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Exploring barriers to accessing mental health care services in Ndola, Zambia

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Abstract

Objectives The objectives of the study were to identify barriers that impede access to mental health services and formulate informed targeted interventions and policies to enhance service delivery and utilization.

Data description A qualitative study was conducted employing a descriptive phenomenological approach to explore the economic, social, cultural and religious barriers to accessing mental health (MH) services. The population of the study constituted family members and care givers of MH patients who resided in Ndola. Purposive sampling technique was used to recruit forty (40) participants who received informed consent forms to give them the right to participate in the study or withdraw from the study at any given time. Semi-structured interviews were utilized to explore views, experiences, beliefs and motivations of study participants and data was analyzed thematically.

The study revealed that barriers to accessing MH services in Ndola included lack of finance, stigma, cultural myths, religious beliefs, social isolation and family breakdown. Therefore, there is need to adopt deliberate comprehensive MH care policies, which include increasing budgetary allocation of resources for procurement of essential MH drugs and implementing a coordinated response to MH care service provision.

Keywords Mental health · Care services · Universal coverage · Accessible · Schizoaffective disorder

Abbreviations

MH	Mental health
UHC	Universal Health Coverage
WHO	World Health Organization
MOH	Ministry of Health
NHIS	National Health Insurance scheme
NHIMA	National Health Insurance Management Authority

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1 Introduction

Zambia is committed to attaining Universal Health Coverage (UHC) [43]. This initiative aims to ensure all individuals have access to necessary health services without experiencing financial hardship [5]. According to Tristiana et al. [47] health encompasses physical, mental, and social aspects not merely the absence of disease or infirmity. Mental health (MH) is a state of well-being where individuals realize their abilities, cope with normal stresses, work productively, and contribute to their communities, the authority further states that MH is crucial for achieving the highest standard of health and sustainable development [48]. For instance, people with MH disorders are more susceptible to physical health challenges, leading to early mortality and suicide. Moreover, the disorders make it hard for someone to think clearly, make judgements, respond emotionally, communicate effectively, understand reality and behave appropriately [24].Hence, there is need to provide accessible, timely, effective, and equitable mental health services to the people of Zambia.

In line with the UHC agenda, the Ministry of Health (MOH) pursues the mission of providing the population with equitable access to cost-effective, quality health services as close to the family as possible [43]. Additionally, the enactment of the National Health Insurance Act No. 2 of 2018 led to the establishment of the National Health Insurance Scheme (NHIS) under the management of the National Health Insurance Management Authority (NHIMA), which includes MH services. Objectives of NHIMA include widening health coverage, protecting families from high medical bills, ensuring equitable distribution of health care services, and improving the quality and efficiency of health care [30]. Despite progress, challenges in accessing MH care services persist, hindering the attainment of UHC [43].

2 Background information about Zambia and Ndola district

Zambia, a landlocked country in Southern Africa, is known for its rich cultural heritage and natural resources, including Victoria Falls, one of the Seven Natural Wonders of the World. The country is divided into ten provinces, with Ndola in the Copperbelt Province. Ndola is one of Zambia's largest cities and serves as an industrial and commercial hub. The city has a diverse population with varying socioeconomic backgrounds and is home to numerous health facilities, including the Ndola Teaching Hospital, one of the largest in the country.

The demographic characteristics of Ndola reflect a young and growing population. According to the Central statistical office of Zambia [12], the city has a population of approximately 528,330 people. The majority of the population is under the age of 30, and there is a high rate of urbanization due to migration from rural areas in search of employment opportunities in the mining and industrial sectors. Despite economic activities, many residents face challenges related to poverty, unemployment, inadequate access to essential services, including mental healthcare. The common types of psychotic disorders include Schizophrenia, Schizoaffective, Delusional and Substance-induced psychotic disorders.

3 The rationale for the research

Understanding the barriers to accessing MH services in Ndola District is essential for several reasons. First, addressing these barriers is crucial for improving the overall health and well-being of the population, aligning with Zambia's commitment to UHC. Second, identifying specific economic, social, cultural, and religious factors that impede access to MH services can inform targeted interventions and policies to enhance service delivery and utilization. Finally, exploring these barriers can contribute to the global discourse on health equity, providing insights that can be applied in similar contexts.

