DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS INFLUENCING MEDICAL CARE-SEEKING BEHAVIOUR AMONG PEOPLE WHO EXPERIENCED MENTAL HEALTH ISSUES IN NAMIBIA

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BY

KUARA TJIMUINE

200828835

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MAIN SUPERVISOR: Dr Anna Shilunga

ABSTRACT

The current study originated from the effort to establish if the demographic and socio-economic factors influence the medical-care seeking behaviours of people who experienced mental health issues in Namibia. The study identifies geographically diverse populations in Namibia through the secondary data collected from the 2013 Namibia Demographic and Health Survey (NDHS) to gain information regarding overall influences on medical-care seeking behaviours. The study employed a quantitative approach, and cross-sectional, analytical design. Thereafter, descriptive and inferential statistics, lineal regression and Chi-square were used to determine the demographic factors and socio-econmic factors influences on medical-care seeking behaviours of respondents with mental health problems. The study established an association between the medical care-seeking behaviour of respondents with mental illnesses and demographic factors such as age, gender, place of residence, and their regions. This association includes the socio-economic factors such as wealth and education. Women were found to develop mental challenges than their men counterparts, yet are likely to seek medical care than their men equivalents. Other results showed that mental-health illness were more common among women than their men counterparts and they are more likely to seek medical care compared with men. Although the age group from 15-44 is more susceptible to encounter mental health challenges, they are more likely to seek medical care than those in the age group from 45 and above. Rural resopndents are more likely to seek medical care compared to urban dwellers. It is important to study whether these influences are changing over time, and

whether help seeking for mild and common disorders versus severe mental illness is becoming easier or harder as a result of the overall combination of influences.

LIST OF ABBREVIATIONS

ABHM	Andersen Behavioural Health Model
ADHD	Attention Deficit Hyperactivity Disorder
CSPro	Census and Survey Processing System
EA	Enumeration Areas
GBV	Gender-Based Violence
GP	General Practioner
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HSB	Health Seeking Behaviour
MOHSS	Ministry of Health and Social Services
NDHS	Namibia Demographic Health Survey
RTA	Road Traffic Accidents
WHO	World Health Organisation

DECLARATION

By submitting this thesis, I declare that the entire work contained therein is my own and is my original work. I also declare that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any other qualification at any other institution of higher learning.

Signature:  **Date:** April 2023

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CHAPTER 1

ORIENTATION OF THE STUDY

1.1 Introduction

Globally, 14% of the global burden of disease is attributed to mental illness with 75% of those affected being found in low-income countries, which includes a broad spectrum of diagnoses, from common mental illnesses such as anxiety and substance abuse, to severe illnesses such as psychosis. .In 2002, mental disorders accounted for 5% of the total burden of disease and 19% of all disability in Africa. The burden of depression is particularly significant, accounting for 5% of all disability [1]. Thus, mental illness is a major cause of morbidity and a burden to the patients, their families and society. Mental illness is a taboo subject that attracts stigma in much of Africa. A study conducted in Uganda revealed that the term‘depression’ is not culturally acceptable amongst the population [2], while another study conducted in Nigeria found that people responded with fear, avoidance and anger to those who were observed to have a mental illness. The stigma linked to mental illness can be attributed to lack of education, fear, religious reasoning and general prejudice [3]. Social stigma has meant that in much of Africa, mental illness is a hidden issue equated to a silent epidemic and as one might expect, this has an influence on the medicalcare seeking behaviours.

Mental illnesses are the leading source of disability in the world, representing 37% of all healthy life years lost to disease[10]. Mental disorder is a debilitating, chronic disease that presents significant management issues as well as risk variables for other health issues[11]. It highlights considerable costs to the patient in terms of personal distress, to

communities as a result of the shift in care burden and lifelong lost productivity, and to society as a whole[12].

Mental health is a socially constructed and defined concept, implying that different societies, groups, cultures, institutions and professions have diverse ways of conceptualising its nature and causes, determining what is mentally healthy and unhealthy, and deciding what interventions, if any, are appropriate[3]. However, according to the World Health Organisation (WHO), mental health is defined as a “state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community"[3]. Mental illness, on the other hand, refers to all the diagnosable mental disorders, which are characterized by abnormalities in thinking, feelings or behaviours[4]. Although mental well-being is believed to be instrumental to quality living and personal growth, people often take mental health for granted and may not notice the components of mental well-being until problems and stresses surface[4].

Ward, Mertens and Thomas[4] defined health seeking as any remedial actions that are undertaken by individuals to rectify perceived ill health to find appropriate interventions. The health-seeking behaviour of a community determines how health services are used and in turn the health outcomes of populations[5]. Factors that determine medical-care health seeking behaviour may be physical, socio-economic, cultural or political[5]. Indeed, the utilisation of a health care system may depend on educational levels, economic factors, cultural beliefs and practices. Other factors include environmental conditions, socio-demographic factors, knowledge about the facilities, gender issues, political environment, and the health care system itself[5-6].

Medical-care seeking behaviours is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health[6]. Studies that have attempted to describe factors that significantly affect medical-care seeking behaviours during illness episodes can be broadly classified into two groups. The first group are studies that emphasize the utilization of the formal system, or the healthcare-seeking behaviour of people[6]. The studies that fall under this category involve the development of models that describe the series of steps people take towards health care. These models are sometimes referred to as 'pathway models'[7].

While there are several variations of these models, the Health Belief Model and Andersen's Health Behaviour Model are often used as a basis in discussions involving HSB[7]. The second category includes studies that focus on the sickness response process or medical-care seeking behaviours. These studies show that a range of characteristics such as socioeconomic background, age, sex, social standing, kind of illness, availability of services, and observed quality of service impact the decision to engage with a specific medical framework[8]. The majority of research in this area concentrate on various types of variables that exist between patients and services, including location, economical, social, cultural, and organizational traits[8]. For instance, access to health facilities, socio-economic status and perceived quality of service is significant influencers of health-seeking decisions among different population segments.

Inappropriate mental health-care seeking behavior among people who experience mental health issues has been linked to worse health outcomes, increased morbidity and

mortality, and poorer health statistics[8]. Research into medical-care seeking behaviours suggests several factors influence the mental health of people who have experienced mental health problems, and certain segments of the population are more likely to use appropriate medical-care seeking behaviours than others. Inappropriate mental-health seeking behaviors among those with mental health problems and their previously mentioned effects are skewed among different population segments. For instance, in Pakistan, households whose average income was below the minimum wage were less likely to seek formal medical care for their mental illness than those whose incomes were above the minimum wage[9].

This disparity makes it necessary to determine the factors affecting medical-care seeking behaviours among different segments of the population who are suffering from mental health issues. This is essential to guide policy formulation and implementation. An important aspect of medical-care seeking behaviours is the choice of healthcare providers made by people when responding to mental illness episodes[10]. This study seeks to identify which socio-demographic and health service-based factors influence HSB among people who experience mental health issues represent a sizeable proportion of the total population in the country.

Measures of disability and mortality combined show the significant level of disability created by mental disorders and the enormous economic, social and psychological burden imposed on families of people with mental disorders. These findings emphasize the need for governments to take mental health illness seriously as a major public health issue. This includes the promotion of mental well-being, prevention of mental illness and disability, treatment and rehabilitation.

Namibia is among the countries with a high rate of people suffering from metal health issues. With recent evidence of the significant and growing burden of mental health disorders and WHO recommendations to address mental health as a major public health issue, mental health services need to be strengthened and integrated into the network of health services offered. Namibia has acted in this direction. Following independence in 1990, the government of the Republic of Namibia extensively restructured the health services. The guiding principles for this process were equity, accessibility, affordability, community involvement, and participation through the Primary Health Care (PHC) approach, of which the goal was and remains "Health For All". However, this goal cannot be achieved without developing a network of health services that includes mental health care with outreach to the community.

According to a study on mental health, the prevalence of mental illness in Namibia has increased by 26% since 2021 and is projected to increase by a factor of two by 2025 [81]. Further, according to estimates from the Ministry of Health and Social Services (MoHSS), at least 8,567 people were treated for mental illness in various health facilities around the country in 2016, a decrease from the 9,257 treated in 2014. Mental health is related to several stigmas. Everyday, people are worried and engaged in numerous confrontations for a variety of reasons. As a result of accumulated stress, anxiety, antisocial personality disorder, broken homes, and failure to meet society's expectations can all contribute to inappropriate behaviour [83].

There was no study carried out on the utilization of mental health services among people who suffer from mental health issues. However, considering the large number of Namibians who require mental health services but do not obtain them, it is critical to

investigate the factors that influence treatment usage, particularly the hurdles that Namibians face when seeking help[1]. Studying the factors that influence service utilization is crucial to ensuring that Namibians in need receive timely and appropriate support. However, there is little to no understanding or knowledge of the issues that may impede residents' use of mental health treatments [12].

Understanding and improving the irreconcilable nature of mental health service usage requires identifying and characterizing how specific causes and impediments, perceived or otherwise, influence mental health treatment utilization[13]. As a result, the current research focuses on identifying and explaining the variables that lead to people's underutilization of mental health care. It also fills significant gaps in current research to better comprehend how these variables influence people's usage of mental health care.

Andersen's Behavioural Health paradigm[13] is used to contextualize the current investigation. The major goal of this paradigm is to identify variables that either help or hinder service use. This model is widely regarded as the most popular for predicting and explaining service use[14]. It provides a complete and flexible framework that incorporates key major essential components related to adolescent, family, and agency-related character traits that may impact the use of mental health services.

Studies aimed at mental health promotion and prevention have identified many strategies to maximise the public's mental health, such as increasing public awareness[15] improving public knowledge about mental health problems [15-16] reducing the stigmatisation and discrimination of individuals with mental health problems[16] and enhancing public attitude towards seeking help from mental health

professionals[16,17,18]. However, any strategy intended to initiate change will have to take into consideration the range of people's knowledge and perceptions[18]. To devise an effective mental health promotion campaign, assessing the public's knowledge and prevailing attitude would be the prerequisites. Hence, understanding the factors which influence help-seeking behaviours among people who experienced mental health issues is an essential step towards improving the mental health of the community. Therefore, the present study examined the demographic and socio-economic factors that influence the behaviours towards seeking medical care for mental health symptoms in Namibia.

1.2 Problem statement

According to the 2013 Namibia Demographic Health Survey (NDHS), a large proportion of Namibians who experienced mental illness symptoms do not seek professional help. Further, according to the NDHS, 91.3% of rural men and 91.7% of urban men with mental health symptoms in Namibia did not seek medical care. Additionally, 82.3% rural, and 82.7% of urban women did not seek medical care for their mental illness symptoms.

Although NDHS provided the prevalence and distribution of mental health symptoms and indicated that a large segment of people with mental illness symptoms did not seek medical care, it did not do further analysis to explain why medical care-seeking is very low, at least based on the variables (demographic and socio-economic) that the survey collected data on. This study attempts to further research analysis to explain why the demand for medical treatment is so low, at least based on the demographic and socioeconomic parameters for which the NDHS 2013 survey obtained data.

Furthermore, it has been discovered by Shaikh and Hatcher [35] that in countries with low rates of mental-health service utilization, there is an impediment to closing the mental-health treatment gap, which is a major impediment to maintaining public mental health because it interferes with early detection and intervention for mental illness. Given this concern, this study serves to carry out statistical and epidemiological analysis of existing NDHS data to fill the knowledge gap on the demographic and socio-economic risk factors for not seeking medical care for mental health symptoms in Namibia.

1.3 Purpose of the study

The purpose of the study is to determine the demographic and socio-economic factors that influence the mental health services seeking behaviours among people who experienced mental health issues in Namibia.

1.4 Research objectives

The objectives of the study were:

- To determine the demographic factors that influence the medical care-seeking behaviour for people who experienced mental health issues in Namibia.
- To determine the socioeconomic factors that influence the medical care-seeking behaviour for people who experienced mental health issues in Namibia.

1.5 Significance of the study

The study provides demographic and socio-economic factors that could enable the researcher and potentially the Ministry of Health and Social Services (MoHSS), the custodian of health to identify and target population groups with mental health symptoms that are likely not to seek medical care. The information generated will be useful for the Ministry of Health and Social Services and its mental health partners for policy-making, programming and planning of interventions, but also monitoring and evaluation of national mental health programmes.

