacy, autonomy, competence, and self-actualization and emotional potential (WHO, 2001b).

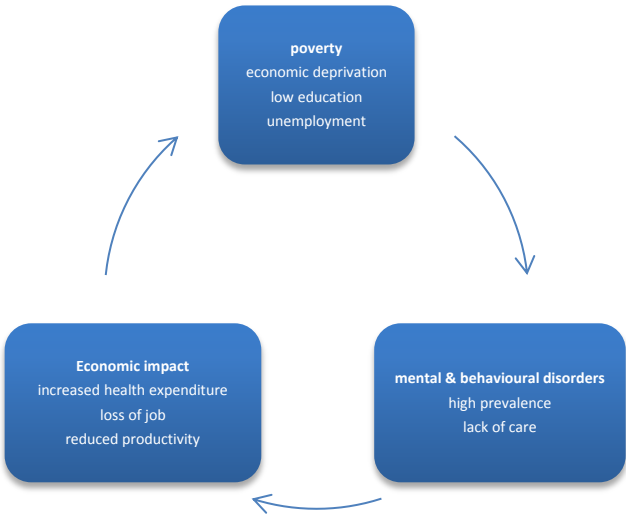
Mental illnesses are considered as clinically significant conditions that affect thinking, emotions and or behavior (Manderscheid et al., 2010; WHO, 2001b). They are also associated with impaired functioning and present as either mild or severe, lasting for few weeks and for others it may last a lifetime (WHO, 2001b). Severe mental illnesses are considered as major illnesses that include schizophrenia, bipolar disorder and severe depression that are associated with significant impaired functioning (Drake, Mueser, Brunette, & McHugo, 2004), leading to disability (Wang et al., 2007). This form of mental illnesses may require hospitalized treatment.

Despite the recognition that mental illnesses are among the primary causes of disability globally with an estimated 37% of all healthy life years lost through disease (Wang et al., 2007), they do not receive the required consideration. This result to a wide treatment gap (Eaton et al., 2011; WHO, 2003). Similarly, the burden of mental illnesses is also projected to rise to 15% of DALYs by 2020, due mainly to the increase in a number of people entering the age of risk for these illnesses (WHO, 2001a). The disability-adjusted life years (DALYs) is a measurement unit to quantify the burden of disease on human population (Anand & Hanson, 1997; Murray & Acharya, 1997)

As a result, mental illnesses causes increased health and social care costs, poor quality of life, increased risk of disability, reduced work hours, loss of employment, and increased risk of mortality (Kirigia & Sambo, 2003). Also, people with severe mental illnesses experience higher chances of premature death compared to the general population. For instance, individuals with major depression and schizophrenia have about 40% to 60% higher chance of dying prematurely than the general population (WHO, 2013). In high-income countries, men with severe mental health illness die 20 years and women 15 years earlier than those without mental health problems (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011; Lawrence, Hancock, & Kisely, 2013; Thornicroft, 2011). Mental illnesses are also linked to other physical health problems that are frequently not taken care of such as; cancers, diabetes, cardiovascular diseases, HIV infection and suicide (WHO, 2013). These figures could be higher in low and middle-income countries, due to the wide treatment gap that exists in those countries.

Mental illnesses are also associated with social determinants such as poverty, gender disadvantages and poor maternal and child health; demography; such as age, sex, and ethnicity; socioeconomic status such as; low income, low education and low social support (Patel et al., 2016; WHO, 2001b).

Figure 3: Vicious cycle of poverty and mental illnesses



Source: the world health report 2001 (WHO, 2001b)

These social determinants portray on one hand increase risk of mental illnesses due to socioeconomic adversities. On the other hand, people affected by these illnesses drifting into poverty during the course of their life due to low economic productivity associated with disability, stigma, and discrimination (Patel et al., 2016). Also due to low education, increased health expenditure and often insufficient social support impoverish individuals with mental illness, as demonstrated in the vicious cycle of poverty and mental illness in figure 3 above (WHO, 2001b).

In a study of the relationship between poverty and common mental disorders, Patel and others observed that mental illnesses have a reciprocal relationship with poverty (Patel & Kleinman, 2003). Whereas a large number of people with mental illnesses live in poverty, population base studies of risk factors for mental disorders also demonstrate that poor and marginalized people are at greater risk of suffering from these illnesses (Patel & Kleinman, 2003).

2.2: Barriers to development and help- seeking for mental illnesses

Many studies suggest the existence of factors that influence access to mental health care service, especially in developing countries. A survey of international mental health experts and leaders on barriers to mental health service development (Saraceno et al., 2007) identified the following five barriers to the development of mental health that needs to be addressed by governments: 1) the prevailing public health priority agenda and its effects on funding; 2) the complexity of and resistance to decentralization of mental health services; 3) challenges to implementation of mental health care in primary care settings, 4) the low number and few types of workers who are trained and supervised in general mental health care and 5) the frequent scarcity of public health perspectives in mental health leadership. The study concludes that progress towards access to mental health care will require more attention to politics, leadership, planning, advocacy and participation.

Albeit, a recent review that examined the above 5 barriers to scaling up of mental health service in low-income and middle-income countries (Eaton et al., 2011), reported some improvement in some of the areas. For example, the reported indicate evidence in some countries that political leaders and decision makers are giving priority to mental health care. Similarly, funding by international development and research agencies is also said to have increased even though it is recognized as not widespread. Some progress in the area of

decentralization of services and integration into primary health care are also said to have improved in some countries.

Despite these gains, the bulk of health care resources is still targeted at communicable diseases, and the allocation for mental health is less than 1% of the health budget in many low and middle-income countries (Dan Chisholm, 2007). Scarcity of human resources and services for mental health care persist especially in low and middle-income countries, and where available, they are mostly disproportionately distributed, favoring the urban setting (Saxena, Thornicroft, Knapp, & Whiteford, 2007).

Similarly, the argument for the lack of attention on mental health in the international development agenda is that where there is poverty, the more urgent issues are the serious physical health problems facing populations (McGovern, 2014). However, a case has been compellingly made that “there is no health without mental health”(Prince et al., 2007). However, recent moves by the global leadership in the inclusion of mental health in the recent United Nations Sustainable Development Goals (SDG) is an important step to addressing the barriers to availability of mental health service. This inclusion of mental health is likely to have a positive impact on communities and countries where millions of people will receive much needed help (WHO, 2015b).

Several studies suggest that local concepts about mental illness such as attributes of causation, treatment acceptability, and stigma impede care seeking even where the services are available (Miranda & Patel, 2005). For instance, in Nigeria Izibeloko Omi and others in their study of barriers to mental health service utilization (Jack-Ide & Uys, 2013), identified among other things negative perceptions about mental illness leading to the stigmatization of families and persons with mental illness. As a result, people with mental illness, thus fear of stigmatization does not seek care for their conditions. The findings of this study is based on the views of people who have at least used mental health services for one year; therefore a critical look at the people who are not able to use services could give a broader picture or barriers (Jack-Ide & Uys, 2013). Similarly, In East Cape, South Africa (Schierenbeck et al., 2013), also found cultural beliefs, stigma and lack of information about mental health services as barriers to accessing services.

According to Corrigan, stigma impedes treatment participation by diminishing self-esteem and depriving people of social opportunities. As a result, people with mental illness either do

not pursue treatment or those who start treatment fails to adhere to services as prescribed (Corrigan, 2004).

Corrigan distinguish stigma into public and self-stigma. Public stigma is described as what the public does to people whom they stigmatized, while self-stigma refers to what stigmatized people do when they recognized public stigmatization. He argued that many people who could have benefited from health services choose not to pursue or do not fully participate when they started. One of the reasons for this disconnection is stigma, mainly to avoid the label of mental illness and the harm it brings such as loss of employment.

In a study of local concepts about mental illness in four African communities (Ventevogel, Jordans, Reis, & de Jong, 2013), the decision about treatment was found to be strongly influenced by perceived cause of the illness which varied from supernatural to psychosocial and natural. The respondents according to the study, held the belief that local syndromes that look like psychotic disorders are abnormalities that require treatment. However, local syndromes that resemble non-psychotic mental illnesses are seen as conditions for which help should not be sought from biomedical services. However, such syndromes are expected to improve with social and emotional support from relatives, traditional healers and community members.

On manifestation and causes of mental illnesses, a study conducted in northern Nigeria (Kabir, Iliyasu, Abubakar, & Aliyu, 2004) indicated aggression, talkativeness, eccentric behavior and wandering as common manifestation of mental illness according to the study respondents. For the cause of mental illness, respondents identified divine wrath or God's will, magic and spirit possession. Similarly, about 34% and 18% of the respondents also opted for spiritual healing and traditional herbal medicine respectively.

In a similar study (Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014) among Congolese and Somalis living in the United States, the study participants relate causes of psychiatric problem to being a bad person, witchcraft or bad spirit. The study identifies among other things use of religion, use of a traditional method of healing and depending on families or friends as methods of care seeking for mental health problems. About one-third of women in the study stated that they would not seek help from mental health professionals even if they have mental health problems. This could be due to the fact that mental health

problems are not accepted and fear of been labelled as bad persons as this is considered as one of the causes of mental health problems among the study group.

It is noted that beliefs about spirits and bewitchment as a cause of illness is not only limited to mental illnesses. For example in a study which looks at treatment gap for epilepsy in rural Gambia (Coleman, Lopy, & Walraven, 2002), Rosalind Coleman and colleagues reported a lifetime prevalence rate of 4.5 per 1000 and less than 10% treatment continuous rate. The study points out that people with a lifetime history of epilepsy have used traditional treatment and 74% had tried treatment from more than one source. Most people in the study are reported to attribute the immediate cause of epilepsy to malign spirit, a belief that shapes their choice of treatment.

The use of substance such as cannabis has also been associated with mental illness. For instance, in a study conducted in Gambia (Rolfe et al., 1993), that determined the association between psychosis and cannabis abuse among patients admitted to Capama psychiatric unit over a 12 month period demonstrated a strong association. The findings indicate that the onset of symptoms was pre-dated by cannabis abuse.

In a cross-sectional survey (Kinyanda et al., 2011), involving 4660 randomly selected respondents who were 15 years and above indicate an increased risk of major depressive disorder with 34.7% among females compared with 24.2% among males. However, in both genders, socioeconomic factors relating to deprivation (no formal education, having no employment, broken families) and poverty (low socioeconomic status) are identified as risk factors of major depressive disorders. Socioeconomic factors operating at both ecological and the individual level were the strongest independent determinant of depression. Adverse life events which could be considered as determinants of depression in this study were much less strongly associated with depression.

In a review of barriers to use of health services among ethnic minorities (Scheppers, Van Dongen, Dekker, Geertzen, & Dekker, 2006), indicate that potential barriers to the use of health services occur at three different level; patient level, provider level and system level. The patient level barriers are related to patient characteristics such as demographic variables, social structure variables, health beliefs and attitudes, personal enabling resources, community enabling resources and personal health practice. The provider level barriers are related to provider characteristics such as skills and attitude. The system level barriers are ascribed to the system characteristics like the organization of the health care. The

researchers argue that because barriers are tied to a particular situation of the individual, which are subject to constant adjustment, therefore, there should not be generalization.

Although many studies support that traditional health beliefs and practice function as barriers to accessing medical care, however, Jenkins and other in their study on health care access among Vietnamese immigrants (Jenkins, Le, McPhee, Stewart, & Ha, 1996), conclude that cultural attributes did not explain either lack of health care access or underutilization. What they identify as the most consistent predictor was poverty status.

Several studies have also documented wide use of traditional healers, especially in sub-Saharan Africa for the treatment of mental illness. Various factors such as shared cultural beliefs between patients, their families and the traditional and faith healers could be an important factor in this. A qualitative explorative study in the widespread use of traditional and faith healers in Ghana (Ae-Ngibise et al., 2010) suggest that the popular use of this system of care is because their understanding of mental illness is consistent with cultural explanatory models of mental illness aetiology. The other reasons for their popularity according to the study are that they provide psychosocial support. Their easy accessibility, availability, and affordability are recognized as contributing factors to their wide use and popularity (Ae-Ngibise et al., 2010).

Similarly, the limitations of antipsychotic medication, failing to provide a permanent cure is also suggested as a possible influential factor in the use of traditional systems of care and the discontinuation of biomedical treatment. An ethnographic study in rural Ghana (Read, 2012) found that all the participants in the said study used biomedical services. However, the use of biomedical service was discontinued by many study participants even though its benefits in controlling aggression and inducing sleep were recognized. Side effects such as feelings of weakness and prolonged drowsiness experienced by the study participants were other reasons put forward for the discontinuation of the antipsychotic medication.