According to Alfayumi et al. [1], economic factors, such as the high cost of health services, hinder access to healthcare. For instance, wealthier individuals have better access to health services compared to their less wealthy counterparts, and transportation costs can be a significant barrier [3]. Furthermore, social and cultural factors, including myths, misconceptions, and lack of consensus between married people, also affect access to health services [7, 13]. The situation is further complicated by stigma, attitudes, beliefs, perceptions, peer pressure, family support, social institutions and social networks [42].

Stigma, in particular, can be categorized as self-stigma, family stigma, and community stigma [29]. Self-stigma involves internalizing negative public perceptions, leading to self-harm [2, 9]. Family stigma can perpetuate negative reminders of the illness, while community stigma stems from misconceptions and stereotypes [28]. This stigma negatively affects

medication adherence, access to MH services, self-esteem, and goal attainment [9]. Therefore, addressing stigma is crucial for improving access to MH services and overall patient well-being. Religious beliefs and practices also influence access to MH services [6]. Highlights that while religion can provide social support and improve well-being, it can also pose barriers through myths, misconceptions, and lack of spousal approval [14, 29]. For instance, some individuals may avoid health services due to beliefs about illness being a punishment from God [37]. Conversely, religious affiliation can enhance the uptake of certain health services, such as breast cancer screening [35]. However, the extent of religiosity can impact trust in healthcare providers [7, 17]. Religion determines the life responses, attitudes and behavior of individuals or groups of people in many aspects of life [7]. Religion is translated into cultural practice like actions and attitudes. For example, a person who believes that illness is a form of punishment from God may shun health services [38]. On the other hand, religion can empower individuals through social connections and superior forces that might have positive effects on one's wellbeing [6]. It is, therefore, anticipated that religion will have a greater impact on accessing MH services for those committed to their religious beliefs than others. Considering the above assertions, it is hoped that the findings of this study will highlight pointers of what needs to be addressed in order to improve access to MH services and ultimately accelerate progress towards the attainment of UHC in Zambia.

4 Research method and design

The research study utilized a descriptive qualitative approach to explore the perceived economic, social, cultural and religious barriers to accessing mental health (MH) services. This method was adopted because qualitative research enables in-depth understanding of the problem while focusing on unquantifiable aspects of reality [34]. Thus, the qualitative approach facilitated the collection of detailed illustrative information about the problem. In order to understand meaning of the participants' experiences in accessing MH services, a descriptive phenomenological approach was proposed [35]. The approach aligned with our aim of identifying and exploring the barriers to accessing mental health (MH) services.

4.1 Population and recruitment

The population of the study constituted family members and care givers of MH patients who had; Schizophrenia, Schizoaffective, Delusional and Substance-induced psychotic disorders who resided in Ndola district urban area. Forty (40) participants were recruited using purposive sampling technique to ensure that individuals and families who could contribute meaningfully were included to better match the sample to the study's goals and objectives hence, boosting the study's rigor and trustworthiness of the data and findings [8]. Drawing on the works of Creswell & Creswell [10] the sample size of 40 participants ensured data saturation and inclusivity, the researchers estimated the number of participants depending on several factors which included; the quality of data, the scope of the study and the nature of the topic. This is supported by Morse [30] who states that in qualitative research, there are no available guidelines or references for prior estimation of the sample size. The participants were recruited through faith groups and community organizations who invited their members to take part in the study. Only those who expressed interest to take part in the research had their names and contacts forwarded to the researchers to schedule time for interviews. Each participant was provided with relevant information and an informed consent form to give them the right to withdraw from the study at any time and that they agreed to be part of the study.

5 Inclusion criteria

Members of the population with the following characteristics were considered for participation in the study; male and female adults who have cared for at least one MH patient with Schizophrenia, Schizoaffective, Delusional and Substance-induced psychotic disorders for a minimum period of six months in Ndola and persons fluent in either English or Bemba.

6 Exclusion criteria

Anyone who was not an adult as defined by Zambian legislation for example all people who were under the age of 18 years were not included in the study.