1.6 Limitations of the study

Constraints are limits that exist outside of the scope of this study that limit the application of the study's findings to other situations [18]. Access to NDHS data from the Ministry of Health and Social Services was difficult, but was overcame by securing research permits from the Office of the Executive Director of the Ministry of Health and Social Services. The analysis of risk factors is restricted to demographic and socio-economic characteristics that were included in the NDHS, and this was limiting the scope of the study.

1.7 Delimitations of the study

This study utilizes pre-existing data collected on a national sample population studied for mental health issues by the 2013 NDHS. The data used is about the Namibian context only.

1.8 Operational definitions of terms

Medical care seeking behaviour: Has been defined as, any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy [19]. Medical seeking behaviour can also be referred to as illness behaviour or sick-term behaviour. Medical seeking behaviour is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health.

Mental health: Refers to the state of well-being 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", according to the WHO [58].

1.9 Summary

The importance of the study, the essence of the study, and the meaning of terminology were all reviewed in this chapter, along with the project setting, problem description, and specified study objectives.The literature evaluation that sparked this research was thoroughly described in Chapter 2. In Chapter 3, the research methodologies are addressed, while Chapter 4 covers the study's findings and discussions of results. The study's conclusions and recommendations were presented in Chapter 5.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter lays the theoretical groundwork for this research. The status quo with respect to mental health seeking behaviour in Namibia is discussed followed by a discussion of the demographic factors and socio-economic factors that affect the medical seeking behaviour in various contexts. A theoretical framework is finally given which the author used to interpret the results of the study followed by a chapter summary.

2.2 Overview of mental health in Namibia

Namibia is a Southern African country with a population of 2.4 million people that gained independence on March 21, 1990. The Republic of Namibia is a vast, sparsely populated country located along Africa's south Atlantic coast between 17 and 29 degrees south of the Equator. With a land area of 824,292 km^2, Namibia is the world's 34th largest country. It stretches for about 1300 kilometers from south to north and varies in width from west to east by 480 to 930 kilometers[20].

Namibia, formerly known as Southwest Africa, is bounded on the south by South Africa, on the north by Angola and Zambia, and on the east by Botswana and Zimbabwe. Namibia has the world's oldest desert, the Namib Desert, which runs along the country's entire west coast, and the Kalahari Desert, which runs along its southeastern border with Botswana. It is divided into 14 regions: the Zambezi, Kavango East, Kavango West, Kunene, Omusati, Ohangwena, Oshana, and Oshikoto in the north, and the Omaheke in

the south. The central regions include the Otjozondjupa, Erongo, and Khomas regions, as well as the Hardap and! Karas regions in the south[21].

Although unique cultures pervade throughout Namibia across ethnic groups (e.g. Ovaherero, Aawambo, Damara, and others), researchers have empirically explored psychological characteristics pertinent to well-being and mental health throughout Namibia. Such evidence provides an indication or baseline for psychological needs across Namibia. The development of this body of literature is, in many ways, pivotal in offering a greater understanding of the psychological needs in the country. The current situation in Namibia is also that there is a rapid increase in the number of incidences of psychosocial problems. These, for instance, range from Gender-Based Violence (GBV), suicide, alcoholism and Road Traffic Accidents (RTAs) which are directly linked to mental health problems[22]. Oftenly many people who commit suicide suffer from mental illnesses and/or have mental problems and thus need psychological interventions[22].

Athough, there has been very little research on mental health in Namibia to inform policy and interventions[22], there is high prevalence of mental disorders reported in literature[23]. In Namibia, mental health services lag behind other health services[23]. This pattern is common in many developing countries where mental health is often given low priority. With limited resources, health policies are focused on communicable and life-threatening diseases[23]. Another issue confronting the mental health care system is a lack of trained and qualified professionals in the public health sector. The MoHSS currently employs only five psychiatrists and three psychologists, which severely limits service delivery to state patients[24].

It has been revealed that, “disorders leading many to suicide attempts are treatable: depression can be treated and alcoholism can be overcome”[24]. This goes to show that difficult life moments that seem unbearable can be surpassed with better solutions, given some times; and that negative emotions people experience when depressed such as feelings of hopelessness and worthlessness amongst others can be overcome with proper psychiatric or psychological help, but to the contrary, most do not seek psychological interventions.

2.3 Mental disorders

One out of every four persons globally will experience mental illness at some point in their life [24]. Bipolar affective disorders, unipolar depressive disorders, alcoholism, schizophrenia and obsessive-compulsive disorders, drug use disorders and panic disorders are among these disorders[25]. They alter a person's perception and cognitive processes, as well as his role in the society and production in the community. Even though mental illnesses are deactivating and can last for years, they put a significant strain on the emotional and financial resources of those who care for the service user[25].

The worldwide negative impacts of mental illness are considerable and likely to continue to climb[25]. Anxiety and mood disorders are currently the most frequent mental issues worldwide, and unipolar depressive disorders are expected to be the second-biggest source of illness burden in 2030. The majority of persons suffering from mental illnesses reside in developing nations, where they frequently do not obtain the care they require, although it is readily available and very inexpensive[25]. Mental illness is more stigmatized in these countries than it is in more industrialized

countries[26]. Mental health has remained a taboo subject to this day. Interventions to reduce the burden of mental illness are scarce, particularly in low- and middle-income nations.

The burden of mental illness is high and appears to be increasing, but the healthcare system continues to ignore mental illness[26]. Few health policies target mental health, and access to mental health care is constrained[27]. For a long time, the nationwide plan of action was solely focused on the hospital-based treatment of schizophrenia and epilepsy. Even though epilepsy is a neurological disorder, it is frequently (as in Namibia) treated by psychiatrists in mental health settings even though individuals with epilepsy almost always have significant psychiatric comorbidity and share much of the same complications with the mentally ill in terms of training, policy development, and treatment[28].

2.4 Health determinants

The reasons for ill-health are numerous[28]. The measures a society employs to preserve and enhance the health of its citizens are heavily influenced by its knowledge of the determinants of health. Age, gender, and hereditary characteristics are all important, but they cannot be changed[29]. Global influences, on the other hand, have an impact on health and well-being. Population health is affected by demographic changes as well[30]. Predicted demographic trends, such as the increase in one-parent families, an ageing population and people starting a family later in life, will influence both the nature of Namibia's social and economic environment and the health status of the population[30]. Individual lifestyle factors such as diet, smoking and alcohol, physical

activity and sexual behaviour are also important. Many population health interventions target these lifestyle factors and health gains have been made as a result.

However, health is also affected by social and community influences, living and working conditions and broad socioeconomic, cultural and environmental conditions[30]. A healthy environment, sufficient money, important roles in society, excellent housing, population-based services and utilities, affordable nutritious food, education, and social support all contribute to good health[30]. Improvements in these elements are largely responsible for the general improvement in health in Namibia. These major factors that determine health are sometimes beyond the person's control, but societies can act together to promote the community's health[30].

2.5 Factors influencing medical care-seeking behaviour

In a number of past studies, several demographic and socio-economic factors like gender, age, marital status, work classification, education background, income, and language were found to affect the medical care seeking in different contexts other than Namibia. This section reviews past studies on the various factors influencing the medical care seeking behaviour of mental health patients.

2.5.1 Education and mental health services utilization

The significance of the global health risk factors has led to a major emphasis in public health policy on education interventions[30]. This role for education has traditionally focused on providing information and skills to help people make choices and changes that will promote individual and societal health and well-being[31]. Contemporary health education had three main aims. These include reducing morbidity and mortality

through changing the behaviour and beliefs of individuals; fostering the appropriate use of health services; and creating general awareness of health issues[32]. Education has been found to affect health via the adoption of health-related practices, raising awareness of health information, and increasing personal resilience to effectively cope with difficulties or stress-inducing circumstances[33]. Certain aspects of education improve how individuals understand their health situation, express their symptoms, and communicate with the health practitioner[34]. More education can either increase or decrease the demand for treatments. Education may improve access to services if it enhances the inclusion of individuals in society and provides the means and incentive for individuals to know and demand their rights to receive health care from the government.

2.5.2 Ethnicities and mental health services utilization

The black ethnic minorities are significantly more likely than whites to delay or forego needed mental health care, and, if they do seek treatment, they are more likely than whites to drop out [34]. Mental illness stigma and discrimination are thought to contribute to these racial/ethnic disparities in service utilization[35]. The negative attitudes, beliefs, and behaviours that the public holds toward people with mental illness (i.e., public stigma) may lead people to deny or conceal their mental health symptoms and avoid treatment[35,36]. Moreover, when people with mental health challenges internalize negative societal beliefs about mental illness (i.e., self-stigma), normally leads to feelings of hopelessness or the "why try" effect, whereby individuals give up on treatment, employment, or other important endeavours that are integral to recovery [36].

People from minority ethnic communities have historically been underrepresented in health research[36]. The impact of racialization historically has been impactful on ethnic

minorities attempting to navigate a discriminatory landscape permeated by institutionally racist structures. Within ethnic minority communities, there are cultural differences regarding the way mental health is perceived, accepted, and acknowledged[36]. Globally, there is stigmatization that has accompanied mental illness[37]. Addressing this imbalance to ensure that people from all sections of society are represented equally is important in reflecting mental illness as a problem that affects all types of people regardless of race, class, religion, gender, sexuality, or disability[38]. Two significant factors contribute to how mental illness is framed societally.

First, there are limited research within existing mental health research to ensure that all aspects of this subject are fully studied[38]. Furthermore, research on this subject repeatedly fail to acknowledge the salient differences in how ethnic minority groups experience mental health in comparison to entire Namibia.

Such factors include psychological issues that are commonly found in particular racial groups that could be a consequence of continuously encountering varying forms of discrimination[38]. Invariably, potential differences in the experiences of such issues within and between population sub-groups emphasize the continual development of effective services or interventions for minority groups[39]. Secondly, there is a social justice element that encompasses the dialogue of mental illness, which has often omitted ethnic minorities from mental health research[39]. The disparity in phenomenon indirectly maintains existing power imbalances and disparities, as ethnic minorities may not always receive the same sorts of cognitive treatment and rehabilitation, which can lead to patients being misdiagnosed and overmedicated. Stigmatization is a concern in

many communities, which is compounded when we examine views regarding psychological suffering and the availability of resources for ethnic minorities[40].

2.5.3 Place of residence and mental health services utilization

Place of residence was found to have an impact on people's health-seeking behaviour[40]. Villagers sought medical attention in illness more than urban populations[41]. They self-medicated less than urban residents and had less inattention to treatment[41]. These villagers were the following findings from other studies done in Pakistan, India, and Sri Lanka[41,42,43]. In studies that showed more self-medication in rural people, the tendency to go for traditional medicine was noted[44]. This pattern was also detected as city residents visited drugstores as the main way of self-medication while village residents used herbal medicine instead[44]. The difference observed between city and village residents in terms of self-medication may reflect the difference in educational and economical status between these groups.

Under-utilization of mental health services has been identified as a major problem in rural areas[45]. Rural residents have unique mental health needs, many rural Namibians are reluctant to accept services even when they are available. The research established that stigma for mental health may be more of a risk factor for individuals in rural as opposed to urban settings because of the small size and the increased pressure to conform[45]. Numerous studies [63;68;69] identified a lack of anonymity and the probability of being labelled as major deterrents to mental health treatment in rural areas. A frequently identified problem with the entry of the mental health system into the community is the general public's attitude toward mental illness, which included superstitions, labelling and the stigma associated with being a patient[46]. The difficulty

with maintaining confidentiality in a small-town setting was also listed as a factor affecting treatment seeking. In smaller communities, if a patient walks into the mental health centre they feel as though everyone in town saw them[46].

Another factor cited as influencing the seeking of mental health services is rural values[46]. Stigma, cultural ideas and values, such as submission to nature, individualism, stress on main connections and family, traditionalism, fatalism, protestant work ethic, conservative attitudes, and strong religious values, all impede rural acceptance of mental health care[47]. Family and local church organizations in rural regions are more likely to conduct the crisis intervention work that mental health centres in urban areas did[48]. Help-seeking is influenced by the strength of a person's social support system. Individuals who have conveniently accessible close friends and relatives are less likely to seek official psychological care.

According to one study, real usage of professional care for psychiatric issues increased with education and income level, with persons living in metropolitan areas using the most[48]. Another study, which looked at the difference between service need and service usage rates in a five-county, mostly rural region, discovered that those who needed services but had not used mental health care recently reported higher stigma barriers to using these services[49]. The rate of felt stigma among nonusers was nearly double that of users[49].