The study reiterates that failure of antipsychotics to achieve a permanent cure also cast doubt on their efficacy and strengthens doubt of a spiritual illness which could counterattack medical treatment. The study concludes that efforts to improve the treatment of mental illnesses in low-income countries should take into account the limitations of antipsychotic drugs for those who use them and consider how local resources and concepts of recovery can be used to maximize treatment and support families (Read, 2012).

Similarly, the commonly used diagnostic and statistical manual (DSM), that is used in many countries is increasingly criticized by many mental health practitioners and members of the public. The DSM is considered by these critics as deeply flawed and dangerous primarily because of the steady increase in the number of diagnostic criteria which were previously regarded as normal behaviors. This has often resulted in inappropriate labeling and treatments with powerful medications and side effects that can be worse than the disorder (Zur, 2014).

2.3: Therapeutic itinerary for mental illnesses

Several studies have suggested multiple pathways taking by psychiatric patients in an effort to get treatment. In Malawi for instance, a study on pathway to care for psychiatric patients (Kauye, Udedi, & Mafuta, 2015), indicates that 88.3% of patients go through a first carer and 36.7% to a second carer before reaching a psychiatric unit. While 22.7% of the patients had a native healer as their first carer, 8% of those who had a paramedic as their first carer also had a native healer as their second carer. In this way, referral to psychiatric unit prolonged. Knowledge and understanding of factors that influence care-seeking are crucial for effective planning and implementation of any intervention that is geared towards the improvement of access to mental health services. For example, attributes of causation of mental illness, treatment acceptability and stigma influence help seeking and impact on the use of services, even if services are available (Patel et al., 2013). By extension, treatment acceptability can variably be influenced by attributes of causation and determine the help-seeking behavior of people with mental illness. For instance, if cause of mental illness is attributed to witchcraft or demons, the likely behavior for help-seeking will be with witchdoctors or spiritualist. Therefore, efforts to improve access to mental health services should take into account the cultural belief of the people (Patel et al., 2013) and also take account of all aspects of existing systems of treatment (Eaton et al., 2011).

In order to reduce the treatment gap, many more people need to have access to evidence-based mental health services and also need to choose to use them. This can be done not only providing good services but ensuring that they are culturally appropriate (acceptable) and that social beliefs and attitudes that reduce service use are addresses (Patel et al., 2013).

In the Gambia, the prevalence rate of mental illnesses is estimated at 120,000, of which 27,000 are severe cases and 91,000 are moderate to mild. However, about 90% of these people do not access services for their condition (MOHSW, 2007). These figures emerge from an old study and therefore the prevalence rate could be higher than this for now as the population of the country has increased significantly. The increase in population indicates a youthful population and movement of more people from rural to urban areas (GBOS, 2013), which are risk factors for mental illness (Patel et al., 2016).

Chapter 3: Research methodology

In this chapter, the study design, as well as the data collection methods and tools that are used to explore the factors that influence access to mental health care service in western 2 health region of the Gambia are elucidated. The data analysis, ethical issues, my reflection and ethical consideration and data storage are also present.

3.1: Study design

As this study aimed at exploring local concepts, experiences, perspectives and knowledge about mental illness and its care, in an attempt to understand how these factors influence access to mental health care, a qualitative approach was used to understand the phenomena of interest.

Qualitative methods as elaborated by Yilmaz (Yilmaz, 2013) are a useful tool for exploring complex behaviours, attitudes, and interactions which other methods cannot. It helps in understanding phenomena of interest from a broader perspective with the aim of describing, interpreting and contextualizing it.

Unlike quantitative method, which is deductive in nature and uses experiments and survey, qualitative explorative methods are concerned with answering questions such as what the phenomena of interest is, how does the phenomena vary in different situations and why (Pope & Mays, 1995).

Qualitative methods are effective in finding data from individuals and groups regarding their sociocultural practices, behaviours, opinions, beliefs, values, norms and how these affect their lives (Pope & Mays, 1995).

3.2: Theoretic perspective

The theoretical perspective that grounded this study is Phenomenology and the concept of “*structural violence*”. As referred to by Malterud, theoretical frame are theories, models, and notions that are applied to interpretation of the material and for understanding a specific situation. In other words, she refers to the theoretical frame metaphorically as ‘the analyst’s reading glasses’ (Malterud, 2001).

The phenomenological approach, as described by Lester, is to illuminate the specific, to identify phenomena through how they are perceived by the people who has the experience (Lester, 1999). This approach is based in a paradigm of personal knowledge and subjectivity, and emphasise the importance of personal perspective and interpretation, thus important at

bringing to the fore the experience and perception of individuals from their own perspectives (Lester, 1999).

The objective of using phenomenological approach is to clarify, analyze and develop in-depth meaning, structure and essence of the lived experience of a person, or a group around a specific phenomenon (Simon & Goes, 2011). In this research, the phenomena of interest are the factors that influence access to mental health care services, while the participants are the people who are mentally ill and are using the community mental health service. The other participants are the members of the community living in the same health region as participants with mental illness. Phenomenological approach underpinned this study to enable me to explore the factors that influence access to mental health care service among people who has the experience and the general population.

The main theoretical perspective that inspires this study was the concept of structural violence, a phrase that was first coin by the pioneering professor of peace and conflict, Johan Galtung. Paul Farmer who further expounded on the concept of structural violence, referred to it as one way of describing social arrangements that put individuals and populations in harm (Farmer et al., 2004). According to Farmer, because the social arrangements are embedded in the political and economic organization of the social world, therefore they are structural. Similarly, because they cause harm to people, thus they are structural.

Structural violence comprises forces such as poverty, societal factors, inequality and discrimination all of which influence on people's health (Farmer, 1999). According to Kelly, the adverse effects of social, economic and societal factors and also the social stigma of mental illness constitute a form of structural violence which hampers access to treatment services (Kelly, 2005).

3.3: Data collection methods

This study uses a combination of qualitative methods of focus group discussions and in-depth interviews as the data collection method.

To have a wider view of the subject of study especially from the standpoint of other researchers, a literature review was done before and after the data collection. The literature is presented in chapter 2. To have a guided conversation, an interview guide was developed for both FGD and in-depth interview which was pre-tested before used. The pretesting was

done purposely to check the clarity and applicability of the guides. They were piloted on people who have the same characteristics as the intended research participants. The methods used are discussed below.

3.3.1: In-depth interview

In-depth interviewing involves conducting in-depth individual interviews with a small number of participants to explore their perceptions, perspective, ideas, and views on a particular phenomenon. It is useful when detailed information is needed about a person's thoughts and behaviours or wanting to explore new ideas thoroughly (Boyce & Neale, 2006). This method can provide much more detail and complex information than other methods can do, such as surveys. As it provides a more relax atmosphere in which people may feel comfortable having conversation, it is therefore more appropriate for exploring subjects that are sensitive, tabooed and controversial in nature (Newton, 2010).

The limitations of this method are that, since its time consuming, limited number of interviews can be carried out and because each of the interviews been unique, comparison is difficult. As a result, the findings of this method are unlikely to be representative of a given population (Boyce & Neale, 2006; Newton, 2010).

Another challenge was relying on the community mental health team to recruit participants. This was a challenge as they provide service to very limited number of health facilities at the time of the data collection, which led to the recruitment to be done at only two health facilities as opposed to three which was planned for.

The participants in the in-depth interview in this study are patients using the community mental health services in western 2 health region. Mental health is a stigmatized illness and culturally difficult to associate anybody to it, therefore it is difficult to identify and to recruit people at community level. Therefore, the service points where people with mental illness go to access service become the best alternative for identification and recruitment of study participants. Study participants are therefore recruited from two health facilities where the community mental health team provide services. However, important to note that the third health facility that was plan for the recruitment could not be used due to the fact that the team was not going out to the rural area health facilities to provide service due to resource constrains. As a result, only two health facilities where used for recruitment of participants.

The recruitment was started by the service providers inviting service users to participate in the study. Those who accepted to participate were referred to the researcher. However, this preliminary acceptance was not taken as consent and therefore the service users are formally invited by the researcher to participate in the study. Upon acceptance, they were asked to decide where they would prefer the interview to take place following which an arrangement is made.

Among the fifteen respondents, eleven opted for the interview to be conducted at the service point, while the rest chose to have the interview at a later date and at home.

Of the fifteen participants interviewed, nine were male, while six were female and their ages ranged between 18 to 54 years old. Five of the participants were married at the time of interview, while, four were single, three divorced and two widowed. Eight of the respondents are Mandinka, three are Wollofs, while two are Jolas and one Fula and one Manjako. For a detailed description of the participants see figure 4 below.

All the interviews were tape-recorded, except two people, who did not want to be recorded. All the interviews were done in the language Mandinka. In the Gambia, 42% of the population are Mandinkas and the most common tribe in western 2 health region where the study is conducted. The Mandinka language is understood by most people in the Gambia, even those who may not be that tribe. As Mandinka is not a written language, taped recordings become very useful during the transcribing of the interviews which was done verbatim into English.

An interview guide which was developed and pre-tested was used during the interviews. The guide covers three thematic areas; experience about their illness which covers perceived causes of the illness, when it started and how it started and also what was done. The second theme explore about the therapeutic itinerary; how decisions were made about treatment how decisions were reached and the role of the family, friends and neighbours in the decision making. The last theme looks at the experience about accessing services that are used.

However, the use of the interview guide was very flexible and therefore, allowed probing and exploring about issues that come up and are relevant.

The participants interviewed in this study lives in the urban or semi urban area, thus have opportunity to access radio, television, newspapers and other health services that are not easily accessible in the rural areas. Such opportunity might have influence the perspective

and experience of the study participants, which may be different from those who live in the rural areas without such opportunity.

Figure 4: Demography characteristic of the participants for the in-depth interviews

interview	gender	age	Educational level	Marital status	tribe	religion
1	male	40	Senior school	married	Wollof	Muslim
2	female	38	tertiary	married	Jola	Muslim
3	male	38	Senior school	married	Manjako	Christian
4	male	34	Tertiary	Single	Mandingo	Muslim
5	male	44	None	Married	Mandingo	Muslim
6	female	67	None	Married	Mandingo	Muslim
7	male	44	None	Divorced	Mandingo	Muslim
8	male	46	Tertiary	Single	Mandingo	Muslim
9	female	37	Primary	Divorced	Mandingo	Muslim
10	female	37	Tertiary	Widow	Fulla	Muslim
11	female	34	Senior school	Married	Wollof	Muslim
12	male	45	None	Divorced	Mandingo	Muslim
13	male	27	Senior school	Single	Mandingo	Muslim
14	male	41	None	Single	Jola	Muslim
15	female	30	Senior school	widow	Wollof	Muslim

3.3.2: Focus group discussion (FGD)

Fern defines Focus group discussion (FGD) as a small group discussion addressing a specific topic, usually consisting of six to twelve participants, either matched or varied on specific characteristics of interest to the researcher (Fern, 1982).

FGD, according to Kitzinger are relevant for finding out knowledge and experiences of people and also useful for exploring what people think, how they think and why they think that way. Group discussions allow for the use of different forms of communication that people use in day to day interaction such as jokes, anecdotes, teasing and argument. These

forms of communication are useful as people's knowledge and attitude are not entirely captured in logical responses to direct question (Kitzinger, 1995).

In my study, the objective of the FGD was to create an interactive environment in which participants discussed and reflected on local concept, beliefs, experiences, and knowledge about mental illness in an attempt to understand how these factors influence care seeking for mental illnesses.

The participants of the focus groups in this study were recruited from five communities in western 2 health region. One community was selected from each district through convenient sampling and the process was facilitated by the Community Health Nurse (CHN), who supervises primary health care activities in these villages.

In each village six participants were identified, one participant from each ethnic group to have a fair representation of all the ethnic groups in the community so as to have a broader view of the phenomena of study. However, in some groups, this was not possible as we could not find up to six different ethnic groups in the community.

Three of the focus groups consisted of male, while two groups were made up by women. This arrangement was done for cultural reasons as when men and women meet; women are mostly quiet and allow the men to talk. The age of participants are 25 years and above. All focus group discussions were conducted in Mandingka and tape recorded.

A guide was used during the FGD which covered four thematic areas. The guide was meant to ensure relevant issues for the researcher are asked in all the FGDs. However, there was flexibility which allowed the researcher to ask about issues that come up that are not part of the guide and also allow the participants to discuss openly on different issues, but important for the subject under discussion.