7 Data collection

The researchers employed semi-structured interviews to explore views, experiences, beliefs and motivations of study participants on the subject. The interview guide was prepared based on the literature review. See appendix 1 details of the interview protocol. A pilot study involving five study participants was conducted to test the validity of the interview protocol. The five participants in the pilot study provided feedback which indicated no need to adjust the questions. In line with the 2021 World Health Organization (WHO) Covid-19 guidelines, virtual interviews were conducted using WhatsApp, Zoom and Microsoft Teams. Additionally, the researchers used memos to record hunches, impressions, and ideas for further exploration. To increase reliability, triangulation was employed, where the researchers verified interview data against documented sources including religious beliefs and practices and medical bills. The interviews were stopped after reaching a saturation point when no new data were generated [18, 19].

8 Data analysis

All interviews were audio- recorded. The audio files were uploaded to a secure server within two hours and the original recordings deleted. All recordings were transcribed verbatim and analyzed thematically to discover the participants' perceptions, suggestions, understanding, and experiences on the topic. The researchers applied thematic analysis of the interview transcripts using the process of familiarization, coding, generating themes, reviewing themes, defining and naming themes, and writing up, as outlined by Caulfied [9].

9 Ethical considerations

The researchers sought ethical approval from the Tropical Disease Research Committee (TDRC) of Ndola Teaching Hospital, before undertaking the research. Additionally, study participants read and understood the information about the research and their participation. Participation in the study was voluntary and the participants were given the right to withdraw from the study at any time without giving reasons. See appendix 2 and 3 for details of the research consent written in English and Bemba, respectively. Furthermore, the researchers protected the anonymity and identity of the participants by maintaining confidentiality and security of study artifacts.

10 Findings

The study revealed that barriers to accessing MH care services in Ndola included poverty, stigma, cultural myths, religious beliefs, social isolation and family breakdown.

11 Poverty

On this particular factor, poverty seemed to be the major challenge as highlighted by the following responses;

"The cost of transport to take the patient to the hospital has been a big challenge especially that we Always have to book a taxi to and fro in most instances".
"The long distance to the hospital facility makes it very difficult to find transport money for booking A taxi to take the patient".
"It has been a challenge buying food for the patient"
"We have challenges in buying some drugs for the patient because they are very expensive"
"We receive adequate mental health services at the health facility but some drugs are rare to find and

If we do find them, they are very expensive".

12 Stigma

Community Stigma is entrenched in our society such that it hampers societal progress in many aspects [23]. The following are views by caregivers of how social interactions affect the process of access to mental health services.

"Neighbors gossip about the patient, saying they have been bewitched due to bad behavior".
"They think that someone has done something bad or one of the family members has bewitched the Patient or simply that the patient is affected by prevailing Satanism in the family".
"The community think that the mental condition is due to witchcraft in the neighborhood and are Verbally and physically abusive".
"The community think that the patient has been bewitch or possessed by an evil spirit"
"The community members encourage us to seek medical assistance from the hospital or traditional Healers".
"The community put pressure on care givers to refund if the patient damages someone's property".
"Family members consider mental health problem as unclean spirit of which the patient should be Taken to the witch doctor for cleansing".
"Family members are very supportive and understanding".
"Family members mainly put the blame on the patient for his/her action, and also, they assume the problem could be spiritual so they encourage care givers to go for prayers".
"They begin to look down on the mentally ill person or merely pity them and that is why they are Taken to the mental health unity".

13 Cultural myths

On the cultural front, culture is deeply entrenched in the lives of many people as it involves the way of life and the belief system of people in a particular community. Therefore, from the cultural perspective the respondents had this to say;

"That mental illness is as a result of being bewitched or as a result of ancestors being unhappy with the person".
"That mental illness is due to bad behavior of the person, so he/she should apologize or sacrifice Something to be restored".
"Someone is bewitched by a relative who feels jealous of their success".
"Mental illness is the result of bad behavior in society"

14 Religious beliefs

Religion influences the lives of the people to the point that it dictates their way of life, thinking and belief system [17]. In this regard, the participants had this to say;

"Mental illness is the result of one being possessed by demons"
"Religious organizations has come through to help by counseling and prayers"
"No religious organization has come through to help with the problem"
"They respond by praying for the patient, however when the situation worsens, they advise taking the patient to the hospital".
"The church believe only prayers can heal mental illness and they come for help to support the patient financially and spiritually".