In an investigation to find out whether rural people reported more stigma connected with requesting treatment for depressive symptoms than urban persons, rural inhabitants with a history of depressive symptoms were more critical of people who sought professional

care for the disease than their urban contemporaries[49]. They discovered that the more unfavourable the labelling connected with getting therapy, the less likely rural persons with a history of depressive signs were to seek care[49].

Labelling linked to treatment-seeking, on the other hand, had no effect on the utilization of care among city dwellers with a history of depressive symptoms[50]. While it is commonly agreed that stigma against seeking mental health care is higher in rural locations than in metropolitan areas, actual research to support this claim is few[50].

Geographic location has been studied as an enabling factor in the use of mental health treatments in a modest number of studies. Individuals with mental illnesses and members of ethnic groups are over-represented in high-poverty areas, according to research[50]. There are frequent shortages of services and resources in these communities, limiting access to mental health services and supports[51]. For instance, it is estimated that 50-70 per cent of teenagers living in metropolitan areas who require mental health care do not obtain it, and those who do receive it are more likely to discontinue therapy prematurely owing to transportation issues[51]. In addition, there are inequalities in service utilization between teenagers in rural and non-rural locations. Another study discovered that teenage treatment needs in rural locations are frequently unfulfilled due to a lack of professional staff, such as child psychiatrists, and limited specialist services[51].

2.5.4 Gender and mental health services utilization

The terms "gender" and "sex" are frequently used interchangeably[63]. Gender is a social construct that encompasses not only biological ‘sex' distinctions between men and

women, but also the various roles and expectations, behaviours, and restraints that are imposed on an individual by culture and society as a result of their sex[63].

The fundamental critique of mental health services utilization solutions is that they are based on the notion that women are passive recipients of whatever is deemed to be beneficial to them[63]. The truth persists that in emerging economies, there is still a lack of awareness of how gender affects health-seeking behaviour, service utilization, provider perspectives, and health outcomes[63]. This is significant because, if we believe that health is genetically, biologically, environmentally, culturally, and socially influenced, gender must be acknowledged as one of these variables. After all, it is linked to physiology and the socio-cultural elements that influence health[61].

Once it has been established that gender may contribute to mental health issues, the focus can be changed from "gender" to "gender relations," or the social differences between the sexes[53]. This expansion of thinking and theory is reflected in certain works from nations where issues like literacy do not have the vast disparities that they do in underdeveloped nations. Current studies on gender and health have a wide range of conclusions that are often inconsistent[53]. There's no denying that race, culture, and social roles play a role. It's also worth noting that in extant research, there was no discernible gender disparity for some mental health issues, particularly in industrialized countries [53].

Research carried out by Buglar, White, and Robinson [53] was unsuccessful in identifying substantial disparities in the health of girls and boys as a result of the family system, social, interpersonal, and material assets despite their study's assumptions.

Mental Health trends were more prone to alter by age and condition than by gender. Some gender variations in health-care utilization may be stronger throughout a woman's childbearing years, which could explain some of the findings from previous studies that indicated women were more regular service-users[55]. However, in terms of availability, it has been recognized that a lack of available time may also prevent women from getting mental health care[55]. Having childcare and domestic duties makes it hard for them to leave the house especially if they also have income responsibilities.

A wealth of evidence implies that males are less inclined than women to request assistance from health experts for problems like anxiety, depression, substance misuse, and physical disability, based on the observation that particular circumstances can influence health care seeking and gender disparities[54]. Men are more inclined to be hesitant to seek any form of health services, according to previous studies in the United Kingdom, and thus delay treatment for longer[54]. The researchers concluded that "typical masculine behaviour" was the reason for male hesitancy. Alternatively, as Gorczynski et al,. [55] has observed, societal standards that are employed to sustain men's social authority and sense of masculinity sabotage their attempts to adopt healthy behaviours and attitudes placing them at a higher threat of bad health than women.

In certain emerging economies, gender is said to have an impact on the use of mental health care services[55]. Many studies have found a link between gender and mental health-seeking, as well as disparities in seeking care for other close relatives, such as female versus male children. Other research, however, reveals that for specific mental illnesses, gender, income, and literacy variables have little effect on the time it takes to seek medical help[55].

Various African countries' studies have revealed a variety of mental health-seeking habits[56]. Females in Ghana are more inclined than males to seek medical attention, whereas females in Zambia were more inclined to defer obtaining assistance, especially if their educational attainment was low[56]. There are further concerns about how the implementation of user fees influences women's usage of mental health care, with one of the key concerns for women being the consideration of family finances.

2.5.5 Regular income and mental health services utilization

According to Gebreegziabher, Girma and Tesfaye [56] earnings are used as a predictor of mental healthcare-seeking behaviour, and it has previously been used to ascertain not only health-seeking behaviour, but also risk variables linked with health consequences obstacles to requesting health care, types of treatment, and postponements in service use[56].

Income is one of the factors used to evaluate the socioeconomic status and it is commonly used to assess health[56]. There is a significant substantial literature of research on health status and its consequences as a result of socioeconomic status. Such research is evaluated in a variety of ways, with metrics such as educational attainment, literacy level, job opportunities, and other lifestyle matrics, or a combination of these factors being the most common[57]. Separate from the category of socioeconomic status, there is less literature on income. Several studies have found that economic position is the most important determinant of service utilization, and that money influences the frequency with which health care services are sought and used[58]. Whereas the cost of mental health treatment is frequently weighed against the perceived value, it is not always the case.

The usage of mental health services is influenced by one's financial ability to pay[58]. Lack of financial resources has a significant impact on mental health-care access, so even if the desire to pay for services exists, the ability to do so may not. Low income, unsurprisingly, has been proven to be a deterrent to seeking health care and can place an undue financial burden on those who need it[58].

Income is not solely related to the cost of treatment when it comes to preventing people from seeking medical help[58]. It also includes the cost of physically obtaining treatment, as well as the trade-off between losing income as a result of illness versus seeking treatment[59]. In a study conducted in Namibia, the main reason given for self-treatment was that individuals did not have sufficient money to seek health care, which involved not only the expense of medication from hospital outpatient departments but also the evidence that individuals had to commute there once to schedule an application and then come back for the appointment time at a later date, resulting in increased transport costs.

In regards to the real expenses of medical services, one of the causes for the debate over the implementation of cost-sharing and cost-recovery schemes in developing nations is the impact these programs have on lower-income groups. A phenomenon that has surfaced in extant research concerns the perception of healthcare quality[60]. Even though the cost impeded individuals seeking preventive care in Guinea and Benin, it was discovered that if a product was not otherwise accessible, if availability became simpler, or if the apparent quality of service enhanced, even the lowest-income members would use curative services considerably more and even pay extra. Mali, Ghana, Cameroon, Rwanda, Guinea-Bissau, and Liberia all confirmed the findings[60]. Even those in Sri

Lanka's lowest income bracket were likely to forego the free option in favour of a low-cost private facility, believing that the service would be of higher quality[61].

In general, those with lower incomes were more vulnerable to mental illness and there were disparities in mental health [61]. Sareen et al. [62] pointed out that there are correlations in the data between low levels of education, affluence, and health, showing that people are more likely to be exposed to factors that may promote ill health over the course of their lives, such as geographic issues or taking more sick days[62]. There is accumulating evidence that females in developed and developing nations hold inferior jobs with lower pay and that this wider material restriction exacerbates mental health disparities between males and females, despite the fact that if the mental health impact of earnings inequality and individual income can be examined simultaneously, individual income distinguishes men from women.

Income was found to be a factor of health-care seeking behaviour in a study conducted in Zambia[62]. Financial resources measured in terms of earnings were shown to be more closely linked to health, especially in rural areas. One consideration for those who are self-employed in agricultural or small businesses in the tourism sector, for instance, is that earnings can be unstable in terms of amount and regularity, which can make it difficult to use health care[62]. According to a study conducted in Southeast Nigeria, rural communities were less probable to pay for health care medication up front[62]. The current study hypothesises that, for these particular survey populations, consistency of earnings may be a better predictor of not just readiness to pay for medical services, but also capacity to do so.

2.5.6 Age and mental health services utilization

Young people are especially concerned about being labelled as "mentally sick" by their peers[62], and the stigma of mental illness is linked to a lower willingness to seek care[62. Young people are frequently unclear whether specific sources of assistance will genuinely help them. For example, while general practitioners are one of the most frequently accessed initial sources of professional help, young people often do not know whether seeing a General Practitioner (GP) for a mental health problem will be helpful[63]. Furthermore, young people have been shown to prefer active treatment to watchful waiting, and counselling approaches medication[63]. Past experiences of seeking help that proved unhelpful also contribute to negative attitudes. This can include experiences in which the young person felt that they were not listened to or their problems were not taken seriously [64]. Occasions when confidentiality was not kept, and fears about breaches of confidentiality, also contribute to negative attitudes toward mental health services, such as school counsellors [64,65].

Age is a factor that has been connected to a lower use of mental health services. It can act as a deciding factor on its own or in conjunction with other factors [65]. Age can indicate more sensitivity, such as in children under five or the elderly, or greater resilience, such as in the 18 to 25 age group, which is more likely to participate in higher-risk behaviors, including sexual behavior and the use of alcohol, cigarettes, and other drugs[65]. It is an important demographic indicator.

Age can be impacted by differences in socioeconomic status as measured by work, education, and wealth, as well as higher economic dependency, subpar living conditions, social isolation, and low self-esteem[65]. The absence of adequate healthcare for the

elderly can exacerbate their already precarious health. This concerns both developed and developing countries [66]. Although older women are more likely than older men to live longer, they are also more likely than older men to experience functional limitations in their ability to move and take care of themselves[66]. There have been ongoing differences based on age, gender, and socioeconomic class in terms of resources, access to official and informal care, and the value attached to later life[67]. Concerns concerning the health of the elderly, income distribution across ages and genders, accessibility to formal and informal care, and the suitability of the latter for the frail elderly are raised by these disparities, which are brought on by differences in status and resources[67]. According to research, adolescent's age can predict their usage of mental health services[74].

Another research investigated accessibility to public mental health treatments in Vermont, as well as whether and how service utilization varies by age and gender, as well as the magnitude of the disparities[74]. The authors classified mental health care as one or more meetings with a psychiatrist, psychotherapist, or counsellor for their study. They distinguished between consultations only and consultations plus therapy by defining treatment as four or more visits to a single practitioner in a calendar year[75]. According to the findings, age has an impact on the usage of mental health services. Young adults aged 18 to 21 were less likely than adolescents aged 11 to 17 to get or access mental health care[75].

Another research found that increasing age was a substantial predictor of mental health care usage in a sample of youths aged 12 to 17[75]. The incidence of outpatient visits was used by the researchers to characterize mental health treatment utilization. These

results contradicted other findings[76]. While the explanation for these contradictory results is unknown, the different ages of teenagers probably included in the research influenced the results, with the probability of using services increasing with age up to a point. It is also likely that the study's conclusions were influenced by the type of mental health services investigated[76]. In any case, the research suggests that age is a possible determining factor in teenage mental health service usage.

The senior citizens in Namibia are more probable to use informal health care, home and folk treatments, alternative medicines and healthcare, and even faith healers, not only because of cost (even though traditional medicine is often more costly), but also because of habit, culture, or individual beliefs and attitudes. Lower-income people are more likely to make health-related decisions based on routine, a link between patterns and lifestyle, a tendency to rely on habits, and a lack of willingness to modify behaviour[67].

Kroeger[68] in his research has shown that the use of mental-health services by the elderly is poor. Kroeger[68] looked into several factors that contribute to the elderly's low use of mental health care. Professional attitudes, practical limits, and elderly attitudes were the three sorts of impediments he discovered. According to the study, the biggest barrier to proper mental health service utilization isn't perceived "ageism" on the part of mental health practitioners, but rather biases against mental health care held by the elderly themselves[69].

Although when mental health treatments were available, elderly persons used less speciality mental health services than other adults, according to another study by [69] that included some of the "practical limits" (i.e., reimbursement, transportation, etc.) as

factors. The final hurdle mentioned by [69] is the mindset of the elderly. Variations in experiences lead to variations in attitudes regarding a variety of topics, including mental health and the use of mental health services, among the various age groups. Based on their social, cultural, and educational experiences, elder generations appear to have varied conceptions of mental health.

According to another survey, the current generation of senior people follows the reciprocity standard[70]. This is based on the elderly's high regard for independence and autonomy. They don't want to be helped until they can help others in return[71]. According to another study, the stigma of mental illness is particularly severe among the present generation of older people, who link mental illnesses with personal failure, spiritual lack, or some other stereotypical attitude.