The four thematic areas covered, local concepts about mental illness which includes what mental illness is, its causes, whether it can be treated or not. The second part covered the therapeutic itinerary and this looked at what determine where treatment is sort for mental illness. This is followed by the third theme which looks at what services are available and use for the treatment of mental illnesses, while the last theme looks at experience about the use of the available services for mental illness.

3.4: Data collection tools

Two interview guides, attached as appendice, one for the in-depth interview and the other for the focus group discussion were developed and pretested and used for the data collection. A tape recorder was also used to record the interview and the focus group discussions. Note pads were also used for taking notes during the sessions.

3.5: Study setting

In the Gambia mental health care service is delivered through outreach services, outpatient clinic and the psychiatric hospital for those who required hospitalization. For the purpose of this study, the health facilities in western 2 health region where outreach services are conducted and the communities within this same region served as the study setting.

Western 2 health region (figure 5) is one of seven health regions in the Gambia, and part of Brikama local government administrative area. This administrative area is further divided in to nine districts, with a population of 699,704, which account for 37.2% of the national population, according to the 2013 population and housing census. It has the fastest growing population, which is attributable to the influx of migrants from other parts of the country in search of job.

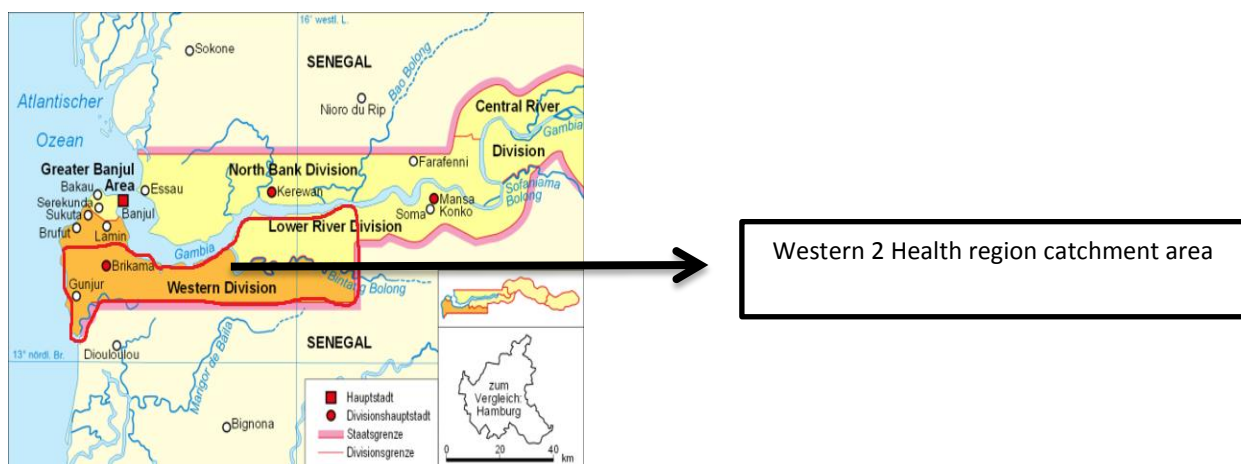


Figure 5: Section of map of the Gambia with Western 2 Health region catchment area

The region is partly urban and partly rural, a peculiar characteristics from all other health regions in the country. The region has 111 primary health care villages which are further grouped in to twelve circuits. Each circuit is overseen and supervised by a community health nurse. There are 34 health facilities in the region which include both public, private and community clinics.

Of these, 14 are community clinics, 9 are private/NGO health centres and clinics; 2 major health centres and one hospital. The rest are minor health centres, dispensary and health post.

3.6: Inclusion criteria

- Users of community mental health outreach services at Brikama, Gunjur and Bwiam health facilities.
- Service users willing to participate in the study and attain the age of 18 years.
- Community members willing to participate in the study and attain the age of 25 and above in the selected communities.

3.7: Exclusion criteria

- Service users who were too sick to be competent to give informed consent.

3.8: Data analysis

Analysis is an ongoing, iterative process that begins in the early stages of data collection and continues throughout the study (Bradley, Curry, & Devers, 2007). In this study, the data obtained from the FGD and the in-depth interviews were analysed using the framework analysis method, proposed by Gale and others. They refer to seven steps which are; 1) transcribing the interviews verbatim from audio recordings; 2) Familiarising with the interview by listening and or reading the interviews; 3) thorough reading of the materials to apply codes; 4) grouping the codes identified into categories to have an analytical frame for analysis; 5) applying the categories on the rest of the transcript; 6) reducing the data by charting into the identified categories using a matrix and lastly, 7) giving meaning to the data (interpretation) (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

Each day when I returned from interview or focus group discussion, I listened to the tapes and read the notes taken. This was meant to give me an idea of initial findings. During the field work, two FGDs and three in-depth interviews were transcribed. The transcription of the other FGDs and the in-depth interviews took place after the field work. All transcripts and tapes were anonymized using numbers.

As the interviews were conducted in Mandinka, which is not a written language, audio recordings were transcribed verbatim from Mandinka language to English. This was done to have a better way of managing the data for the analysis. Transcripts were read several times to have a prior idea about the data and become used to it, following which thorough reading was done to apply code as the second step of analysis. Then the codes were grouped base on their similarity into categories, which was followed by applying the categories on the rest of the transcripts. Then the date was reduced by charting the relevant points or quotes into a frame with reference to the transcript. Then lastly the interpretation of the data was done. The use of different data collection methods such as in-depth interview with service users and FGD with community members were used in order to increase the validity of the data. The data complement each other, and helped me reached an in-depth understanding of the phenomena am looking at.

3.9: Reflexivity

According to Horsburgh, reflexivity refers to the active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation (Horsburgh, 2003).

Similarly, Malterud describe reflexivity, metaphorically as ‘the knower’s mirror’. She refers to reflexivity as an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process (Malterud, 2001).

Therefore, it is imperative to account for how my position may have impacted on the research. First, the rationale for the choice of this topic was based on my earlier interest to understand issues surrounding mental illness, such as if effective treatment are available for mental illness, as is very common to see people with mental illness in public places such as markets areas especially in towns.

So in 2014 when I got admission to do a master’s program in International community health at the University of Oslo (UiO), I still had the interest of doing something on mental health, although I did not know exactly what. My interest was rejuvenated by a lecture on global mental health and thus the idea to do my thesis on mental health rekindled. I then decided to find out factors that influence access to mental health care services using a qualitative approach, in western 2 health region of the Gambia, as my study.

Although, I obtained ethical clearance from the joint ethics committee of MRC/ Gambia government, I sought permission from the director of health services, under whose purview is the National mental health unit. This permission enabled me to have easy access to staff and service points to do my research. As a former work colleague at the Ministry of health, I was embraced as still part of the “team”, which gave me the opportunity to continue with my work. However, I decided to take my position as a researcher so as not to down play the ethical requirement and to follow the methodology as set in the research protocol. As such, I was able to stand back from anything that could compromise ethical and privacy issues as some of my participants are considered a vulnerable group.

Questions such as why I am doing my thesis in mental health when I do not have any background in that area were asked by my colleagues. To them, not much can be gained from studying mental health and this goes to indicate some of the possible reasons for the inadequate human resources for mental health and the gross treatment gap that exist. I tried to give reasons for my choice, but avoided being occupied so much about such discussions as they are discouraging.

I also paid courtesy call on all the village heads in the selected villages and asked for permission to conduct focus group discussions with selected community members. I assumed that following traditional and cultural formalities would give me the opportunity to carry out my work without hurdles. However, this permission was not taken as any form of consent in part of study participants.

For each of these individuals and institutions, I took the time to explain to them the objective of my study and how I wanted to carry it out.

While waiting for ethical clearance to conduct data collection, I took time to visit the psychiatric hospital and the ministry of health’s head quarter where units are housed, to interact with staff and engaged myself in doing something. I presented myself as a master’s student from university of Oslo, there to collect data.

Despite this presentation, some saw me as coming with a lot of money from Norway, an oil rich country, while others see me as coming with a new project that could change the status quo for mental program in the Gambia. Some would jokingly called me ‘the mental health researcher’, can you take me for your data collection, so that I can also get ‘my share’. ‘My share’ meaning some part of the money I came with. While some ask for small token of money, as a cultural practice that juniors give seniors small amount of money to buy colanut

(‘kuruson’), some others were curious about how to get the quota scheme scholarship to be able to get into Norway for a master’s course. Unfortunately, this was at a time when Gambia was removed from the scheme; unpleasant news for those interested in applying.

These questions, surely gave me an ‘added job’ in the field work; talking about how to get scholarship and higher education in Europe. This however, though not related to my study, availed me the opportunity to interact with staff who I worked with during field work.

During my data collection, I was astonished by the fact that when the objective of the study and the subject of the FGD were explained to the participants of the focus groups, they express how they felt, when they were first invited to take part in the FGD. They expressed like; ‘I thought is about Ebola or HIV or malaria. I have never attended a discussion on mental health’. This could explain that, mental health is not given as much prominence as other diseases like malaria, Ebola or HIV and thus could be some of the reasons for the large treatment gap that exist for mental illnesses in the Gambia. This however, serves as a good starting point for me to start the discussion as they agreed that mental illness is a problem but people don’t talk about it and not much is known about it compared to other illnesses like malaria, HIV, Tuberculosis.

However, it also serves as a point of reflection for me, remembering when I worked as a district public health officer at community level and at the health communications unit of the ministry of health. Like the participant of the FGD puts it, I have not also participated in any health education during those periods. Again an indication of how much little priority is given to mental health.

The existence of joking relationships between ethnic groups and between different regions in the Gambia makes it easier to talk about issues that could be considered tabooed or even sensitive. Such joking relationships were used during focus group discussion and even with patients. When I introduce myself in the focus groups, I hesitate to state where I came from and this give those my region has joking relationship with to start teasing me or I tease them. This creates an atmosphere where everyone feels comfortable and can talk freely, while respecting others. I would use phrases like, ‘our lunch is going to be porridge, so those of you from Kiang, be assured of an enjoyable lunch’. On the other hand, people from Kiang would also say ‘we don’t want donkey meat for lunch’.

Again being able to speak 'mandinka' language that majority of the people speak have also enable me to conduct all the interviews and focus group discussions. Understanding this language enabled me to ask questions and probe where necessary.

3.10: Ethical considerations

Abuses in research such as the Nazi atrocities and the Tuskegee experiments where African Americans were deliberately denied effective treatment for syphilis has raised and led to research ethics code and regulations such as the Nuremberg code and the Council for international organization of medical sciences (CIOMS) to protect humans used as research subjects (Benatar & Singer, 2000).

Therefore, inviting vulnerable groups and individuals to participate in medical research has to be justified and where they participate, their rights and welfare has to be respected (CIOMS, 2002). As such, according to CIOMS, research involving human subjects should be conducted in accordance with three basic ethical principles such as respect for persons, beneficence and justice (CIOMS, 2002).

In light of this and cognisance of the fact that some of my study participants are vulnerable groups (people using the mental health service), I applied for ethical clearance from both Norway and the Gambia for this study. The research is exempted from review by Regional Committee for Medical and Health Research Ethics (REK) of Norway, but Norwegian social science data service (NSD) reviewed and granted approvals for the study.

Ethical approval was also sought from the Gambia as the country of study. Both the scientific committee and the joint MRC/Gambia government ethics committees approved the conduct of the study. The approval letters are attached at the appendix.

The ministry of health under whose purview the mental health service delivery fall under was notified through the directorate of health services, which houses the national mental health and substances use unit.

As the study was conducted in Western 2 health region, a formal courtesy-call and discussion was held with the director of the Regional Health Management Team (RHMT), who happens to be a former student of this program. A similar courtesy-call was paid to the head of the community mental health team.

A courtesy-call to inform the heads of the villages about the study was done in villages where focus group discussions were conducted. This was done to observe cultural norms and not a substitute for consent for study participants.

The researcher is responsible of ensuring that the dignity and privacy of all research participants is respected and maintained. The researcher is aware that mental health is a sensitive issue and therefore responsible ensuring that the process of the data collection does not add any burden to the participants.

On consent to participate, all the participants were give detailed information about the study and that they can withdraw from the study anytime they want and this will not stop them from receiving the service that they should receive. However, the vulnerable group (people with mental illness) offered written consent, while the people from the community offered oral consent to participate.

Although no financial incentives were given to people using the community mental health service, snacks was prepared for the participants who took part in the focus group discussion.