15 Social isolation (family/individual)

People with mental health illnesses and their families are isolated due to this condition [21]. Below are the narratives of some family members;

"As a family we are isolated in the community and all the people isolate themselves from the Patient……."
"We do fear to interact with the mental health patient due to shame and for fear of being attacked and as such we Distance ourselves from the patient".

16 Family break down

The study revealed that in the event of having a mental patient in the family, family unit is at stake or affected as stated. By the respondents as follows;

"Usually there is serious family breakdown when you have a mental health patient in the family, Women are blamed and are left to take care of the patient alone. They are accused of causing the illness, which leads to family breakdown".
"In most cases as women, as mothers we shoulder the responsibility of taking care of the patients".

17 Meaning of the findings

The findings demonstrate that there are several factors that hinder accessibility of mental health services such as lack of financial resources, stigma and discrimination from community members [23], lack of knowledge about the condition and how to manage MH patients. The findings underpin the importance of implementing counseling services, health education and engagement of stabilized mental health patients in awareness programs. This approach emerges as a valuable strategy, tapping into their experiences to serve as impactful examples within the community.

18 Discussion

18.1 Poverty

Effective and holistic mental health care demands regular access to mental health care professionals and a variety of other support services. Unfortunately, mental health care service access is hampered by various challenges. In developed countries, the percentage of individuals who need mental health care but do not receive treatment ranges from 44 to 70%; in developing countries, the treatment gap can be as high as 90% [47].The gaps mentioned above are attributed to among other things unavailability of essential medicines which is particularly prevalent in developing countries. The World Health Organization reports that nearly 20% of countries do not have at least one common antidepressant, one antipsychotic, and one antiepileptic medication available in primary care settings. In addition, some psychiatric disorders are not covered by insurance policies in many countries, making mental health care unaffordable for many people [50]. The views of majority respondents in this study are consistent with above assertions. They lamented that because of the unavailability of some essential drugs they are asked to buy for their patients. The high cost of most mental health medications, lack of money to meet transport and food costs severely restricts access to holistic mental health care. This results in patients missing appointments for consultation and or reviews. This makes management of patients with mental health problems even more complicated.

There is need to adopt deliberate comprehensive mental health care policies, which will consider increasing budgetary allocation of resources for procurement of essential mental health drugs and implementing a coordinated response to mental health care service provision. The general outlook of care givers in this study clearly sympathized with retributive perspective of mental illness and recognized the rampant inclination toward pluralistic health-seeking methods.

This is consistent with the findings of Mufamadi & Sodi [31], which highlighted heavy dependence of some African communities on traditional healers based on cultural belief systems. According to Rumun [42] and, Kapungwe et al. [25, 45], behavioral dysfunctions in Asia, were patterned in socio-centric construct, based on context-specific and relational features of interactions as compared to egocentric constructs in the western context. Consequently, Asia, and Africa tend to approach mental illness from socio-centric construct, thereby leveraging cultural and historical methods of managing mental illness.

18.2 Stigma

Respondents shared experiences of wide spread negative attitude toward their patients and associated blame deeply rooted in the Zambian cultural and religious context. According to Hernandez [22], the negative attitude and associated blame is rooted in perceiving mental illness as a divine punishment for bad behavior in society. The study showed a wide acceptance of other causes of mental illness such as heredity and substance abuse. However, the predominant perception on the cause of mental illness was witchcraft in the family or community. Consequently, herbalism or traditional healing was the naturally preferred method of treatment. As observed by Marsella & White [27], the methods of diagnosis and treatment was based on cultural congruent systems, whose effectiveness could not be measured in this study. The mental health facility was a last resort after the situation became unmanageable.

18.3 Cultural myths religious beliefs

The cultural and traditional approaches to managing mental illness provides opportunities for social support structures but at the same time catalyzes cultural congruent systems which in most cases worsen the condition of the patient before the health professionals are engaged [25]. This contributes to differences in acceptance, access and utilization of health care services. Therefore, mental health education should be prioritized by the government and non-governmental organizations (NGO) as primary intervention. Mental disorders continue to increase, and these disorders remain poorly understood mostly in developing countries [8]. This postulation concurs with prior studies that indicated that the negative attitudes of communities toward mentally disordered patients are the major barrier which caused mentally ill patients not to seek mental health services and to develop poor adherence to mental health interventions [4]. Social isolation can be overcome as a barrier to accessing mental health services by sensitizing people on mental health and treatment services that are available to help people suffering from such.