It was discovered that as people get older, their willingness to seek aid decreases[72]. Numerous studies have found that being older, having a lower income and schooling, being male, and belonging to a racial or ethnic minority are all linked to a reduced likelihood of accessing mental health care when they are needed[73]. Growing older is also linked to a slew of health issues. The confounding variable of health must be controlled for in any age cohort's usage of health resources[73]. The research discovered that the elderly were less open to professional mental health treatments and were particularly concerned about probable family reactions in their study of demographic characteristics and attitudes toward mental health services[73]. They also discovered that between the ages of 25 and 44, the most reliance on the mental health specialized sector occurred. They stated that these people were nurtured in an era when mental health was promoted and stigmatization of mental disease was reduced[74].

2.6 Medical insurance coverage

Insurance status has been demonstrated to be a substantial predictor of service consumption in several studies[76]. Van den Broeck et al. [40] looked at how teenagers with substance use and mental health disorders used mental health services and drug treatment [77]. Even though 90% of the participants had health insurance, just 69% were covered for behavioural health care, according to the findings[77].

Furthermore, it was discovered that among three nationally-comparable samples of children and adolescents aged 3 to 17, a higher proportion of teenagers with public insurance used mental health services than adolescents without insurance or adolescents with private insurance [77]. Other researchers have found that Medicaid-eligible households are more likely to receive mental health treatment[77]. In a nationally representative population of adolescents, however, [78] showed that insurance type (public, private, or no insurance) did not influence receipt of psychological treatment. The absence of prognostic effect insurance coverage had on mental health service use in this study could be explained by the fact that the bulk of adolescents in the research had private insurance[78]. The majority of people in the low-income countries of Africa, such as Namibia, actually pay out of pocket for health services, including mental health services.

2.7 Poverty

Poverty or socioeconomic position, another enabling variable, is frequently linked to the usage of mental health services. The underutilization of mental health treatments has long been linked to a lack of financial resources. [78] looked at the relationship between poverty and children's mental health service use and discovered that adolescents from

middle-income homes used the least amount of mental health services, even less than those from poorer families. In this view, this could be because middle-class teens are frequently ineligible for subsidized programs[78]. Adolescents from low-income homes (those whose family income was below the poverty line) were less likely to get mental health treatments than those from high-income families[78].

Despite inconsistent findings across research, poverty may reduce adolescent mental health service utilization due to financial constraints and a lack of insurance coverage. Impoverishment reduced the likelihood of getting mental health care, whereas medical aid eligibility increased the probability of obtaining mental health services among poor teenagers[79].

2.8 Need factors affecting mental health service use

The most obvious reason for using health services is a necessity[79]. The parent's view of his or her child's mental health and the need for services are crucial factors in deciding whether or not to seek and use mental health services for their child[79]. According to research, parental opinions of adolescent mental health care use are a major determinant. Parental attitudes were the biggest predictor of teenage use of speciality mental health care[79]. Other researches have found that parental attitudes play a significant role in the choice to seek help[80].

Adolescent perceptions can also have a big impact on whether or not they use services[80]. Adolescents are more aware of their mental health requirements than young children, have a stronger involvement in accessing resources and attending treatment sessions, and are more likely to demand control over their treatment[80].

According to research, when teenagers perceive growing degrees of symptoms and problem severity, they are more inclined to seek professional treatment[80]. According to Dennill et al., [80] 6% of teenagers sought help when they thought they had mild emotional or behavioural issues, whereas around 18% of adolescents sought help when they thought their problems were serious. Corrigan et al[16] discovered that stigma-related concerns, as well as a poor opinion of services and providers, were among the reasons why teenagers did not seek or continue mental health care in another study.

Finally, provider attitudes can have a big impact on whether or not people use mental health services[81]. In a study by [82], provider view of teenage mental health was found to be the most important predictor of adolescent mental health treatment. The outcomes of this research revealed a link between provider awareness of mental health resources and the delivery of mental health services[82]. Furthermore, the results of this study showed the importance of provider burden, with a higher work burden indicating a lower likelihood of providing mental health services[83].

The importance of provider impression goes beyond speciality mental health. Ndjaleka [84] studied the parameters linked to specialized therapy for children aged 12 to 17 who had been assessed for serious behaviour problems at school. Teachers' opinions of mental health treatment usage were found to be a major predictor of treatment used in this research; children whose educators saw behavioural difficulties were more likely to obtain treatment than children whose educators did not observe challenges[84].

2.9 Theoretical framework

It is very important for all research studies in the social and behavioural sciences to have a conceptual framework on which they base their research. This is the framework that provides rationale or guide the study. Theoretical framework provides an overview of what should be expected, clarify concepts and propose relationships among concepts in the study; it is usually a broad collection of ideas and principles that relates to the research under study. The framework also provides a context for interpretation of the study findings. Jabareen[50] defines a conceptual framework as a network of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena. In this research, a number of theories will be reviewed such as Andersen Behavioural Health Model and the Health Belief Model. These theories allows health behaviour of individuals to be studied in different dimensions. These theories allows explanation of people's engagement in behaviours for disease control. Health care professionals could use these explanations to design interventions to promote medical care-seeking behaviours. If explanations of care-seeking behaviour were supported empirically for one condition, then these explanations could be tested in relation to care seeking for other health behaviour. Although this research will unpack two theories, only the Andersen Behavioural Health Model has been adopted to create a conceptual framework for this research.

2.9.1 The andersen behavioral health model

A behavioural health model that can study the interaction between people, family traits, and systemic concerns is one way to better comprehend the challenges Namibians encounter in getting treatment and the reasons why they choose to leave treatment.

Several frameworks have been established and utilized to assist explain why people seek and use health services in the first place. However, the Andersen Behavioural Health Model (ABHM) is the most commonly utilized model for analyzing service usage trends. It was created by Andersen in 1968 and revised in 1995 to explain why families needed health care and to aid in the development of policies that would improve equitable access to such services[83]. The updated ABHM also proposes a method for analyzing healthcare utilization patterns. We can build interventions to address barriers to service consumption by knowing these behaviours.

According to the ABHM, three types of variables affect the use of health services: 1) risk factors, 2) the need for care, and 3) the availability of enabling resources[83]. Individuals' usage of health services is characterized as a consequence of their proclivity to do so based on variables that facilitate utilization and their need for care[84]. Even though the paradigm prescribes a causal sequence, each component may have a direct impact on the consumption of services.

Demographic variables, societal structure, and health views are all contributing factors. Gender and age are demographic variables while schooling, ethnic background, profession, and religion are social factors[84]. People' perspectives, values, and understanding regarding health and health services influence their eventual views of their need for and use of health and mental health care.

The term "need for care" encompasses both perceived and assessed needs[84]. Perceived need is a cultural construct that social systems and health ideologies can explain. The greatest way to characterize perceived need is how a person views his or her overall

health, level of functioning, and the significance of having an issue handled[84]. A professional's assessment of a person's health status and need for health care is known as assessed need. The p,erceived need has to do with patient compliance, but the evaluated need has to do with the type and amount of intervention.

Family and community characteristics are examples of enabling resources. Earnings, medical insurance, and access to a consistent provider of care, as well as travel and waiting times, are all issues that affect families[84]. The ratio of healthcare professionals and amenities to the population is one of the community elements. Enabling resources might include processes and actions that are perceived as obstacles or enablers to care from a services usage perspective[85]. Each of the concepts, as well as the identified factors that are the focus of the current investigation, are depicted in the diagram below:

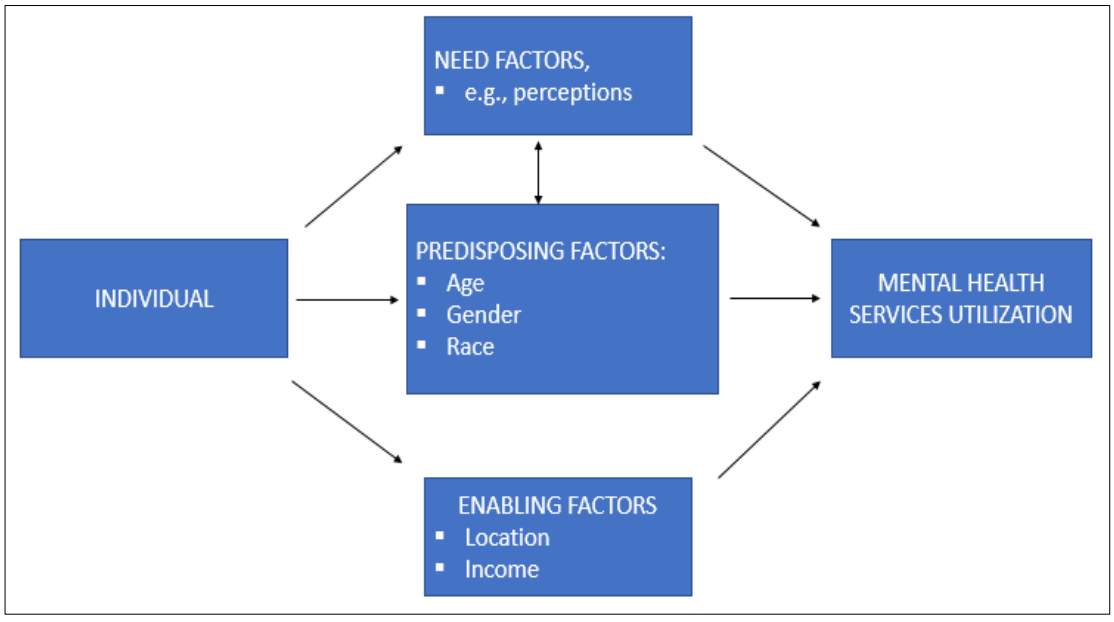

Figure 2.1: Andersen Behavioural Model of Health Care Utilization (ABHM)

2.9.2 Rationale for using this model

The ABHM offers both a thorough theoretical framework for analyzing population variations in usage and a valuable technique for evaluating health and mental health inequalities, because mental health services adoption may be considered as a sort of health behaviour [85]. The ABHM has been used in a wide range of adult demographics and settings for treatment and service user research. This paradigm has been used to look at determinants of entry and preparedness to be treated in a variety of treatment settings, including substance misuse, medical, and mental health[85]. Depression and anxiety, mental illnesses, HIV, and post-trauma illnesses have all been treated with it. Several determinants of mental health care users have been examined using the elements of ABHM as a paradigm. This approach, for instance, has been used to investigate determinants of Attention Deficit Hyperactivity Disorder (ADHD) treatment requesting in foster children health services and drug addiction treatment, homelessness, and teenagers with asthma, Human Immunodeficiency Virus (HIV), and sexually transmitted infections [85].

2.9.3 Critical analysis of the ABHM

The ABHM has several advantages that make it a good fit for this study[85]. For starters, it's a comprehensive model that takes into consideration demographic, psychological, and biological elements, as well as social and cultural ones. Secondly, ABHM concentrates on the person and the variables that influence his or her decision to seek treatment, while also taking into account the influence of society. In alternative words, an individual's personality, together with the nurturing of his or her social surroundings, determines his or her willingness to seek help.

Although people have underlying variables that impact their help-seeking behaviours, according to this concept, it is feasible for them to change their help-seeking behaviours [85]. Enabling elements, for example, are very beneficial in encouraging such a shift. Finally, although most research on mental health treatment seeking focuses on overcoming barriers to service usage, the ABHM emphasizes boosting access to services, allowing for a strengths-based approach to evaluating treatment-seeking determinants[85].

While the ABHM provides a broad and adaptable framework for investigating factors that influence people' usage of mental health services, it does have significant drawbacks. The ABHM, for example, is primarily focused on client-centred variables and hence does not directly evaluate other contextual elements that support or hinder treatment utilization. Individuals typically do not seek assistance on their own and rely on their families for assistance. As a result, a focus on family advantages connected to service utilization is included in this study.

Another problem is that the ABHM is intended to provide an underlying theoretical framework, therefore it is wide and vague[85]. This study, on the other hand, solves this restriction by taking into account specific criteria connected to the utilization of mental health services by people of all ages. While the ABHM provides a good foundation for addressing the study's research questions, direct evaluation of the model's limitations during the study's execution provides the chance to improve it, particularly for usage in all age groups of people with mental illnesses[86]. The sections that follow take a deeper look at the many variables that impact the utilization of mental health care in the framework of the ABHM.