To ensure anonymity, no personal identifier was collected from any participant and therefore codes were used instead of names. The researcher gave all the relevant information about the study including its relevance, the benefits, the role of participants and the time it will take in a language that they understood.

This research can contribute to the improvement of access to mental health service by making some positive changes in practice and policies in the provision of services by targeting some of the factors identified by this research.

3.11: Data storage

Although no personal data that can be traced to the study participants was collected for the study, to ensure confidentiality and anonymity, all notes and tapes recorded during the data collection were kept in a cupboard under lock and key, that no second person gets access to them.

Similarly all names of people who were interviewed are anonymised. The names of communities where focus group discussions were done are note mentioned as some stories narrated can be traced if these communities are mentioned by name.

Chapter 4: Research findings

In this chapter, the research findings are presented in five thematic areas. The first thematic area described the demographic characteristics of the study participants. The second thematic area describes research participants' concepts about mental illness which include; definition and causes of mental illnesses. The third thematic area dealt with classification of mental illness. The fourth theme elaborates on the therapeutic itinerary of mental illnesses, which include; traditional, religious and biomedical treatment systems. The last thematic area looks at experiences of accessing the above mentioned services which include decision making process, their access, cost of treatment and accessing medication.

4.1: Demographics

The 15 participants using the community mental health service in this study were between 27 and 67 years. One of them was 27, seven were between 30 and 38, six were between 40 and 46 and one was 67. Five of them had no formal education, five had reached senior secondary (grade 12), four of them had attended tertiary level and one has stopped at primary level.

The 30 study participants who took part in the five focus group discussions were also from different ethnic background. Out of the 30 participants, 18 were male and 12 were female. Their ages are 25 years and above. All names used here are anonymized.

4.2: Concepts about mental illness

The study participants' knowledge about mental health highlight it as a broad concept that can be identified from the way they call it (definition), its different types and their perceived causes as well as the services used for their treatment.

4.2.1: Definition of mental illness from the community perspective

A distinction is made between the body and the mind in the definition of mental illness by the study participants. For example, in the Mandinka language, a phrase; 'Sundomi Kurao' (which translate to sickness of the mind) is use to refer to mental illness. Similarly, in wolof; 'Febari Hull' (sickness of the mind) is also used to refer to mental illness. This is common for other languages of the Gambia. Also, the word; 'Nyamato' is also used to refer to mental illness. This word is used to refer to someone who is completely out of order, that is cannot be cured anymore according to local concepts.

Sickness of the mind is a condition in which a person's behavior changes to a behavior that differs from what is known about that individual. So if a person starts doing something strange, like what he is not known for, like when he talks he does not make any sense, is an indication that he has mental illness (sundomi kurao). (FGD 1, male 60 years)

From the quote it can be noted that the calling of mental illness as 'sickness of the mind' is an indication of change in behavior in individuals from what they used to do before and what they do currently as strange. 'Sundomi kurao' (sickness of the mind) can therefore be considered as a form of mental illness that is reversible.

On the other hand, 'Nyamato' refer to the most complicated degree of mental illness as stated in this quote.

A sickness that result to a change in some body's behavior such that he undresses in public, start violent behavior, isolate from people, talk to himself, eat garbage [.....] (nyamato). (FGD4, male 60 years)

As we see 'Nyamato' refers to what leads to a shameful act, becoming violent and doing degrading acts like eating garbage. 'Nyamato' is also a degrading and stigmatizing word. As such, even people with mental illness do not accept the word 'Nyamato' as stated in this quote from one interviewee.

[.....] yes I know I am sick, but I am not suffering from mental illness (Nyamato), this is a family fight [.....]. (Tuba, Male 45)

The definition of mental illness from the participants is related to change in behavior, which varies according to degree of severity. However, referring to someone as 'nyamato' is both stigmatizing and degrading as this form of mental illness is considered irreversible and relate to doing shameful acts.

4.2.2: Causes of mental illness

Perceived causes of mental illness fall into four categories; external power; use of substance; live events and social status, and heredity. These perceived causes are mostly views of study participants who took part in the FGDs. People with mental illness were not asked about the

cause of their illness. This was done purposely not to be too invading. However, some people with mental illness mentioned the perceived cause of their illness, which are similar to causes mentioned in the FGDs such as use of cannabis and family problem.

4.2.2.1: External 'power' or the invisible cause of mental illness

External power refers to those things that are outside of the body and mostly cannot be seen in normal circumstances, but yet they can cause harm to the body. They include demons, evil spirits, magical powers such as witchcraft and fouled wind.

These are common perceived causes of mental illness among the study participants. They are believed to be responsible for a large number of mental illnesses. The onsets of this type of mental illness are believed to be sudden and persons affected appeared very aggressive in nature.

This is how one participant talks about cause of mental illness due to external powers:

Before this problem of cannabis, which is going to destroy our youths, devils or demons cause a lot of mental illness. You know now because of all these cars, they are not very common, because they don't like gasoil. But most mental illness was due to them. We cannot see them and they can see us, so when they appear to us makes us frighten, mostly that is what leads to mental illness. (FGD 5, male 50 years)

In another focus group discussion, the case of demons was explained this way:

People who get mental illness because of demons are different from other people with other types of mental illness, because they are mostly very aggressive and the illness appears very spontaneous. It does not show prior signs. You can be with someone today and tomorrow he gets mental illness. (FGD 2, female, 40 years)

These excerpts are typical of the responses of the study participants in the different FGDs as most of them express similar views as these quotes above.

It was also a common perception among the study participants that mental illness can be intentionally inflicted upon someone. For example they explained that some people with special knowledge, which can be black magic or some other means, are able to cast spells on targeted individuals. This can happen when one wrongs people or steal others property or in

some case when one has an affair with someone's wife. It can also be a result of jealousy or just out of wickedness.

When a spell is casted to a targeted individual, the spell according to the participants will find the target where ever he or she may be in this world, according to the study participants. This is how a woman in her 50 years in FGD 3 explained a particular community where people go to do such acts.

[.....] there is a community here that is very popular for such things (inflicting mental illness and other forms of human suffering on people), in that community, there is a place where people who are offended goes to and make sacrifices and ask the owner or the custodian to inflict what he/she wants on the person who offended him/her. These inflictions can be mental illness, loss of job, impotency, or even death. Huh, you don't trust this until you see it with your two eyes. You know you cannot run away, this thing will follow you to anywhere you go to. The bad thing about this is that unless the one who did the sacrifice goes back there and asked the custodian to undo the act, the person will never get well. (FGD 3, female, 50 years)

In another narration, a woman re-counted her personal experience with a family who had problems relating to witchcraft. This is her tale:

[.....] this happen in my neighborhood, a co-wife accused the other wife as bewitching her child. So the one who was accused took the matter to the idol and then makes sacrifice and asked the custodian to curse her if she is the one who bewitch the co-wife's child, but if she is not the one responsible, let her accusers be cursed. Haaa, this was serious, the woman who accuse the other wife development mental illness within a very short time. She started talking making narration, try to run and also undress. Haaa, unless you see it yourself [...] the family and other relatives had to come together and discuss the matter and ask the wife who went to the idol to go back there to undo what was done. When this was done, the women got well, but could not live in that marriage [.....]. (FGD 2, female, 45 years)

These quotes represent the typical beliefs that are held by most of the study participants about infliction of mental illness on someone. Such beliefs could not only affect delay in

seeking treatment, but also lead to possible conflicts and shame for affected people and their families and discrimination.

4.2.2.2: Social status and live events

These refer to situation or conditions that can bring about change in some one's life and could affect one's mental health status that could lead to mental illnesses. However, if the situation changes again, normality can be restored. These include poverty, employment status, child birth, unmet desire to travel to Europe and living in a chaotic family.

The relationship between mental illness and poverty

Mental illness according to the participants can be both a cause and a result of poverty. As a cause of mental illness, however, according to the participants, if a man cannot provide for himself and his family when he is expected to do so, that creates an environment for that individual to indulge in thinking about that so much so that he ends up being mentally ill.

When poverty was mentioned as a cause of mental illness and the participants were asked to elaborate on it, a man said:

You know here men are responsible to provide for the family, your mother, father, brothers, wife, children and other family members and other relatives all depend on you. So if you cannot provide for these people, is like you have failed in your responsibility. So that make people to think too much about their situation and some end up becoming mentally ill. You see, is good to help each other, but here people depend too much on each other. If you are working you have a problem [.....].
(FGD5, a man 40 years)

This excerpt is typical and indicates the common perception of the study participants and illustrates the expectations from men. It also emphasized the gender role in the society and how such roles can push men to critical circumstances such as traveling to Europe through the back way to fulfil such gender roles.

Similarly, when the third focus group was asked to elaborate on how poverty can cause mental illness, a man use his son as a case to explain the phenomena.

[.....] Because most of his friends are working and they provide for their families and he cannot get a job. He said he cannot live in that kind of situation where he should

provide but instead they provide for him. Then he will go through the back way to Europe, so that he will go out of poverty. Then he embarks on the backway journey. He said he went up to Libya and he was capture and seriously tortured and then he has to come back. He arrived here sick and that finally develop to mental illness. So is poverty that plunge him into that journey. So poverty can lead to mental illness. (FGD 3, male, 65 years)

Similar stories were also narrated by others. However, from the above quote in FGD 3, what is striking here is that the father perceived the cause of the mental illness to be poverty probably because that influenced the son to take up the back way journey. Another possible cause of the son's mental illness could be as a result of the torture; however, that is not mentioned by the father, emphasizing the importance attached to poverty as perceived cause of mental illness among the study participants.

In a similar narration on poverty as a cause of mental illness, in FGD 5, a man explained that failure for one to provide what he and the society expect him to, leads to deep thinking that could lead to mental illness. They assert that although now that is not common, but family heads used to run away from their families because of poverty. This is how one participant talked about this subject.

[.....] When a head of family cannot provide for the family due to poverty, you know, this becomes a very difficult situation for him. And therefore thinks day- in- day- out about the problem. This makes them ashamed of themselves. In those days some people run away from their families and some end up getting sick and become mentally ill because of this. So poverty is very bad, it can lead to anything. (FGD 5, male about 70 years)

Unmet desire to travel in Europe: Migration and vulnerability towards mental illness

For the unmet desire to travel to Europe, the participants explained that because most young people, who are able to build good houses, buy big luxurious cars, take their parents to Mecca, and established good business, are people who mostly travelled to Europe. According to the participants, young people who do not have the means to go to Europe, keeps thinking about it, some ending up mentally ill. This was explained in FGD 3 by a woman like this:

You know now our young people are also faced with another issue that is travelling to Europe. Because they see what their colleagues are able to do; building big houses, buying big cars, taking their parents for pilgrimage, establishing big business. So they all want to go. You know this is why does who cannot go take the back way, which has led to the death of so many people. Those who cannot take the backway which is also very expensive, end up becoming mentally ill, because they think too much about it. (FGD 3, female 40 years)

This quote is a typical illustration of how the respondents felt about traveling to Europe as a means of getting out of poverty. It raised a lot of discussions in all the focus groups which indicates its present importance in the society as many young people under take the journey and many do perish through the journey. This happens in a context where the Gambia is one of the countries with high rate of immigration, unemployment among youths and high rate of poverty among the population.

Loss of property as a cause of mental illness

Loss of property which can result from mismanagement either by the owner of the property or by his family member can also lead to mental illness according to the participants. In this excerpt, a man explains how this could happen.

[.....] Some people get mental illness when they travel and come back because they found that all the money that they send home was lost. When they send money for their relatives to build houses for them or buy animals or put the money in to business, what they do is they take pictures of somebody's property and send that. So the man will trust them and when he comes back and finds out that those information they were give him are not true. They start to think over that and some end up developing mental illness. In fact it becomes very serious for someone who is returned from Europe, America, who has the hope that at least there is something for him at home that he can rely on. (FGD 1, male, 50 years)

This quote is very typical of the way this phenomenon has been illustrated by the different study participants in the different focus groups.

Living in a chaotic extended family

How living in a chaotic extended family can lead to mental illness was narrated like this by a participant in FGD 4.

Here we used to live in big families and that was very helpful because the head of the family is well respected by every member of the family and we support each other, even if you don't have, no one knows outside the family. You see, but this has changed. Now people with the same mother and father cannot pull well. When they live together, small problems starts to break especially between the different wives as they come from different back ground and this usually end up between the brothers. You know the way we use to choose our wives has changed so much [.....]. so when small problems starts, it mostly ends up by breaking the family as everyone feels big and no respect anymore for the head especially if younger one are better off than him. Things like this can lead to mental illness ('sundomi kurao') for the head of the household. (FGD 4, male 60 years)

This is not mentioned by many study participants, but it however illustrates how some changes like family size and setup could influence mental illness as perceived by the study participants. It also illustrates that people of different age groups may ascribe different causes for mental illness in the same society or culture.