18.4 Social isolation (family/individual)

Health systems in low and lower-middle income countries, particularly in sub-Sahara Africa, often lack the specialized personnel and infrastructure to provide comprehensive care for mentally challenged patients. In such a situation family based care is a low-cost way to give basic care to mental patients. Unfortunately, mental disorders are considered to take a toll not only on the patient but has been observed to be a strain on their caregivers. Caring for a family member with a serious mental illness often has an impact on the quality of life of caregivers and associated family members [24]. They often affect the caring relative's social and leisure activities, and financial problems arise frequently [12]. As is the case in many countries, the deinstitutionalization of mental health services in Zambia, has meant that informal caregivers are shouldering responsibilities for which they are not usually prepared. The magnitude of burden is potentially exacerbated by other factors related to the patients and households [4]. According to Iseselo et al. [20] family members bear much of the burden of the patient's mental illness and this affects them psychologically and socially.

The respondents shared that the increased burden leads to strains in the relationships within the family, sometimes influenced by traditional/cultural beliefs that put the onus of responsibility on female family members or indirectly even blaming them for such a situation. An unsupported attitude from fellow family members can lead to a non-functioning family unit unable to strategize to cope with the burden of caring for a patient in addition to the daily rigors of living. Lack of sensibility to the burden from fellow family members can overburden the caregiver leading to emotional and physical strain in relationships [26]. Loneliness was also articulated against a background of relational deprivations and losses as well as sentiments of powerlessness, helplessness, and a sense of sole responsibility [45]. Lack of responsiveness to the burden from fellow family members can overburden the caregiver leading to emotional and physical strain in relationships. Previous studies and findings have highlighted the high household burden of care-giving for people living with mental conditions in low income settings [32].

18.5 Religious beliefs

Zambia is one of the few countries still struggling with how to handle mental illness and treatment. However, one key factor associated to mental handling and treatment is religious factor. First and foremost, religion is one of the most powerful forces in human history. Thus, religion and healing have been intertwined since earliest recorded history. According to one of the empirical study, religion is one of the first resources people rely on when faced with a serious illness [15]. In this case religion gives people something to believe in, provides a sense of structure, and usually provides a group of people to connect about similar beliefs. Therefore, these aspects can have a significant positive or negative impact on mental health.

Studies show that religion plays an important role in mentally ill persons. This is supported by Al-Mujtda et al. [3] who state that there is a strong relationship between religion and mental illness. Religious beliefs could influence patients' perception about mental illness and determining their treatment. The treatment methods by the religious or traditional healers include alternative medicine/herbs, spiritual cleansing (deliverance), asking help from the spirit or pray**]**while there is a noticeable presence of other religions in Zambia such as Islam, Bhai faith, Christianity is the dominant religious influence in the country [3]. In view of the above understanding, majority of the respondents who seemingly to be associated with Christian religion believed that mental illness is as a result of demon possession. When someone is mentally challenged it means that, that person has been attacked by the demons and as such prayers of deliverance or the rite of exorcism has to be performed. It is in this perspective that religious organizations only come through to help by offering prayers and sometimes counselling.

18.6 Stigmatization and discrimination

Finally, religious organizations in most cases respond to mental health problem by prayers, specifically praying for the family and the patient as they believe that mental illness can be healed by prayers. Stigmatization and discrimination are such critical issues when it comes to mental illness. The study revealed that people with mental health challenges are stigmatized and discriminated in the community. Their families are also stigmatized and discriminated resulting in social isolation, shame and guilty [11]. This situation worsens their condition and make it harder to recover [46] therefore stigma and discrimination must be avoided at all cost so that stabilization of the condition is achieved. This calls for the community and church leaders to change the mindset of people through mass campaigns towards mental health illnesses. The central government through ministry of health should set up anti-stigma organizations at different levels where information about mental health conditions can be disseminated in schools, workplaces and at social gatherings. Emphasis must be put on showing the affected individuals and families that there is no shame or stigma in talking about how they feel could make a huge difference. Ministry of health should set aside or mobilize funds for mental health campaigns and formation of support groups to demystify myths and misconceptions about mental health conditions. In addition, the funds could be utilized to start self-help projects which will help them to meet their socio-economic needs as well as being a diversional therapy. Furthermore, social support and coping mechanisms should be incorporated into treatment to reduce the negative effects of stigma as professed by Bowers et al. [7].