2.9.4 The health belief model

The study will apply the Health Belief Model (HBM) as a conceptual framework. The Health Belief Model is one of the widely recognized conceptual frameworks of health behaviour, focusing on behavioral change at the individual level. As expected, the decision to seek medical care after experiencing symptoms relating to mental illness is a health behavior that individual should make based on evaluation of the benefits and obstacles and this individual behaviour makes HBM applicable in this study. According to Green and Murphy [77], the model suggests that individuals make calculations about whether the benefits of a promoted behaviour change outweigh its practical and psychological costs or obstacles. To be exact, individuals conduct internal assessment of the net benefits of changing their behaviour, and decide whether or not to act. The HBM was originally developed as a systematic method to explain and predict preventive health behavior. It focused on the relationship of health behaviours, practices and utilization of health services. Tarkang and Zotor [78] are of the opinion that Health Belief Model was the first model to be developed to explain the process of change in relation to the process of health behaviour.

2.9.5 Brief description of the HBM

The HBM attempts to predict health-related behaviour in terms of certain belief patterns. According to Pryor and Reeder[51] the HBM model is used in explaining and predicting preventive health behavior such as the the decision to seek medical care for mentalk helath related issues. Tarkang and Zotor [78] added that the HBM can be divided into three main categories: (1) individual perceptions about health, (2) modifying factors such as demographic, socio psychological and structural variables, and (3) the benefits

of taking action. [figure 2.2] The decision and/or behaviour to seek medical care in response mental health issues is attributable to the demographic and socio-economic factors and it is for that reason that many theories such as the HBM focuses on the way individuals change their behaviours.

According to Tarkang and Zotor [78], HBM theories look at the psychological and social factors that such as knowledge attitude, personality and belief that affect the way people behave. In the context of this research, the focus is the demographic and socio-economic factors that influences individuals' decisions not to seek medical care and/or to seek medical care for mental health related issues. Dennill, King, Lock, and Swanepoel[80] contend that individual's perceptions are factors that affect the perception of illness or disease, they deal with, the importance of health to the individual, perceived susceptibility, and perceived severity.

Modifying factors include demographic variables, perceived threat, and cues to action. The likelihood of action discusses factors in probability of appropriate health behavior; it is the likelihood of taking the recommended preventive health action. The combination of these factors causes a response that often manifests into action, provided it is accompanied by a rational alternative course of action. The mental health seeking behaviours may be influenced by the demographic variables. If regions, place of residence, education, wealth, etc are viewed as obstacles that hinder individuals to take action pertaining to seeking medical care, subsequently, the medical care seeking behaviours and/or medical care response will be affected.

Abraham, Sheeran, and Orbell[52] adds that HBM states that the perception of a personal health behavior threat is itself influenced by at least three factors: (1) general health values, which include interest and concern about health; (2) specific health beliefs about vulnerability to a particular health threat; and (3) beliefs about the consequences of the health problem. As expected, there may be variables (demographic, socio-psychological, and structural) that can influence an individual's decision.

Key Aspects: The model identifies four aspects of this assessment which are perceived susceptibility to ill-health (risk perception), perceived severity of ill-health, perceived benefits of behaviour change, and perceived barriers to taking action. The concept of self-efficacy, or the perceived ability to actually take a recommended action, was later recognized as an important component or factor[79].

Perceived Susceptibility - Weld, Padden, Ramsey, and Bibbs [79] expound that each individual has his/her own perception of the likelihood of experiencing a condition that would adversely affect one's health. In the context of Namibia, this may apply to susceptibility to endure the probable outcome of mental illness if medical care is not sought. There is wide variation in a person’s feelings of personal vulnerability to an illness or disease [85]. Those at low end of the extreme deny the possibility of contracting an adverse condition. Individuals in a moderate category admit to a statistical possibility of disease susceptibility. Those individuals at the high extreme of susceptibility feel there is real danger that they will experience an adverse condition or contract a given disease [85]. Raising awareness about mental health and the benefit of seeking medical care in response to mental illness and/or mental illness will influence the behaviour to seek medical care for mental health issues.

Perceived Severity - Weld, Padden, Ramsey, and Bibbs [79] expound that perceived seriousness, refers to the beliefs a person holds concerning the effects a given disease or condition would have on one's state of affairs. Buglar, White, and Robinson[53] explained that these effects can be considered from the point of view of the difficulties that a disease would create. For instance, when evaluating the severity, a person considers medical consequences such as death, blindness, hearing loss, loss of taste but also susceptibility to future conditions. Additionally, a person may consider social consequences such as family life, social relationships. This means the challenges that an individual may confront due to mental illness can lead a person to do what they can to protect themselves. In Namibia, this awareness of perceived seriousness of mental illness may lead to enhanced medical care seeking [84].

Perceived Benefits of Taking Action - Taking action toward the prevention of disease or toward dealing with an illness is the next step to expect after an individual has accepted the susceptibility of a disease and recognized it is serious. The direction of action that a person chooses will be influenced by the beliefs regarding the action. Sareen et al., [63] perceived benefits of taking action implies that individual actual appraise a situation in order to see the benefits that may accrue to them due to that action. This means that in Namibia, researchers will weigh the pros and cons of seeking medical care versus forgoing it. This is relevant to the development of knowledge regarding the behavior of those who have experienced mental health problems in seeking mental health care.

Barriers to Taking Action - However, action may not take place, even though an individual may believe that the benefits to taking action are effective[63]. This may be due to barriers. Barriers related to the characteristics of a treatment or preventive

measure may be inconvenient, expensive, stigma, and belief that there is no one to do the job or do the diagnosis. These characteristics may lead a person away from taking the desired action. In the context of medical seeking behaviour among people who have experienced mental illness issues, the barriers may be related to the lack of qualified staff, lack of capacity on the part of health and medical services, distance from medical services or affordability of services to be offered.

Cues to Action - An individual's perception of the levels of susceptibility and seriousness provide the force to act and/or the stimulus needed to trigger the decision-making process to accept a recommended health action. Benefits (minus barriers) provide the path of action. However, it may require a 'cue to action' for the desired behavior to occur. These cues may be internal or external such as media, advice from others or illness of family member.

Self-efficacy – This refers to the level of a person's confidence in his/her ability to successfully perform a behaviour. This construct was added to the model most recently in mid-1980. Self-efficacy is a construct in many behavioural theories as it directly relates to whether a person perform all the desired behaviour.

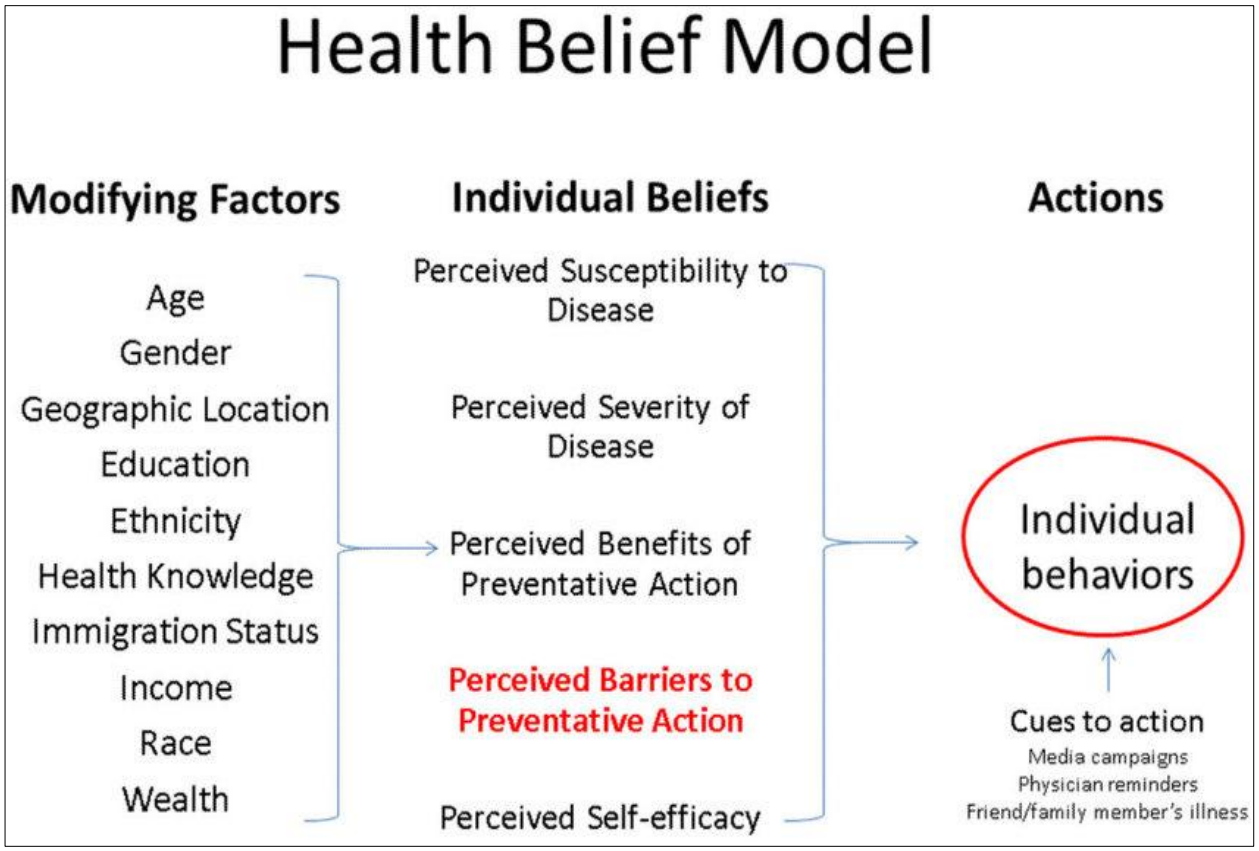

Figure 2.2: Health Belief Model (HBM*)*

2.10 Present knowledge gap in mental-health care service use in Africa

Despite the high prevalence of mental illness, Africa places little focus on mental health. Little to no study has been conducted on the demographic and socioeconomic factors affecting medical care-seeking behavior among people with mental health problems. The viewpoints of mental health specialists on the causes of the low priority of mental health have been studied.

In Namibia, the Ministry of Health and Social Services [22] and the National Demographic and Health Survey (NDHS) undertake little research on the 2013 Demographic and Health Survey and the NDHS. Chipare's [84] other work is titled "Mental Health Research in Namibia: A scoping literature review. However, no research

on the socio-economic factors influncing medical care-seeking behavior among people with mental health issues has been undertaken in Namibia. This is a gap in the research because no such studies have been undertaken in Namibia. This study will fill a gap in the research by looking at the demographic and socioeconomic factors that make Namibians with mental health problems more or less likely to seek medical health services.

2.11 Summary

The literature on health seeking and health care seeking behavior among people who experienced mental health issues has been outlined in this overview. Due to the large number of factors that may be discussed, a few have been chosen from the literature. Each parameter has been discussed in terms of its importance to this research and why it was selected as a variable. These variables identify two aspects of health-care seeking: the individual's socio-economic status and demographic traits and their ability to receive health-care services.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research design, population of the study, sampling methods, methods of data collection, data analysis techniques, and ethical considerations. The methodology contains a link between the study's methods and intent, as well as how the methodology aids in achieving the research's objectives. Data collection, sample strategy, and data analysis are all described as part of the research approach. Research quality and study ethics are also described to demonstrate the thesis's reliability and ethical ideals.

3.2 Research design

In this study, secondary numerical data was collected at one point in time and analysed to establish a correlation between the medical care-seeking behavior among people who experienced mental health issues and the exposure factors (demographic and socio-economic). The study employed a quantitative, cross-sectional, analytical design to determine the demographic and socio-economic factors that influence medical care-seeking behaviour for people who experienced mental health issues in Namibia. Hence, the focus was on gathering numerical data at a defined time and generalizing it across groups of people to explain the medical care-seeking behaviour of people who experienced mental illness symptoms.

From the 2013 NDHS secondary data collected from a defined population of Namibians who were found to have mental health issues was at the same time assessed on the outcome of this study (medical care-seeking behaviour among individuals who has experienced mental illness issues) and the demographic and socio-economic exposure factors. Therefore, the study analyzed to explain why medical care-seeking behaviour among people who have experienced mental illness issues is very low, at least based on the variables that the 2013 NDHS survey collected data on. This is to determine if such exposure factors; demographic (age, sex, residence, region) and socio-economic (education, wealth) are determinants in medical care-seeking behaviours of those who presented with mental health issues in Namibia.