Child birth as a cause of mental illness

Childbirth as a cause of mental illness for the mother shows a gender dimension as it has been mentioned by the two focus groups consisting of women and only one focus group consisting of men. The other two focus groups consisting of men did not mention it.

The two focus groups consisting of women and one focus group consisting of male group forwarded that some women get mental illness as a result of child birth. Some asserted that it is sometimes temporal, but it can come back in subsequent deliveries. This is how it was explained.

One other cause of mental illness is childbirth. This one affects only women. You know delivery, huu, until you experience it. Is very painful and lot of things can happen. I have seen a woman who developed mental illness after delivery, when he

was taking to the hospital, they clean the stomach to remove the leftovers of the delivery, and she get well. (FGD 2, female, 45 years)

This quote exemplifies the general view of the participants' about childbirth as a cause of mental illness. It stresses the temporal nature of this type of mental illness.

4.2.2.3: Mental illness can be inherited

It is perceived among the study participants that mental illness can be inherited. For example, if the father or mother has mental illness, this can lead the children to also have such type of mental illness. This according to some is very common when the mother has mental illness and she breastfeed. Such children according to them can have mental illness. In FGD 5, a scenario was explained where a mother has mental illness and four of her sons developed mental illness. It was assert that the woman has a co-wife, but none of the co-wife's children has mental illness. So in this case the mental illness was associated to breastfeeding. This was how the ordeal was narrated:

[.....] no need to mention the name of the family, but I know you will all know who am talking about. You see in our village here, there is a lady who has mental illness but it was not very serious, so she is married, but four of her children developed mental illness, because they feed on her breast milk. You know, this woman has a co-wife who also has children but those ones do not develop any mental illness. (FGD 5, Man, 40 years)

In a different view, heredity as a cause of mental illness was explained by a man of about 60 years in FDG 4 like this:

Family members of traditional and religious healers also do have mental illness as a result of revenge from the demons and or evil spirits. This happens because traditional and religious healing involves fighting with the demons or the evil spirit to leave the body of the sick person. So because they cannot do much to the one fighting them, so they end up attacking the family. Mostly this happens, when the healer passes away.

This quote also demonstrates a common way of participants understanding of how heredity can result to mental illness among family members of traditional healers.

4.2.2.4: Substance use connected with mental illness

Although smoking and selling of cannabis is prohibited by the laws of the Gambia, it appears as an important perceived cause of mental illness in the Gambia as illustrated by the response from the different study participants.

Use of cannabis

Cannabis is denoted to be responsible for the high number of mental illness among young people as explained by a sixty-year-old man during a focus group discussion. He states that mental illness was not previously common among young people as opposed to now. This is his explanation:

When we were young we rarely see young people who are mentally ill. Yes in those days it was illness for the old people, but now it is the opposite, the sickness has shifted to younger generation because of this cannabis smoking. Yes is true, now we hardly see old people with mental illness, but young people, they are too many. (FGD 1, male 60 years)

This narration is a typical view of the study participants. It however portrays how some believed causes of mental illness may change over time and how this change can also shift the burden from one age group to the other.

In a similar vein, during an interview with Omar, a man, 44 years, using the community mental health service, also shared the view that his mental illness was due to his cannabis smoking. This is how he explained his story:

You know this illness started long time ago when I was with my brother learning how to do welding. Even though my people don't know, but I smoke bush [cannabis] and drink alcohol. So I was smoking for a long time, then later I realized that if I smoke, I do fell down or I have severe headache and this make me very lazy and always sleeping. So my brother realized that something is gone wrong with me and then informed my parents, who thought it was evil sprites, so they took me to my uncle who is a religionist. But me I know it was because of bush [cannabis]. (Omar, male 44 years)

Sulay who also incriminates cannabis as the suspected cause of the onset of his illness, explained that he didn't smoke cannabis, but the day he tried it was the day his illness started. He explained thus:

[.....] I don't smoke cannabis before, but on this day I was with some friends who do smoke cannabis, so I decided to taste it on that day. So when I smoke with them, after sometime I started to feel dizzy and could not stand. My legs became weak and my head became heavy and I could hear sound in my head. So later I also started seeing images that makes me very frighten so that make me shout. (Sulay, male 34 years)

Although, Sulay admit that he tested cannabis, however, admitting to cannabis smoking may not be common as its illegal and considered as indecent and forbidden by Islam, the most commonly practice religion in the Gambia.

These responses are also in correspondence with the information gathered during my interaction with the staff of the only psychiatric hospital in the Gambia. According to them, about 75% of their admissions are drug induces psychosis cases. [From field notes]

4.3: Classification of mental illnesses

Mental illnesses are categorized based on whether they can be treated or not. The ones that are considered as caused by life events such as poverty, loss of property, unmet desire to travel, and childbirth are consider as ones that may not require treatment, but a change in circumstances. Similarly, mental illnesses perceived to be caused by substance use are considered illnesses that can be treated.

However, one type of mental illness with a specific name has been mentioned in all the focus group discussions. This type of mental illness is referred to as 'Dewdi' [meaning shade.] The treatment of this form of mental illness is perceived to be only done by the Fulla tribe. However the study participants' asserted that this type of mental illness also can affect other tribes. This is how a 45-year-old woman explained Dewdi (shade) in FGD 2.

You know there is a type of mental illness refer to as 'fulla sirsir' (meaning sickness of the fulla's) [participants broke into laughter and a Fulla among the group disagree that is a sickness of Fullas' but rather a sickness that is treated by Fullas which was agreed among the participants, [...], if you have this type of mental illness, you have to go to a Fulla healer to get treatment.

This is a very widespread belief among the study participants and the quote illustrates the sort of belief about this illness among the participants in all the focus groups. This kind of perception can deter people from seeking care from other source order than from the Fulla tribe which can have consequences for the affected person.

4.4: Treatment pathway/ therapeutic itinerary

Although people with mental illness used different systems of care for their illness, as found in this study, there is link between the cause of mental illness as perceived by the community and the treatment pathway.

However, this treatment pathway changes along the treatment continuum. Such change in the treatment pattern could be linked to the level of satisfaction on the part of those seeking treatment and care from the service.

These services include religious, traditional and biomedical treatment systems.

4.4.1: Religious and traditional treatment systems

Religious and traditional treatment systems can be considered as the first services where people seek for help when they feel something is wrong.

For traditional healing, the healers are mostly from families who have a history of involvement in traditional healing in their societies, as the knowledge of the treatment of illnesses is considered as a family asset that is transferred from one member of the family to the other.

In this system of healing, the healers' uses combinations of herbs and 'secret knowledge' and in some cases, rituals are also performed. Healers are usually people who are residing in the community and share sociocultural beliefs with the people. They are mostly respected members of society who are not only involved in treatment, but also settling disputes and other social issues in the community.

Similarly, the religious healers, especially the Muslims also live within the community and share sociocultural beliefs with the society. However, in this system of healing, they make use of religious text that are either recited or written on paper or on special material and prepare solutions from it. These solutions are either used to wash the body, drink and or both.

Religious healers are people with background knowledge in religion and they are mostly highly respected people in society. They mostly lead in social and cultural events like naming

ceremony, burial services, teaching and preaching religion. They are mostly in every community.

The use of these two services depends on the perceived cause of the mental illness. For example, mental illnesses perceived to be caused by external power, such as evil spirit, demons, witchcraft, and foul wind are considered as not curable by biomedicine, but only by traditional and religious systems of treatment.

Most mental illnesses are caused by evil spirits, demons, and devils. These types of mental illnesses are difficult to cure. It involves fighting with the spirit, with the demons, with the devils. Not every healer can do it that is why not many people do it. For these illnesses, the health centre cannot do anything about it and sorting care from health centre, even makes it worst. (FGD 1, man, 50 years)

Similarly, the use of the religious system may depend on the religious background of the sick person and his family.

The costs of these two systems of treatment are not fixed but can change depending on the length of the treatment and the perceived cause of the illness.

My mother paid a huge sum of money to each of the traditional healers. In Cassamance, she was asked to pay half of the cost of the treatment and when I get well, the other half can be paid. So she paid (D7500.00) Seven thousand, five hundred dalasi (\$157) [.....]. (Neneh, female 37 years)

Although the use of these systems of treatment is very high among study participants, it is not without challenges. It has become a lucrative business undertaking according to the study participants, for some people leading to fake healing, where they charge high sums of money or property for healing as demonstrated in these excerpts.

[.....] now the problem is many people pretend to be traditional healers when they cannot do anything, just to take peoples' money. Now traditional healing is more costly than biomedical treatment, why? Before, people pay very little money for traditional treatment, when traditional treatment was at its best. Now everybody in every tribe can do it. (FGD, 5, man 60 years)

[.....] the traditional healer said I should pay eight thousand dalasi (\$187) to get treatment and this I can pay in instalment. But I have to pay more than have of the total sum of the money. I could not pay that much money at that time, so we left.
(L.Boy, male, 27 years)

Similarly, these systems are also reported by a participant to have challenges related to the way patients are treated, such as beating and chaining of patients. This is how one participant who is mentally ill explained what he show when he went to seek treatment from one traditional healer.

[.....] I could not continue to stay to take treatment. Because here you see they chain some people. Also you see people been beating during the treatment. I do not want to see that. (Omar, Male 44 years)

4.4.2 Biomedical services

In most cases as highlighted by this study, the biomedical system is usually a last resort for the treatment of mental illness. People use them when they fail to achieve satisfaction from the other systems of treatment.

This system uses a diagnosis system on which the treatment is anchored. Medications such as antipsychotic drugs, sometimes in combination with psychoeducation are used for the treatment of people with mental illness.

The diagnosis and treatment in this system are delivered by trained psychiatrist, medical doctors, nurses and other health care providers. These people are usually found in established health institutions which are often located in towns and cities thus making access to such services for rural population a daunting task. In the Gambia these services can only be accessed through the outpatient clinic located in the capital city or through the community mental health team or through the only psychiatric hospital located some 30 kilometers from the capital.

Although the community mental health teams (CMHT) do provide mental health service at some health facilities in both rural and urban areas of the country, this team has stopped going for such services to most of the health facilities. Even where they go they only write prescriptions for patients to go and buy the medication where ever they can get it. The

medication are not found in most communities, making it difficult to get it even you have the money, as indicated in this quote.

I used to be given the medicine by the community mental health team, but now they say they don't have supplies, so now they write paper for me to go and buy on my own. But I cannot get the medicine here, so sometimes I send the paper to my brother in Kombo to buy the medicine and send it. Sometimes I give it to my younger brother with transport fares to go to Serrekunda or Banjul to buy it. This makes things very difficult. Sometimes I have to stay without medicine because I cannot get it.
(Borry, male 41 years)

As some types of mental illnesses may require long-time use of medication, their availability and use at all time is important for preventing relapses that could result from inconsistent use of the medication. However, the cost of medication is demonstrated to be an outcry for people using the community mental health service.

According to Fafa and Sulay, both using the community mental health service, it cost them lot of money to get medication, which they depend on their families for as they are not working.

Every month, I take one injection and one tablet a day, sometimes it cost D400.00, D500.00; (\$9, \$12), the prize goes up and sometime it goes down, and sometime is not available here, I have to go up to Serrekunda or Banjul to buy it, the fare is also expensive. (Fafa, male 40 years)

Sulay, 34-year-old, also explains how much it cost him to get a month supply of medication:

Mostly, I buy the medicine in Brikama or if I cannot get it here, my cousin takes the prescription when going to work at the Hospital in Banjul and buy it in Banjul. So for the injection and the tablets, sometime it cost D400.00, sometime D450.00 or sometime up to D500.00. (\$9, \$11), you know me am not working, so is my brothers who give money to my mother for my medication. (Sulay, Male, 34 years)

These quotes depict how much it cost to get antipsychotic medication for people who are not working, but depending on their families and other relative. This is the situation for all the people using the community mental health service in this study.

The high cost of antipsychotic medication also affects its consistent supply and use as demonstrated by an old man, whose wife is also on medication.

[.....] as long as she is taking the medication, she has no problem, she goes on her normal life. But, when the money is not available to buy the medication, which is very expensive, Haaaa, she stays like that until money is available. (FGD 1, old man)

From the above quote, it could be noted that the cost of medication affects the consistent supply and use. This can affect the effectiveness of the medication and may lead to relapse, which could be detrimental on both the patients and the family. These could also affect the trust and confident in the antipsychotic medication, which could lead to abandonment of treatment.