According to WHO [50] the onset and chronic presence of mental illness in the family can be a stressful event or crisis for the family members. Furthermore, Basu-Zharku [6] states that, providing care for a patient with mental illness can be debilitating, stressful and burdensome for care givers. It is in this perspective that the respondents reported that caregivers are restricted as they cannot make any movements such as going out to attend the funeral, church service or any other social events for fear that the patient may disappear or run away which in turn becomes a task for the family to search for the patients, also left alone without any one to control the patient, the patient may end up destroying tearing and burning clothes and sometimes eating faecal matter and smear on the body subsequently remain naked. It is the task of the family to monitor all the activities of the patient to ensure the safety and sanity in the family. It is in this vein that due to enormous responsibility of taking care of the mental ill person, families give up, hence letting them go wandering in the streets which is a public health hazard. The central government through ministry of health and ministry of social welfare should set aside or mobilize funds for building mental health rehabilitation homes and establish self-help projects which will help them to meet their socio-economic needs as well as diversional therapy.

19 Conclusion

Our findings correlate with previous researches, suggesting that poverty, cultural and religious beliefs could be major barriers for accessing mental health care services in Ndola. Factors such as micro financing, group and community level efforts towards transformative mental health training and community mobilization could promote utilisation of mental health care services.There is also need to consider radical approaches in mitigating barriers to accessing mental health services in Zambia.by engaging all stakeholders like the central government, ministry of health and social welfare, NGOs, churches and community leaders to consider robust initiatives to support people with mental health conditions and their caregivers. More importantly there is need to build more rehabilitation centres for mental health patients which will provide occupation and recreational facilities.

19.1 Implications on policy and practice

The findings from this study offer valuable insights for both local and central government in addressing challenges related to accessing mental health (MH) services in Ndola,Zambia.Economic,social,cultural and religious barriers significantly impact access. Therefore, it is essential to address these issues to support caregivers, reduce stigma and ultimately accelerating progress towards Universal Health Coverage (UHC).

19.2 Policy implications

The policy implications with regard to this study suggests that providing economic support through transport subsidies and financial aid, promoting mental health education in communities in order to reduce stigma, integrating cultural and religious perspectives to improve care, acceptance and establishing caregiver support networks and services are essential in addressing the challenges faced by caregivers and eventually improving access to mental health services.

19.3 Practice implications

Expanding mental health services in primary care settings by establishing community-based support networks, collaborating with cultural and religious leaders, and providing crisis management resources for caregivers would enhance accessibility, support and safety, while promoting greater social acceptance thereby reducing caregiver stress.

In conclusion, these policy and practice initiatives, grounded in understanding economic,social,cultural and religious barriers, aim to reduce MH access challenges, promoting an inclusive,supportive environment for MH patients and their caregivers in Zambia.

20 Limitations

This research was conducted in one district of Zambia, future researches should incorporate other districts in Zambia to enhance comparison and possible generalization of the findings across the country. Moreover, the study mainly focused on family members and caregivers of MH patients who reside in Ndola district, in the Copperbelt province of Zambia, therefore other studies can be done in other districts across the country to enable comparisons of experiences. Furthermore, this study utilized a qualitative approach to explore barriers to accessing mental health care services in Ndola, Zambia and in future a research incorporating both qualitative and quantitative methods may be needed to explore a wide range of issues from different epistemological and ontological positions.

21 Relevant guidelines and regulations

The authors confirm that all methods were carried out in accordance with relevant guidelines and regulations.

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Data availability The data that support the findings of this study are available from National Health Research Council of Zambia (NHRA), but restrictions apply to the availability of these data, which were used under license for the current study and so are not publicly available. The data are, however, available from the authors upon reasonable request and with the permission of (NHRA) znhrasec@nhra.org.zm.

Declarations

Ethics approval and consent to participate The study was approved by the Tropical Disease Research Committee (TDRC) of Ndola Central Teaching Hospital and the National Health Research Authority of Zambia.

Consent for publication Informed consent was obtained from all subjects and/or their legal guardian(s).

Competing interests The authors also declare no conflicts of interest regarding the publication of this paper.

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