3.3 Population

Van der Broeck, Sandoy, and Brestoff [40] define a population as the study's interest that consist of a large collection of individuals or objects that is the main focus of a scientific enquiry. The study used secondary data from the 2013 NDHS which constituted the total population of the whole country in each Enumeration Area (EA) classified as urban or rural who experienced mental health symptoms. An enumeration area was the smallest identifiable entity without administrative specification, numbered sequentially within each constituency. The primary focus of the 2013 NDHS was to provide estimates of key population and health indicators for the country as a whole and urban and rural areas. Each of the 13 administrative regions was subdivided into several constituencies (with an overall total of 107 constituencies). Each constituency is further subdivided into lower-level administrative units, and it was this data that was extracted to make up the population of the study.

3.4 Sample and sampling method

A sample is usually a subset of the population[86]. A total sample size 14,499 of men and women who presented with mental health symptoms according to the 2013 NDHS were used for this study. The sampling frame used for the 2013 NDHS was the preliminary frame of the 2011 Namibia Population and Housing Census[22]. The sampling frame is a complete list of all enumeration areas (EAs) covering the whole country. The sample for the 2013 NDHS was a stratified sample selected in two stages. In the first stage, 554 EAs – 269 in urban areas and 285 in rural areas were selected with stratified probability proportional to size from the sampling frame. Stratification was achieved by separating every region into urban and rural areas. This study used secondary data; hence, among the NDHS sample, all the X women and Y men who were found to have at least one mental health issue constituted the study sample for this study.

3.5 Study variables

In this study, appropriate HSB was defined as consulting a qualified medical professional or seeking healthcare at orthodox health facilities such as private clinics, primary health centres, and general hospitals during illness episodes or any situation requiring medical attention[28,36]. Inappropriate HSB comprises seeking healthcare from patent medicine vendors (PMVs), chemists, traditional healers, family members or doing nothing at all. Traditional healers are non-qualified persons who treat patients using traditional non-medical methods. Patent Medicine Vendors (PMVs) or chemists are non-qualified persons who sell drugs without medical prescription.

Study variables used to determine the factors influencing HSB included socio-demographic subject characteristics such as age, marital status, highest level of education completed, family size and socioeconomic status.

3.6 Research instrument

The Microsoft Excel entry tool was used to extract data from the 2013 NDHS database. The primary purpose of Excel was to organize and analyze large amounts of information. Data was stored in a worksheet (grid) organized in columns and rows that was manipulated, sorted, and analyzed. Microsoft Excel can be a useful platform to enter and maintain research study data. Excel is fairly easy to learn and use. Researchers can use Excel's simple statistical and plotting functions to help gain insight into their data. However, most research projects require more extensive statistical techniques that can be most easily performed using additional statistical software packages such as Statistical Analysis System (SAS) or Statistical Package for Social Science (SPSS) software.

The variables captured included gender, age, race, level of education, mental health condition, type of employment, marital status, place of residence and health seeking behaviour of respondents. The data entry form was created; one of Excel's built-in data tools that allow one to add new records containing specific information and/or start a new database by providing column headings or field names to be used in the database for easy entry into the statistics packages. To do so, the data variables from the 2013 NDHS (demographic and socio-economic) that was of interest to the study to determine the medical-care seeking behaviours was filtered and added or imported to the document/spreadsheet to create an entry form.

The imported data variables was then transferred to Statistical Package for Social Sciences (SPSS) 25.0 statistical software for analysis. The instrument allowed the study to capture socio-demographic data to help the study analyze how different groups and/or regions access and navigate the full range of mental health services in Namibia.

3.7 Data collection procedure

The current study used secondary data from the 2013 NDHS. The NDHS 2013 used a Windows-based integrated Census and Survey Processing System (CSPro) for entry, editing and tabulating of data. After obtaining a permit from theMinistry of Health and Social Services, the office of Information System and Research in the Ministry provided a link to access the Global DHS Program. From the DHS Program through the United States Agency for International Developemnt (USAID), registration was required where the research topic, a brief research purpose and objectives were required to be granted permission to access data. This included instructions and oath on handling of this data and thereafter, permission to access data was granted by the ICF. Upon registration, the DHS Program provided the DHS Recode Manual that aided the reading of the dataset with the assistance from the MoHSS. From this 2013 NDHS database, data on all individuals who experienced at least one mental health symptom was filtered out along with their relevant demographic and socio-economic factors variables for this study. The filtered data was secured in a separate Excel database. Thereafter, the separated data was cleaned and was transferred to the SPSS Software where it was analysed. This process involved the technical assistance by officials from the office of Information System and Research in the Ministry of Health and Social Services and it lasted for about two weeks.

3.8 Data analysis

The imported data was recorded in SPSS 25.0 for analysis. Thereafter, descriptive and inferential statistics was used. Descriptive statistics involves tabulating and describing the dataset. Inferential statistics, on the other hand, provides methods to estimate characteristics of a total population based on data from a sample of observations. The Chi-square test was used to ascertain for exposure or risk factors (socio-demographic factors) and the outcome (medical care help-seeking) association. Logistic regression analysis to determine the association between medical care help-seeking behaviour amang people who have experienced mental health issues as the dependent variable and socio-demographic explanatory variables will be used.

The data were coded, checked, and processed with version 20 Statistical Package for the Social Sciences. Descriptive statistics, such as means, standard deviations (SD), frequencies, and proportions, were used to summarize variables. Chi-square tests were used to identify associations between categorical variables using a P-value of 0.05 as the significance level. Logistic regression analysis was conducted to determine significant predictors of outcomes with estimation of the odds ratio and 95% CI (Confidence Interval). Only explanatory variables found to be significantly associated in the Chi-square analyses were entered into the logistic regression model.

The strength of the relationship between each outcome variable and the independent variables was investigated. Each outcome variable was analyzed descriptively using numbers and percentages for each of the independent variables. Each outcome variable was then investigated using univariate analysis and multiple logistic regression analysis to determine odds ratios and 95% confidence intervals. Results were considered

significant at the p< = 0.05 level with confidence intervals that did not cross unity. Other results were taken into account however and interpreted with caution if they fell near these parameters and appeared pertinent to the overall discussion of the strength of the relationship between outcome and independent variables.

3.9 Research ethics

Before conducting this study, permission was obtained from UNAM Research Ethics Committee (UREC), and the Ministry of Health and Social Services (MoHSS) which is the custodian of health-related issues in Namibia. Deception was avoided at all costs in that the study purpose was well communicated to the authorities concerned.

Use of secondary data is in itself, a highly ethical practice: it maximizes the value of any (public) investment in data collection, it reduces the burden on respondents, it ensures replicability of study findings and therefore, greater transparency of research procedures and integrity of research work. But the value of secondary data is only fully realized if these benefits outweigh the risks, notably in terms of re-identification of individuals and disclosure of sensitive information. In light of this, the obatained data for this study was anonymous, appropriately coded and completely devoid of any identifying information. Hence, this process provided for full privacy and confidentiality of the subjects.

3.10 Summary

This chapter has focused on the research design and methodology that underpin this study.The following chapters build on from the methodological propositions made in this chapter by employing the proposed data presentation and analysis approaches to analyze the quantitative data.

CHAPTER 4

FINDINGS AND DISCUSSIONS OF RESULTS

4.1 Introduction

In the previous chapter the researcher looked at the research methodology that was employed in the study and the sampling method used. This chapter will highlight and present the findings of the research to produce meaning and knowledge. This chapter covers data presentation and analysis.It also aims to explore and interpret information gathered from the field. According to Springhill [26], all field research climaxes in the analysis and interpretation of observations, which involves breaking the work into small trends, themes and identify relationships. Finally, a discussion of results is presented.

4.2 Mental disorders

Mental disorders comprise a broad range of problems, with different symptoms. They are generally characterised by some combination of abnormal thoughts, emotions, behaviours, and relationships with others. Mental illness, on the other hand, is characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning. Most of these disorders can be successfully treated.

The 2013 NDHS collected information from women and men age 15-49 on whether they have ever seen or heard things that are actually not there, whether they felt worthless or hopeless or wished they were dead during the past 12 months. Further, this included the average number of days in the past two weeks they had little interest or pleasure in doing

things; and the average number of days in the past two weeks they had felt low in energy, been in a bad mood, or been sad.

A total of 14499 participants who reported mental-health issues were analyzed out of the NDHS data, were involved in the study. There were more females (69%) than males (31%). The study focused on age groups from 15–49, with a mean of 50 and a standard deviation of 23.5. Figure 4.1 below shows the total number of participants involved in the study. All regions were almost equally represented and 49.1% of participants came from urban areas, while 50.9% came from rural areas.

4.3 Demographic information

4.3.1 Gender

The study deemed it vital to assess the influence of gender on mental health seeking behaviour (Figure 4.1). This is because it was perceived that gender was one of the key determinants of the medical care seeking behaviours among people that experienced mental health issues in Namibia.

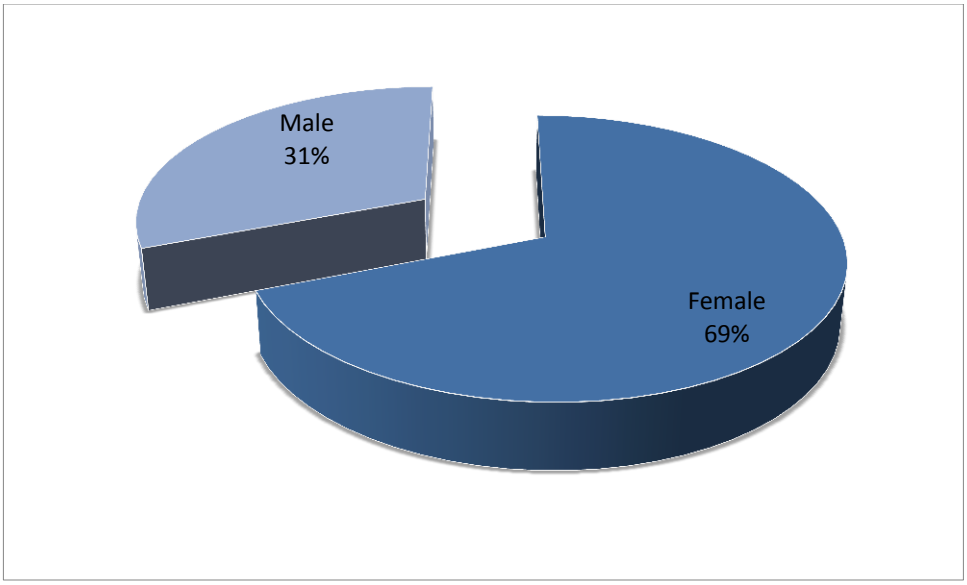

Figure 4.1: Gender

The results show that majority of the people that had mental health issues were female (69%), and only 31% of the target population were males. The results could be attributed to the fact that Namibia has relatively more females with mental health issues than males.

4.3.1.1 Gender and health seeking behaviour

About 74.3% of women reported having seen or heard things that were actually not there in the two weeks prior to the survey. The results show that women are more susceptible to mental health issues in comparison to men. Furthermore, 79.3% of women felt worthless, and 80.3% wished they were dead.76% of the women who said they had at least one of these mental health problems went to the doctor.

On the other hand, 25.7% of men reported having seen or heard things that were actually not there in the two weeks prior to the survey. Additionally, 20.4% of men reported that they felt worthless, hopeless, or that they wished they were dead in the 12 months prior

to the survey. Men who said they had at least one of these problems went to the doctor 23.1% of the time.

Table 4.1: Chi-Square tests for gender in association with health seeking behaviour

	Value	***Df***	***Asymptotic Significance (2-sided)***	***Exact Sig. (2-sided)***	***Exact Sig. (1-sided)***
Pearson Chi-Square	*.070[a]*	*1*	*.791*		
Continuity Correction[b]	*.049*	*1*	*.824*		
Likelihood Ratio	*.071*	*1*	*.791*		
Fisher's Exact Test				*.829*	*.414*
N of Valid Cases	*4865*				
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 215.07.					
b. Computed only for a 2x2 table					

The corresponding p-value of the test statistic is bigger than our chosen significance level $\alpha = 0.05$, we can accept the null hypothesis, and conclude that there is no association between gender and mental health seeking behaviour. Based on the results, thee researcher can state that there was a significant association between gender and health seeking behaviour of mentally sick patients in Namibia ($X^2(1) = 0.070$, $p > 0.05$).