4.4.3: Biomedical versus traditional system: the syncretic use of mental health services

People with mental illness use different treatment systems at different times and sometimes concurrently. All the service users I interviewed have reported seeking care from more than one service.

When people have mental illness, mostly their family takes them to the religious healer, so when the condition did not improve or changed, they proceed to the traditional healers but now people also go to the hospital. (Focus group 2, female, 40 years)

You see, the use of biomedicine for treatment of mental illness is only becoming popular now, but what we know is the religious and the traditional healing. This is what we know and this is what has being in use since days in memorial. Now the problem is many people pretend to be traditional healers when they cannot do anything, just to take people's money. (Focus group 5, man, 60 years)

Now if your relative has mental illness, the family face a big problem, running between the religious healers, traditional healers and the health center. You see, now

is difficult, you don't know where to go, traditional treatment very expensive, the biomedical I don't know what can they do about mental illness. We have more mental illness today than at any time of our history. We want to discourage traditional treatment, but we need to look back, because we have a problem [...].
(Focus group 4, man, 62 years)

Most of the service users interviewed start their treatment with religious healers. Neneh a 37 year old lady explained that when her illness started, she was taken to a religious healer, and then to a traditional healer before she eventually started using the biomedical services.

[.....] when the illness started, I was first taking to a religious healer who live in my community, he prepared some solutions for me to bath with and something else to tied. This did not change anything, so I was later taking to Bakindiki, where I spent some time, when I came back, I was better, but few weeks later, the sickness came back. Then we went to Cassamance in Senegal. It took was a whole day to get to the traditional healer; there too, we spend about two weeks; I cannot fully remember the exact number of weeks. (Neneh, female, 37 years)

Moving between the different treatments systems and also between Gambia and Senegal are typical pattern that is portrayed by almost all the study participants using the community mental health service.

All the study participants using the community mental health service except one have used religious, traditional and biomedical services for the treatment of their illness. What seem to drive their therapeutic itinerary are the influence of the family and also the perceived cause of the illness. But again, the religious healers are mostly within the community at easy access and this could perhaps also influence why most of the research participants visited them.

4.5: Experiences with accessing mental health services

The study participants' experiences with mental health care are presented here in three thematic areas; decision making process; accessing service and accessing medication.

4.5.1: Decision making process in accessing mental health services

Family decision making is common practice especially when it comes to vulnerable members of the family. The responsibility for such family members in terms of basic needs and health care seems to be shouldered by the family members as seen in this study.

These family responsibilities also extend to decisions about health and health care seeking. For instance in this study, it was observed that the decision about where and when to seeking treatment for mental illness is influenced by the family.

Asom, a female, of 38 years, explained that all the treatment systems she visited were decided by the family as explained in this quote:

I cannot remember all the places I have seek treatment from, but all the places I went to I was taking their by my family. You know I was sick, so I cannot do much. So when they learned about a healer who treats this kind of illness, from other family members, friends or neighbors, they then take me there. I was taking to Jappineh, I was taking to Busura and Cassamance, these I can remember very well. (Asom, female, 38 years)

In a similar vein, Borry, also asserted that the family took him to the different places he sought treatment from.

[.....] you know they are helping me, so when they have any information about healers who treat people with this kind of illness, yes they tell me lets go there. So I go with them, because they want to see that I am well again. (Borry, male 41 years)

The family decisions about where to take a family member is seen to be influence by the perceived cause of illness and also by information from other family members, friends and neighbors as explained by, Borry a 41 year old man.

There are some places in the Gambia that are known for the treatment of this kind of illness, so everybody knows those places. But others, you know, they keep asking

from neighbors, and sometimes when people come to see me, they tell my people about healers that they learned treat this kind of illness. (Borry, male, 41 years)

These quotes represent the typical pattern that service users in this study go through. It illustrates how their families, neighbors and other relatives all contribute to identify where treatment can be sort from.

However, distinctive gender roles have been demonstrated by this study; while the family decides about treatment, the mother takes the role of escorting the sick person for treatment. This could be explained by the different gender role in society, where mothers serve as carers of the family especially during times of sickness, while men provide the required resources as illustrated in these quotes:

When my family wants to take me to a place to seek treatment, my brothers, put the money together and gives it to my mother, who goes with me to all the places I sought treatment from. I cannot go alone, when the sickness was very serious, but now I go alone to the health centre when the doctors are around. (Sulay, male 34 years)

[.....] I spend about two months at Bakindiki with my mother, at Busura we spent close to a month. The healer we visited in Cassamance also, I went with my mother. In all the places, I go with my mother. (Ndumbeh, female, 30 years)

More than three-quarters of the study participants using the community mental health service had been escorted by their mothers and this seems to be driven by the sociocultural gender role in the society. These mothers do not only move around with their family members within the Gambia, but they go beyond the geographical boundaries in to neighboring Senegal in search of treatment for their family member.

4.5.2: Accessibility of mental health services

Information gathered by the researcher on the routine mental health service that is delivery by the community mental health team through which most people in the rural population and most part of the urban community access mental health services was that the service now is only limited to very few health facilities in the urban area. According to the team, the service is limited to few health facilities due to lack of supply of medication and other

logistics from the ministry of health. This means that most of those who access services through the community mental health team in their communities or close by, are no longer able to access services at such places, unless if they travel to the capital city. This is not only frustrating but can also prevent people to access mental health service even if they need it. It can also motivate people to use what is available.

The study participants using the community mental health service do not only move between services, but also between the two countries of The Gambia and Senegal in order to access mental health services.

This was demonstrated by Karamba and Fafa in these quotes:

I was taken to my father's healer in Senegal when the illness strokes me. That was the first place I was taking to. The place in Senegal is very far, we spend half of the day travelling even though we went with our own vehicle. (Karamba, male, 46 years)

[.....] then I was taking to Nuimi Bakindiki to a traditional healer who is popular for healing this kind of illness, where I stayed for some time, then came back after taking my medication he gave me. I also went to another traditional healer in Cassamance in Senegal, just like in Bakindiki, I was given some traditional medication that include leaves and roots of trees and some that I brought home. (Fafa, male 40 years)

These quotes depict generally what most of the service users do to access traditional systems and it illustrates how far they can go to access services for their illness. This could explain how concerned they are to find a solution to their predicaments.

Biomedical services are virtually none existent for the rural population and where they exist, patients basically receive prescriptions which they use to buy medication, the cost of which is considered to be exorbitant.

4.5.2.3: The cost of treatment and accessing medication

The service users, who started their treatment with the community mental health team in the last five years, narrated that there is a big difference from before. They reported that they used to get all their medication from the mental health team, but now all that they do is to write a prescription for them and ask them to go and buy on their own which is reported to be difficult even you have the money. Neneh, a 37 year old lady using the community mental health service explained her frustration getting medication.

I don't get any medicine from the mental health team. But they write prescription and give me to buy the medicine, which sometime I go round all the pharmacies in Brikama and I cannot get it, then I have to send my brother to Serrekunda to go and buy it. (Neneh, female, 37 years)

This becomes more frustrating for patients who live far away from the big towns where at least few pharmacies exist. In their case, an additional cost is incurred to get the medication as explained by Borry a 41 year old man, who lives about 60 kilometers away from the nearest town where such medication can be bought.

I used to be given the medicine by the community mental health team, but now they say they don't have supplies. So now they write paper for me and ask me to buy the medicine on my own. But I cannot get the medicine here, so sometimes I send the paper to my brother in Kombo to but the medicine and send it to me. Sometimes I give it to my younger brother with transport fare to go to Serekunda or Banjul and buy it. [.....]. This makes things very difficult. Sometimes I have to stay without medicine, because of the distance from here to Kombo. (Borry, male, 41 years)

Is my son who buys the medicine for me, because now we don't get medicine from these people. When I send him the paper they write for me, he takes that and buys the medicine and sends it to me or when he is coming he brings it. Last month when my supply was finish, it took about one week before I get the medicine. My son said is sometimes difficult to get the medicine. (Tenneh, female 67 years)

Access to antipsychotic medication is demonstrated to be a huge problem for people using the community mental health services as they have to struggle on their own to get it. However, medications used by traditional and religious treatment systems appear to be readily available with the service providers and they are easily accessed when treatment is agreed and initiated.

To sum-up, the findings of this study shows that deviant behavior is the criterion for describing mental illness. The study further revealed many perceived causes of mental illness among the study participants.

The findings further shows that people with mental illness and their families use different treatment systems either singly or concurrently. However, the use of these systems is determined by factors such as the perceived cause of the illness, satisfaction, availability of the service and accessibility.

The family provides financial support for treatment and medication but also decide where treatment for their mentally ill is sought from. Biomedical treatment system is generally scarce, while traditional and religious healers are easily accessible. However, cost for traditional treatment is also considered to be very high.

CHAPTER 5: Discussion

The aim of this study is to contribute to the improvement of access to mental health care services by uncovering the factors that influence access to such services from the perspective of people who has the experience and among the general population. The discussion will be framed around structural violence framework looking at the broader sociocultural, economic and political underpinnings.

Structural violence explains how social structures harm or otherwise disadvantage individuals (Farmer, 1999), and therefore provides a useful framework within which to explore factors that influence access to mental health care service. However, one of the challenges of structural violence according to Farmer (Farmer et al., 2004), is that they are sometimes difficult to identify as they are accepted as the normal. Therefore their identification may require looking beyond the surface, a process that may require interacting with those who has the experience of the phenomena of interest. As such, the use of phenomenology in this study provides a useful approach to collecting data to identifying factors that influence access to mental health care service through how they are perceived by the people who has the experience.

This study, however, includes only people with mental illness who can give informed consent and therefore, those with severe mental illness, who cannot give informed consent, were excluded due to ethical considerations. Furthermore, the perspective of service providers, the mental health policy, and the treatment system were not explored in this study, although they could also illuminate other factors that could impede access to mental health care service.

The perspectives and views of both the service users and the community members in this study are similar. They share similar views and beliefs about causes of mental illness and the therapeutic itinerary. The explanation for such similarities could stem from the fact that these people share the same sociocultural beliefs, lives in the same geographical locations, and also lives in a similar family setting. All of which can influence access to mental health care service as found by this study.

What factors influence access to mental health care services? On the whole, this study shows that there are many factors that could influence access to mental health care services among Gambians with mental illness. The most important of these factors that shed light on access to mental health care services include; the concept of mental illness; family

involvement in the choice of treatment system; the scarcity of mental health services; the high cost of services, high cost of antipsychotic medicine and distance to service. All of these are related to the over-arching structural violence framework of social, economic and political factors that constrained individuals to access mental health care service.

These factors are discussed under three main themes; 1) the concept of and believed causes of mental illness influence on access; 2) Family decision and involvement in choice of treatment system(s) and; 3) Difficulty in accessing and cost of mental health services.

Theme 1: The Concept of and believed causes of mental illnesses influence on access

How the study participants defined mental illness can potentially influence treatment-seeking among mentally ill patients. This study reveals that deviant behavior is the criterion for perceiving someone as mentally ill. As such, one has to demonstrate a change in behavior which is defined by the severity of the deviation.

This study further found that *sundomi kurao* and *Nyamato* are the local words used to conceptualized mental illness, but a distinction is made between them based on the degree of deviation. *Sundomi kurao* is considered as less severe and this could relate to the common mental illnesses in the biomedical system. Severe deviation refers to ‘*Nyamato*’ which leads to doing shameful acts like undressing in public and doing degrading things like eating garbage and also becoming violent. This form of mental illness could also relate to severe mental illnesses in the biomedical system such as psychosis, bipolar and schizophrenia which requires treatment and or hospitalization. The word ‘*Nyamato*’ is not only a definition but also a derogatory word that is synonymous to ‘madman’ or ‘lunatic’.

The use of a derogatory word such as *Nyamato* to identifying people with mental illness is a form of structural violence as it put such individuals in harm. This way of labeling people could lead to stigmatization which may affect treatment-seeking for mental illnesses, as it is associated with doing shameful and degrading acts. This is related to the argument put forward by Verhaeghe and other (Verhaeghe, Bracke, & Bruynooghe, 2007), that use of dismissive local language to conceptualize mental illness contribute to stigma and affects health care-seeking. Stigma, however, is not brought up frequently by the participants in this study, which could be due to limited experiences of such phenomena by study participants. The other reason could be that the participants in this study are not overtly sick as they are

able to give informed consent, illustrating that their level of deviation is not severe, and therefore they may not do shameful acts that could earn them stigmatization.