4.3.2 Age groups

Age was a part of the key demographic factors that influence mental health problems. Figure 4.2 shows age groups of people with mental health issues across the country.

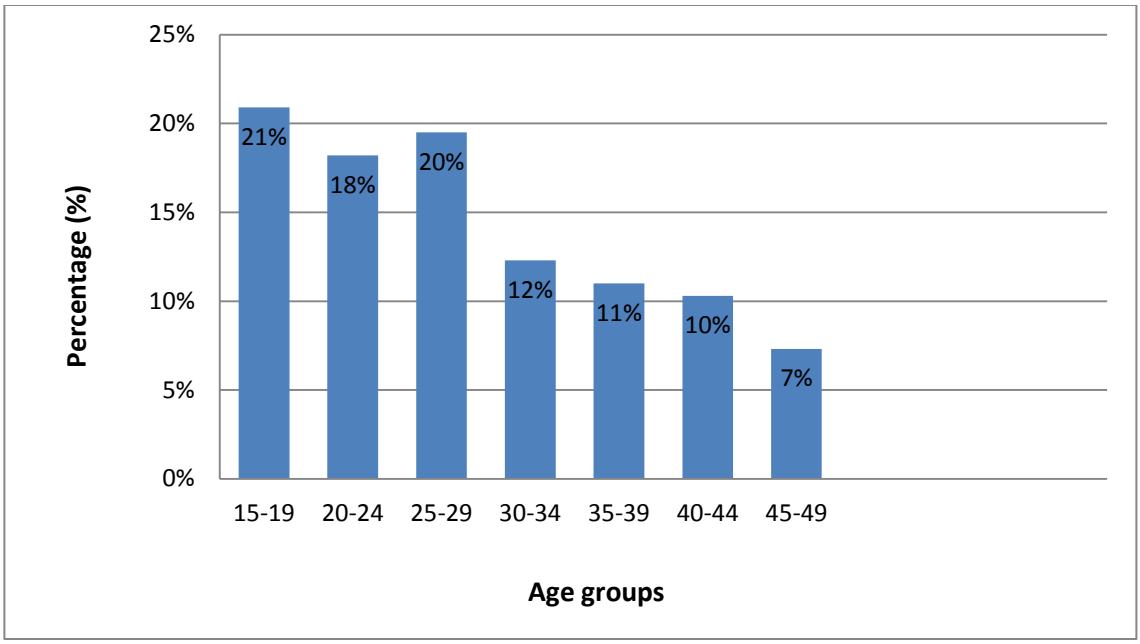

Figure 4.2: Age groups

The results show that there were more young people in the age category of 15–19 years old (21%), followed by 25–29 years old (20%) and 20–24 years old (18%). The least represented age groups were 40–44 years old (10%) and 45–49% (7%) respectively.

4.3.2.1 Age and health seeking behaviour

All age groups in every region reported at least hearing or seeing things which are not physically present. More female (74.3%) than males (25.7%) reported hearing voices or seeing things that are actually not there which is a possible sign of mental health problems as indicated in Table 4.2 below. On the one hand, 76.3% respondents in the age group 15-39 wished they were dead at some point in life while 68.3% of the subjects indicated they had feelings of worthless or uniterested about life while the age group of 60-65 had the least percentage of 1.5%. It is however, the 15-44 year olds who sought medical attention (77.5%)more than the other age groups.

Table 4.2: Chi-square tests for age group in relation to health seeking behaviour

	Value	***Df***	***Asymptotic Significance (2-sided)***
Pearson Chi-Square	*112.708[a]*	*9*	*.000*
Likelihood Ratio	*108.177*	*9*	*.000*
Linear-by-Linear Association	*97.920*	*1*	*.000*
N of Valid Cases	*4865*		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 20.55.			

The corresponding p-value of the test statistic is so small that it is cut off from display. Instead of writing "p = 0.000", we instead write the mathematically correct statement $p < 0.001$. The p-value is less than our chosen significance level $\alpha = 0.05$. Therefore, we conclude that there is an association between age group and health seeking behaviour. Based on the results, we can state that there was a significant association between the age of a respondent and the health seeking behaiviour of mental health patients ($X^2(9) = 112.708$, $p < .001$).

4.3.3 Political regions

Political regions were part of the demographical factors that influence mental health issues (Figure 4.3).

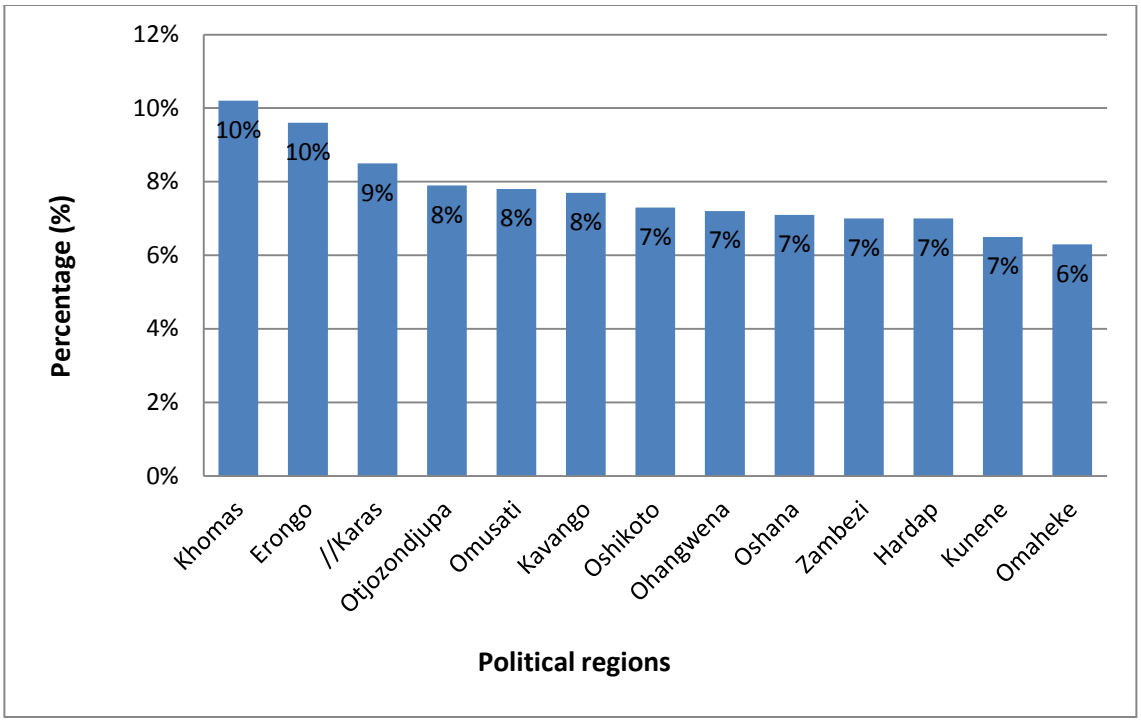

Figure 4.3: Political regions

The results indicated that Khomas Region (10%) was the highest in terms of mental health issues, followed by Erongo Region (10%), and the least was Omaheke Region (6%). Khomas Region is where the capital City of Namibia (Windhoek) is located. This is where most of the people have access to good medical care and mental health awareness.

In addition, Khomas Region is the most populated region, whereas, Kunene and Omaheke are among the least populated regions. Hence, the percentage (10%) of medical care seeking is high in Khomas Region.

4.3.3.1 Region of residence and health seeking behaviour of patients

The region of residence seem to influence the health seeking behaviour of respondents. //Karas Region with (11.6%) and Oshikoto Region with (11.3%) respondents surpassed the list with the highest number of subject who reported to have heard some sounds or

seen some things that are actually not there. Kunene Region had the least percentage of people who reported to have had some mental problems. Similarly, 17.0% of subjects from //Karas reported that they wished they were dead at some point while //Karas and Zambezi region surpassed the list of respondents who felt worthless at some point. Respondents from Kavango Region 8% were on top of the list of those who sought medical attention for mental issues and Kunene were the least with 4%.

Table 4.3: Chi-Square Tests: Region of residence

	Value	***Df***	***Asymptotic Significance (2-sided)***
Pearson Chi-Square	*44.581[a]*	*12*	*.000*
Likelihood Ratio	*43.389*	*12*	*.000*
Linear-by-Linear Association	*.832*	*1*	*.362*
N of Valid Cases	*4865*		

a. 0 cells (0.0%) have expected count less than 5.
b. The minimum expected count is 32.23.

Instead of writing "p = 0.000", we instead write the mathematically correct statement $p < 0.001$. The p-value is less than our chosen significance level $\alpha = 0.05$, therefore we conclude that there is an association between age group and health seeking behaviour. Based on the results, we can state that there was a significant association between the region of residence of a respondent and the health seeking behaiviour of mental health patients ($X^2(9) = 44.581^a$, $p < .001$).

4.3.4 Residence in urban/rural

The Namibian population can be classified as urban and rural. Figure 4.4 shows the proportion of people with mental issues by residence (urban and rural).

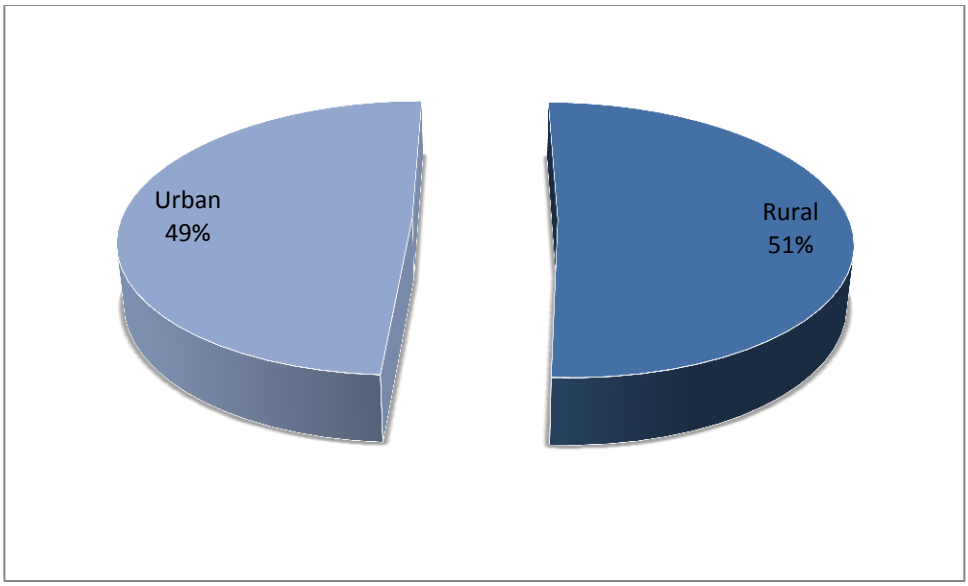

Figure 4.4: Residence urban/rural

The results show that there was a slight margin in the number of people with mental health issues found in rural areas (51%), whereas urban areas consisted of 49% of people with mental health issues.

Of the participants, 49.1% were urban residents and 50.9% were rural residents, The percentages of rural residents to urban residents was almost equally distributed in the study. . Further, 50.9% of rural dwellers reported to have had a mental health problem compared to 49.1% of urban dwellers as is shown table 4.4 . Women aged 45-49, rural women and those living in Oshikoto, women with a primary education, and those in the lowest wealth quintile were most likely to report that they had seen or heard things that were actually not there in the two weeks before the survey. Women aged 20-24, urban women, women in //Karas, women with more than a secondary education, and women in the highest wealth quintile were more likely than women in other regions to report that they had felt worthless or hopeless or wished that they were dead in the past 12 months. There were minimal differences by background characteristics in the average number of

days women felt little interest or pleasure in doing things in the past two weeks and the average number of days women felt low in energy, had been in a bad mood, or had been sad.

Men aged 45-49, rural men, men in Oshana, men with a primary education, and men in the fourth and middle wealth quintiles were most likely to report that they had seen or heard things that were actually not there in the two weeks before the survey. Men aged 45-49, urban men, men in Zambezi, men with more than a secondary education, and men in the highest wealth quintile were more likely than their counterparts to report that they had felt worthless or hopeless or wished that they were dead in the past 12 months. As with women, there were minimal differences by background characteristics in the average number of days men felt little interest or pleasure in doing things in the past two weeks and the average number of days they felt low in energy, had been in a bad mood, or had been sad.