Notwithstanding, stigma has been documented in many studies as an important factor that affects help-seeking especially among the mentally ill who could have benefit from health services (Burns & Tomita, 2015; Corrigan, 2004; Jack-Ide & Uys, 2013). For instance Omi Jack-Ide and colleagues suggested for more efforts to address stigma as it is an influential barrier to accessing mental health services in Nigeria (Jack-Ide & Uys, 2013).

Also, deviant behavior as the only criterion for perceiving someone as mentally ill, presents a very narrow scope of mental illnesses. Such narrow viewing of mental illnesses thus has the potential to exclude other forms of mental illnesses and thus influence the type of treatment people seek who does not demonstrate deviant behavior, as such individuals may not be considered as mentally ill. Furthermore, this narrow way of conceptualizing mental illnesses is not in correspondence with the two commonly used diagnostic systems of WHO's international classification of diseases (ICD) and the American Psychiatric Association's Diagnosis and Statistical Manual (DSM) of mental disorders (Fernando, 2014).

Notwithstanding, it could be argued that these two commonly used diagnostic systems may not be sensitive to all cross-cultural presentations of mental illnesses (Whiteford et al., 2013), especially where there are beliefs in external forces such as witchcraft, magical powers and bewitchment as found by this study.

This study further revealed that there are various perceived causes of mental illness and that the perceived cause of mental illness influences the treatment pathway at the beginning of the illness. However, this pattern of help-seeking changes along the treatment continuum. The most unique perceived cause of mental illness in relation to other studies as found in this study is the 'unmet desire to travel abroad'.

In connection to this, this study found that families sell their properties like land and animals to pay for a family member to travel through the backway to Europe with the expectation that when that person succeed in reaching their lives will be changed. This is indicative of the current importance attached to this phenomenon in the Gambia. Most of the people that are involved in this are young people most of whom has either completed school and has no job, or have not even completed schooling.

This recent attempts by people to travel to the global north affects many other countries in west Africa region and has been largely related to governments' inability to restore economic stability (Kebbeh, 2013).

This unprecedented mass immigration crisis is happening at a time when the Gambia is ranked 175 out of 185 in the United Nations development program's 2015 human development index and with over 60 percent of the population living below absolute poverty line (IFAD, 2016), the unemployment rate is as high as over 22 per cent affecting mostly the youth population. This can variably explain why many young people want to travel out of the Gambia by all possible means, as that is seen as a possible way of going out of poverty as postulated by the study participants.

However, the belief that mental illness caused by unmet desire to travel to global north cannot be treated by any other means but undertaking such a journey were so many people lost their lives, should be a serious cause of concern. Such belief can influence seeking of mental health care service among people who might need such services.

Poverty and the lack of employment, the main drivers of recent immigration to the global north are embedded in the economic and political arrangements that are socially influenced. This social arrangements are structural and because they put people in harm, they are violent (Farmer et al., 2004; Kelly, 2005).

Another very frequent perceived cause of mental illness found by this study is the use of cannabis. Cannabis as a cause was mentioned in all focus group discussions and also in the in-depth interviews with some mentally ill patients, two of whom believed that the cause of their mental illness was due to cannabis. This finding is supported by a previous study conducted in the Gambia among patients admitted at the psychiatric hospital (Rolfe et al., 1993).

Cannabis is perceived to be the main culprit of the recent upsurge in mental illness among young people in the Gambia, who bear the brunt of the problem of mental illness. However, the knowledge that cannabis smoking causes mental illness and that it can be cured through the medical system is plausible.

Notwithstanding, cannabis causes only a small proportion of mental illnesses and therefore focus on it as the main culprit of the recent upsurge in mental illness may sway people from other causes. Similarly, cannabis use is considered immoral and in view of this, a person whose mental illness is perceived to be caused by cannabis use could be seen as an immoral

individual who is responsible of his illness (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). As a result, such individuals may also delay or may not seek treatment for fear of been labeled as immoral or even stigmatized by the public.

Other causes such as “external powers” which include demons, evil spirits, foul wind, magical powers such as witchcrafts, were also highlighted to cause mental illness. Similar findings were also documented in studies in the Gambia, Nigeria and South Africa (Coleman et al., 2002; Gureje et al., 2005; Ohaeri, 2001; Schierenbeck et al., 2013) where such causes were put forward by study participants.

Such cosmology about causes of illness in the Gambia is not only limited to mental illness but also related to other illnesses. For instance, O’Neill and others in their study conducted in rural Gambia about local beliefs of the cause of malaria and its treatment itineraries reports that participants considered sickness to be cause by either; i) an agent or micro-organism inside the body that can be detected by biomedicine or ii) by supernatural forces that reside outside the body and cannot be detected through biomedical diagnosis (O’Neill et al., 2015). However, the belief that mental illness caused by external powers can only be treated by traditional treatment system, has the potential to influence the treatment seeking behavior of individuals and their families skewed towards such treatment system. Similarly, where such treatment system are not available or affordable, there is tendency that such people will delay or will not seek treatment for their mental illness even if they so need it, as the perceived cause plays a key role in the choice of treatment system as evident in this study and other studies (Muela, Mushi, & Ribera, 2000).

Theme 2: Family decision and involvement in choice of treatment system(s)

In the Gambia, the family plays an important role in supporting individuals especially in times of distress and incapacitation. This study has found that the families of the mentally ill are very supportive. They do not only provide financial resources for the cost of treatment and medication, but they also decide where treatment is sought from. This was indicated by all the 15 interviewees and in all the focus group discussions, that the family decides treatment and provides the financial resources for the treatment and medication.

This finding is similar to a finding reported in India, where the primary responsibility for the care of a person with mental illness lies with the family, who makes decisions about treatment and care (Khandelwal, Jhingan, Ramesh, Gupta, & Srivastava, 2004). Similarly,

Stefanovic and others also reported that in China, caring for people with mental illness is mostly the responsibility of families who are expected to take control of the lives of their relatives with mental illness, where often, the decision for admission is not the patient's decision but the families' (Stefanovics et al., 2016).

The special role of the mother in escorting the mentally ill for treatment especially for traditional treatment is very prominent in this study. Most of the mentally ill interviewed stated that they went with their mother to seek for treatment.

This study found that the family provides financial and moral support to the mentally ill which is a plausible attitude on the side of the family. This becomes more important on one hand, as most mentally ill are unemployed as found in this study. On the other hand, there is no social benefit system in the Gambia on which such people can rely and this makes it all more important to have family support.

However, deciding the treatment system by the family for the mentally ill could also stem from how mental illness is understood as something that damages peoples thinking. As such, a mentally ill person could be seen as unable to make decisions on his or her own. This is similar to the finding of Pathare and others in their review of evidence on supported decision making for people with mental illness in low and middle income countries (Pathare, 2012).

However, the finding that the family decides where and when treatment should be sought has the potential to influence access to mental health care services. On one hand, it can lead to unnecessary delays for an agreement to be reached in terms of when and where to seek treatment from. On the other hand, decisions made may not be in the best interest of the mentally ill and his illness, as their choice is likely to be influenced by their perceived believed cause of the illness as evident from the findings of this study. This can affect the continuity of treatment and taking of medication.

Theme 3: Difficulty in accessing and cost of mental health services.

The treatment systems used by people with mental illness as found by this study include; religion and traditional healers, and biomedical. This study revealed that mentally ill patients used all these treatment systems either one after the other or concurrently. This widespread use of different treatment systems found by this study is also reported by previous studies conducted in Nigeria, Ethiopia and South Africa (Abdulmalik & Sale, 2012; Abiodun, 1995;

Mkize & Uys, 2004; Teferra & Shibre, 2012), where use of different treatment systems were reported among mentally ill patients.

Similarly, this study further found that the use of these treatment systems apart from sociocultural beliefs, are influenced by factors such as availability, accessibility, satisfaction and cost involved. This finding is similar to a proposal by Roy Penchansky and others (Penchansky & Thomas, 1981) that access includes five dimensions; availability, accessibility, accommodation, affordability and acceptability: Accessibility refers to the availability of health services within reasonable reach of those who needs it and affordability as the ability of the people to pay for services without financial difficulty. Whereas acceptability is the willingness of the people to seek treatment from the service which can be affected by social and cultural factors such as ethnicity, religion and language (Evans, Hsu, & Boerma, 2013).

This study revealed that the religion and traditional treatment systems are mostly used first by the mentally ill which could be related partly to their availability and easy access. However, as patients and their families fail to get satisfaction from these systems, they continue their search for a system that can address their problem, ending up with the biomedical system with the hope that they will get better. This is evident from this study, that all the 15 mentally ill patients interviewed are using the biomedical system, but have also used the traditional and religious systems.

Also, the traditional treatment system is associated with very high cost which patients described as exorbitant. Such high cost for the traditional treatment is reported by some mentally ill patients as the main factor for not using a particular traditional treatment system. A similar finding was also reported by Muela and others, where traditional healers are reported to charge too much for their service in Tanzania (Muela et al., 2000).

For the biomedical service, this study revealed that this service is scarce, especially for those living in the rural area. Even those living in the urban area find it difficult to access the biomedical system because of its centralized nature and the unreliable mode of operation of the community mental health team that provides mental health service to the majority of the population.

The scarcity of mental health service (biomedical) found by this study is similar to findings recorded in Nigeria (Jack-Ide & Uys, 2013). A similar finding was also reported in Ghana (Ae-Ngibise et al., 2010), where availability of psychiatric care (biomedical) was said to be geographically inequitable and significantly skewed in favor of the urban population.

Similarly, where biomedical system is available and used, the cost for antipsychotic medication are described to be very high which result to erratic supply and use among some of the mentally ill.

The scarcity of mental health care service, high cost of antipsychotic medication and high cost of traditional treatment are related to structural and political arrangements. This structural arrangement hinders people from accessing mental health care service and put them in harm.

In summary, access to mental health care service is affected by many factors in the Gambia, most of which falls within the over-arching framework of structural violence, as revealed by this study. These social, economic and societal factors create a form of structural violence which can impede access to mental health care service (Kelly, 2005).

For example, the use of the word Nyamato to refer to mentally ill, even though is accepted as the normal but is derogatory and stigmatizing, and therefore can hamper access to treatment services. Also sociocultural belief that some mental illnesses cannot be treated by biomedical system also hampers access to treatment as such belief influence where treatment is sought from.

Similarly, the structural arrangement of mental health services affects the availability and accessibility of such service to most of the people who needs the service. As a result, these people are hampered by this arrangement. In the same vein, the high cost of antipsychotic medication and high cost of traditional treatment all harm people and hinder them from using the service and acquiring the medication. Such arrangements of social structures are considered as structural violence (Farmer et al., 2004), as they harms people in this case from accessing mental health care service.

Similarly, poverty also appears as both a cause and effect as demonstrated by recent events on migration among young people in the Gambia in pursuit of economic emancipation. Most of the people engaged in this risky journey are not employed.

CHAPTER 6: Conclusions and implications of the study

This is the first empirical study that explores factors which impact access from the perspective of service users and the community. The aim of this study was to contribute to the improvement of access to mental health care services by mapping out factors that influence access to mental health care through a phenomenological approach. This last chapter concludes by offering implications of the study findings and future research.

6.1: Conclusion

Mental health and access to mental health care service is an area of study that is accorded with very little attention in the Gambia. Findings of this study showed that access to mental health care service is influenced by perception of and believed causes of mental illness at the beginning of the illness. However, this pattern changes along the treatment continuum as they failed to get satisfaction from this system. The lack of satisfaction from these services also leads to syncretic use of treatment systems, coupled with high cost of treatment. Also the scarcity of mental health service (biomedical) result in patients and their families using what is available and also travels long distance to access services. As such, the main challengers to accessing mental health care service are the scarcity of mental health care service, family decision making, the cost involve and the distance to service.

These factors identified indicate that access to mental health care is not only about people who are mentally ill, but an issue that has implications on the family, the society and the government. Therefore, efforts to improve access to mental health services should take these broader socio-cultural and political contextual factors into account.

6.2: Strengths of the study

- This is the first study of its kind in the Gambia that explore factors that influence access to mental health care service from the perspective of service users' and the community and therefore contribute to the existing literature on factors that influence access to mental health care.
- The findings could be used in planning and implementing programs geared towards improving access to mental health care service which is grossly inadequate at the time of this study

- The findings raises issues that could be used as a base to further explore about access to mental health care in the Gambia.

6.3: Limitation of the study

An attempt to carry out a study on a wide and complex health and social issue like mental illness will involve some simplification, which might have excluded important points. Also, people who are able to use the mental health services and the community are included in this study, as opposed to those who are not able to use the services. As such the study might not reflect adequately the factors that influence access to mental health care service in the Gambia.

The inclusion of service providers, immediate family members and those with mental illness who are not able to access services could provide different factors. They could provide a valuable perspective as to why services are not available for the majority of the population, what the constrains are, why they decide to take their mentally ill to the place where they seek treatment and what their experiences were in accessing treatment.

6.4: Implications of the study

In this study, the findings show that concepts about mental illness are limited to very few types of mental illnesses and there are many perceived believed causes. The implication of this finding is that any intervention geared towards improving access to mental health service would have to overcome barriers relating to concepts about causes of mental illness and their treatability. To overcome these barriers, the possibilities to engage the population on information, education and communication programs should be explored. This would mean conducting a nationwide study to map out cultural beliefs about mental illness as bases for the educational program. It would also mean collaborating with different medium of communication to reach the general population, which can include radio, television, social media such as mobile and internet, traditional communicators, and drama and theatre groups.

The findings further showed that the family is highly involved in the treatment and care of the mentally ill. This is an opportunity that can be explored further by establishing

psychoeducation programs involving the family and also establishes user groups among the family members as a platform where the family and the service providers from the different systems of care can meet and exchange ideas.

The study revealed that patients and their families use traditional system mostly before the biomedical system. Therefore a system of collaboration between the services may improve referral and early diagnosis. This can be accomplished through organized dialogue between the different players in the provision of mental health service on what can be done, as they are all dealing with 'one patient'.

The findings further revealed that biomedical services are scarce for most of the population. The implication of this finding is that for people to be able to use this service it should be available and easily accessible. To address this, biomedical services for mental illness should be decentralized, where by basic mental health service is made available at every major health Centre. This will require training of nurses on identification and management of common mental illnesses. Similarly, the community mental health team that provide outreach mental health services could be further strengthen for them to be operational. This will also have logistic implication.

Long term plans to ameliorate poverty, drug use such as cannabis and addressing youth unemployment by the central government can be a crucial step in reducing risk of mental illness among young people in the Gambia. The implications here are that government has to invest on young people which will require financial resources and skills development.

6.5: Suggestions for future research

This study exposes some issues that could be further explored. Some of these subjects could be:

- Factors that influence access to mental health care services from the perspective of service providers (traditional, religious and biomedical), health administrators, immediate family members of mentally ill patients
- How to create collaboration between ministry of health, traditional and religious treatment systems.

- How to strengthen families in caring for their mentally ill
- Beyond cultural beliefs, what motivate traditional treatment among mentally ill patient

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APPENDICE

A. Information sheet

TITLE OF THE STUDY: Factors that influence access to mental health care service: the perspective of service users and the community in western 2 health region of the Gambia.

You are invited to take part in this study, the aim of which is to produce knowledge that can possibly improve mental health care service in western 2 health region of the Gambia.

As part of the study, the researcher will explore about existing services for mental illnesses; local concepts about mental illnesses and how these influence care seeking. Participants experiences about accessing mental health services and the therapeutic itinerary will also be explored. In-depth interviews and focus group discussions will be done as methods of data collection

The study participants will include people using mental health care services and the community. The study is schedule from July 2015 to October 2015.

It is envisaged that the result of this study will help in a better understanding of local concept about mental illnesses and how they influence care seeking. The result of the study may help the Ministry of health and her partners to better improve access to mental health care services.

Participating in this study means you are contributing to the possible improvement of health of people with mental illness and their families.

You are free to take part in the study and that you can withdraw at any stage of the study without given any reason. Taking part or withdrawing from the study will not prevent you from getting anything that you are titled to. No personal information will be collected during the study and all information will remain confidential.

The study has been approved by the ethics committee

Thank you and you are free to ask any question regarding the study.

Contact: Lamin FM Barrow; Mobile +2202392014

Email: laminfmbarrow@gmail.com; I.f.barrow@studmed.uio.no

B. Interview guide for service users

STUDY TITLE: Factors that influence access to mental health care service: the perspective of service users and the community in western 2 health region of the Gambia.

Age: sex: Nationality: Religion:

Educational level: Tribe: Marital status:

Experiences about mental illness

Reason for coming to the health facility today

What is the name of the condition you seek care for?

When did the condition started?

How does it started? (Probe- what the cause is)

What did you experience from before? (Signs & symptoms)

What was done when it started?

How is your relationship with your family, friends since this condition started?

Therapeutic itinerary for mental illness

How did you decided to seek help from here?

What role did family members, friends, other relative play in deciding seeking help from here?

Do you seek help for this condition from somewhere else (probe: why)

Probe: (causation, trust, availability of the service, family decision, cost of service)

Experiences in accessing mental health services

How do you learned about this service?

What can you say about this service in terms of your expectations?

What challenges do you face in accessing this service and or other services you have seek help From

Probe: (staff-client relationship, distance, availability, cost, trust, helpfulness)

Any question that you expected to be asked that was not ask?

C. Interview guide for the focus group discussion

STUDY TITLE: Factors that influence access to mental health care service: the perspective of service users and the community in western 2 health region of the Gambia.

Local concepts about mental illnesses

What do you consider as mental health?

What are the names for mental illnesses?

What are the signs that show that someone has mental illness?

Are there mental illnesses specific to men, women or children?

Probe (causation, types, treatability, curability, transmissibility)

Therapeutic itinerary for mental illness

Where do you seek care for each of the mentioned type of mental illness? (why)

What is done at family level?

The decision making process: who decide where to go; when to go and how to go?

Probe: (causation, trust, availability of the service, family decision, cost of service)

Available services for mental illness

What are the services available for mental illnesses?

Are services available specific to some types of mental illness? (Services & type)

Are different services used for one type of mental illness?

Do patients move between different services? (Why)

Probe (biomedical, traditional, religious)

Experiences about use of mental health services

Experience about dealing with mental illness

Experience about accessing mental health services

Any question that you expected to be asked that was not asked

D. Consent form for service users

TITLE OF THE STUDY: Factors that influence access to mental health care service: the perspective of service users and the community in western 2 health region of the Gambia.

The information sheet has been read by/ to me and I understand the content. I had chance to ask questions and have them answered to my satisfaction.

I am aware that am free to take part in the study and that I can withdraw at any stage of the study without given any reason. I am also aware that taking part or withdrawing from the study will not prevent me from getting anything that I am entitled to.

I understand that no personal information will be collected during the study and all information will remain confidential.

I understand that taking part in the study will contribute to the possible improvement of access to mental health care services. I also understand that participating in this study can possibly help in a better understanding of how local concepts influence help seeking for mental illnesses

Signature/ thumb print of service user _____

Signature of researcher/ assistant _____

Date / ___ / ___ / || / ___ / ___ / || / ___ / ___ / ___ / ___ /

E. Consent form for focus group participants

TITLE OF THE STUDY: Factors that influence access to mental health care service: the perspective of service users and the community in western 2 health region of the Gambia.

The information sheet has been read by/ to me and I understand the content.

I am aware that am free to take part in the study and that I can withdraw at any stage of the study without given any reason. I am also aware that taking part or withdrawing from the study will not prevent me from getting anything that I am entitled to.

I understand that no personal information will be collected during the study and all information will remain confidential.

I understand that taking part in the study will contribute to the possible improvement of access to mental health care services. I also understand that participating in this study can possibly help in a better understanding of how local concepts influence help seeking for mental illnesses

Name of researcher/ assistant _____

Signature of researcher/ assistant _____

Date /___/___/||___/___/||___/___/___/___/

F. Ethical clearance from the Gambia

The Gambia Government/MRC Joint

ETHICS COMMITTEE

C/o MRC Unit: The Gambia, Fajara
P.O. Box 273, Banjul
The Gambia, West Africa
Fax: +220 – 4495919 or 4496513
Tel: +220 – 4495442-6 Ext. 2308
Email: ethics@mrc.gm

17 August 2015

Mr Lamin Barrow
University of Oslo
Norway

Dear Mr Barrow

R015 006, Factors that influence access to mental health care service in western 2 health region of The Gambia: the perspective of service users and the community

Thank you for submitting your proposal for consideration by the Gambia Government/MRC Joint Ethics Committee at its meeting held on 31 July 2015.

Our committee is please to approve your proposed study.

With best wishes

Yours sincerely



Mr Malamin Sonko
Chairman, Gambia Government/MRC Joint Ethics Committee

Documents submitted for review:-

- RePublic approval letter – 23 July 2015
- Proposal

The Gambia Government/MRC Joint Ethics Committee:

Mr Malamin Sonko, Chairman
Professor Ousman Nyan, Scientific Advisor
Ms Naffie Jobe, Secretary
Dr Roddie Cole
Dr Ahmadou Lamin Samateh
Mrs Tulai Jawara Coesay

Prof. Umberto D'Alessandro
Dr Momodou L. Waggeh
Dr Kalifa Bojang
Dr Ramatoulie Njie
Dr Jane Achan
Dr Siga Fatima Jagne

G. Ethical clearance exemption from REK in Norway



Region: REK South-East	Officer: Gjert Bergve	Phone: 22845529	Our date: 30.06.2015	Reference: 2015/1002 REK sør-øst D
			Your date: 12.05.2015	

Ann Færden
Oslo University Hospital

2015/1002 Factors that influence access to mental health care services in Western 2 Health Region: The perspective of service users and the Community

In regard to your application considered by the Committee on the 10th of June 2015.

Responsible for Research: University of Oslo
Chief Investigator: Ann Færden

Project summary

The research project will provide new knowledge about factors that influence access to mental health care service in western 2 health region of the Gambia. This will be done by exploring local concepts, beliefs, knowledge and experiences of study participant about mental illnesses and mental health services. A cross sectional design and Qualitative methods of focus group discussion (FGD) and in-depth interviews will be used to answer the research questions.

We hereby confirm that the Regional Committee for Medical and Health Research Ethics, section South-East D, Norway has received the project "Factors that influence access to mental health care services in Western 2 Health Region: The perspective of service users and the Community" for review. The project was discussed on the 10th of June 2015.

The Regional Committee has the authority to either approve or disapprove medical and health research studies conducted within Norway, or by Norwegian institutions, in accordance with ACT 2008-06-20 no. 44: Act on medical and health research (the Health Research Act "HRA").

Pursuant to section 4 of the HRA, the following definition applies for medical and health research: *Activity conducted using scientific methods to generate new knowledge about health and disease.*

The Regional Committee considers that this study will bring new knowledge about mental health services and local concepts and experiences with the services in Gambia, rather than new knowledge about mental health and disease.

Hence, the above mentioned study falls outside the scope of the HRA, and the project is exempt from review in Norway, cf. §§ 2 and 4 of The Act. Even though the project can be implemented without the approval the Regional Committee for Medical Research Ethics, it may be subject to local legal requirements (i.e. any necessary permits must be collected from the authorities in Gambia). To the extent that identifiable personal data will be processed, the Personal Data Act will apply.

Please do not hesitate to contact the Regional Committee for Medical and Health Research Ethics, section South-East D (REK Sør-Øst D) if further information is required.

Postadresse: Gulhaugveien 1-3, 0484 Oslo Telefon: 22845511 E-post: post@rekeforskning.atkikom.no All post og e-post som inngår i saksbehandling, bes adressert til REK sør-øst og ikke til enkelte personer Kinky address all mail and e-mails to the Regional Ethics Committee, REK sør-øst, not to individual staff

H. Ethical clearance from NSD in Norway

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES



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Orgnr: 980 321 884

Ann Færden

Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 09.11.2015

Vår ref: 44773 / 3 / KH

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 20.09.2015. Meldingen gjelder prosjektet:

44773	<i>Factors that influence access to mental health care service in western 2 health region of the Gambia: the perspective of service users and the community</i>
<i>Behandlingsansvarlig</i>	<i>Universitetet i Oslo, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Ann Færden</i>
<i>Student</i>	<i>Lamin FM Barrow</i>

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Katrine Utaaker Segadal

Kjersti Haugstvedt

Kontaktperson: Kjersti Haugstvedt tlf: 55 58 29 53

Vedlegg: Prosjektvurdering

Kopi: Lamin FM Barrow l.f.barrow@studmed.uio.no

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Årsrapport 2015 / Oslo 2015

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TRONDHØI NSD: NTNU Universitetet i Trondheim, Postboks 161, 1407 St. Olavs plass, 7003, 73 59 30 00, nsd@stud.ntnu.no