Table 4.4: Chi-Square tests place of residence in relation to health seeking behaviour

	Value	***Df***	***Asymptotic Significance (2-sided)***	***Exact Sig. (2-sided)***	***Exact Sig. (1-sided)***
Pearson Chi-Square	*4.154[a]*	*1*	*.042*		
Continuity Correction[b]	*4.006*	*1*	*.045*		
Likelihood Ratio	*4.153*	*1*	*.042*		
Fisher's Exact Test				*.044*	*.023*
Linear-by-Linear Association	*4.153*	*1*	*.042*		
N of Valid Cases	*4865*				

a) 0 cells (0.0%) have expected count less than 5. The minimum expected count is 445.21.
b) Computed only for a 2x2 table

Instead of writing "p = 0.000", we instead write the mathematically correct statement p < 0.001. The p-value is less than our chosen significance level α = 0.05, therefore we conclude that there is an association between level of education and health seeking behaviour. Based on the results, we can state that there was a significant association between the wealth of a respondent and the health seeking behaviour of mental health patients ($X^2(4) = 22.822^a$, p < .001).

4.3.5 Level of education and health seeking behaviour

Education level did not appear to impact upon respondents reporting treatment they needed. Of these, 68% respondents reported that they were literate. However, 67% respondents stated they had some type of formal education and 58.1 % reported having at least secondary education. The majority of those who once felt worthless are those who acquired at least secondary education constituting 60.1%. Yet, only 56.4% of those who acquired secondary education sought medical care.

Table 4.5: Chi-Square Tests for level of Education in relation to health seeking behaviour

	Value	***Df***	***Asymptotic Significance (2-sided)***
Pearson Chi-Square	*17.815[a]*	*3*	*.000*
Likelihood Ratio	*17.360*	*3*	*.001*
Linear-by-Linear Association	*11.310*	*1*	*.001*
N of Valid Cases	*4865*		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 59.75.			

Instead of writing "p = 0.000", we instead write the mathematically correct statement p < 0.001. The p-value is less than our chosen significance level α = 0.05, therefore we conclude that there is an association between level of education and health seeking

behaviour. Based on the results, we can state that there was a significant association between the age of a respondent and the health seeking behaiviour of mental health patients ($X^2(3) = 17.815^a$, $p < .001$).

4.4 Socio-economic factors and mental health seeking behaviour

As mentioned earlier, socio-economic factors were classified into age groups, gender, region, place of residence as urban or rural.

4.4.1 Wealth and Mental health seeking behaviour by age group

Figure 4.5 shows the percentage of people that have displayed mental health seeking behavior in Namibia.

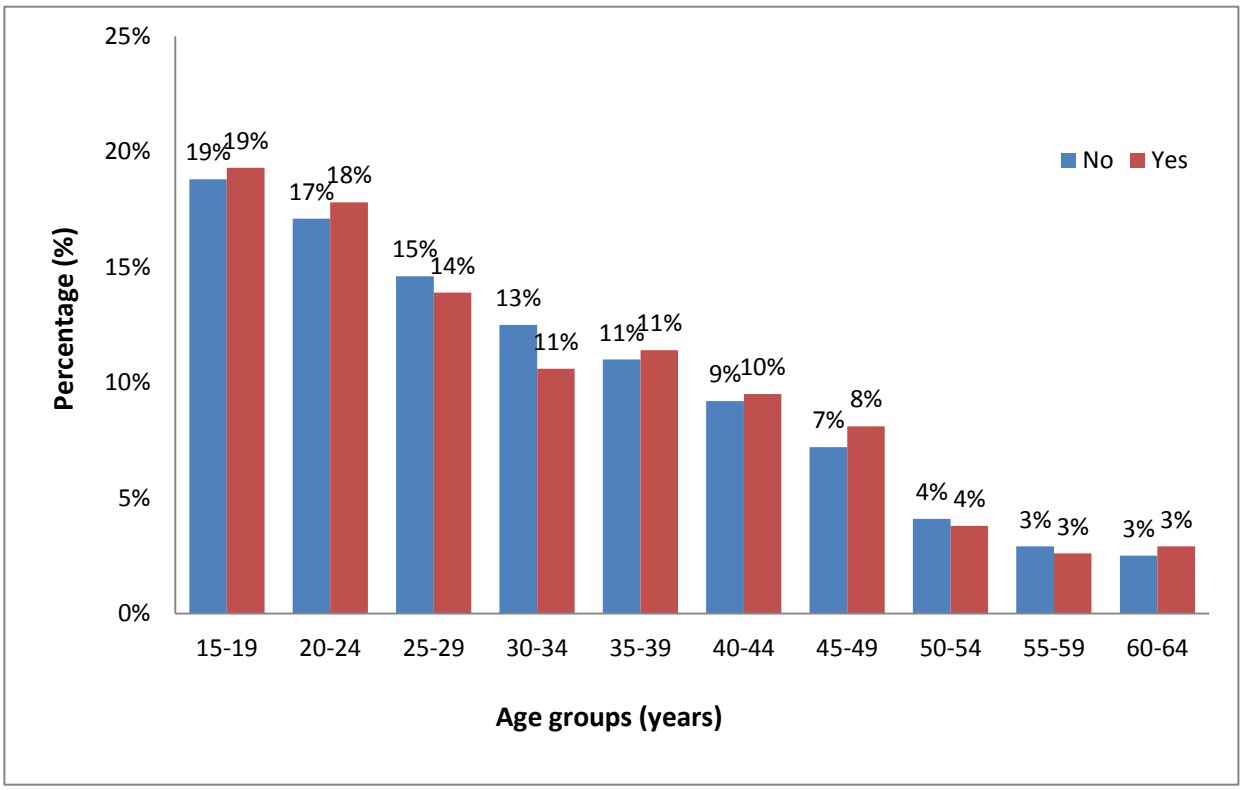

Figure 4.5: Mental health seeking behaviour by age group

The results show that there were more young people (15-19) that demonstrated a positive "yes" (19%) behaviour in seeking mental health treatments, followed by 20-24

(18%) and least were 55-59 and 60-64 years old (3%) respectively. This is an indication that most of the elderly people are not into seeking mental health treatments in comparison with young people.

4.4.2 Wealth and Mental health seeking behaviour by gender

Mental health seeking behaviour can be also influenced by gender (Figure 4.6).

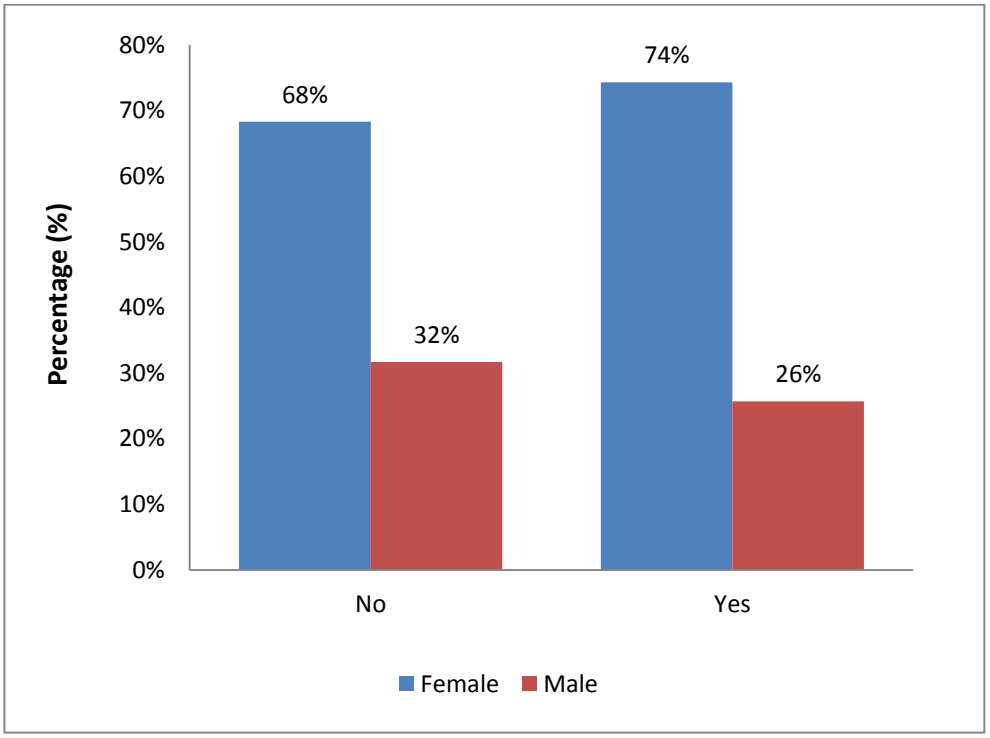

Figure 4.6: Mental health seeking behaviour by gender

The results show that there were more females that displayed a significantly high interest (positive behaviour) in seeking mental health treatment (74%), whereas males displayed only 26% of positive behaviour (yes) towards seeking mental health treatments.

4.4.3 Mental health seeking behaviour by political regions

Figure 4.7 shows mental health seeking behaviour by political regions of Namibia.

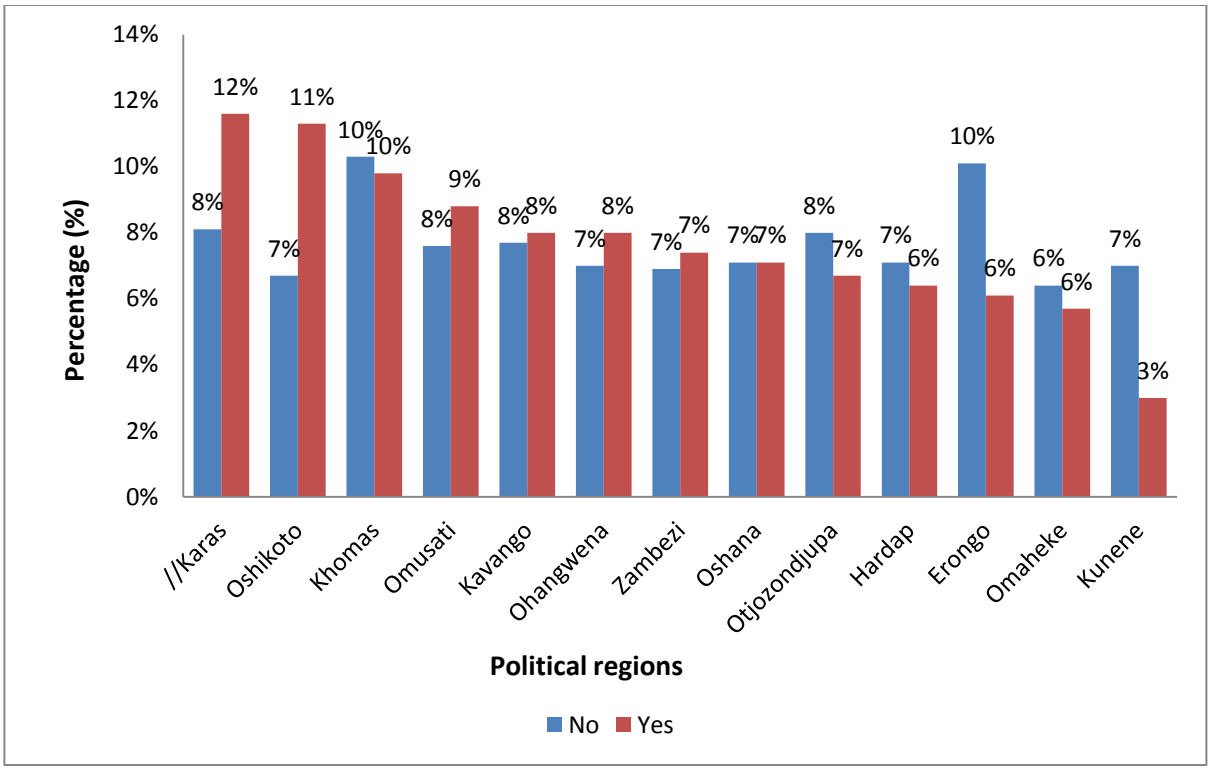

Figure 4.7: Mental health seeking behaviour by political regions

According to the results, there were more people that expressed a positive behaviour towards mental health treatments in //Karas Region (12%), followed by Oshikoto (11%) and Khomas (10%). There were few people that displayed positive behaviour towards seeking mental health in regions like Omaheke (6%) and Kunene (3%).

4.4.4 Mental health seeking behaviour by residence urban/rural

Figure 4.8 shows the relationship between mental health seeking behaviour and residence urban /rural.

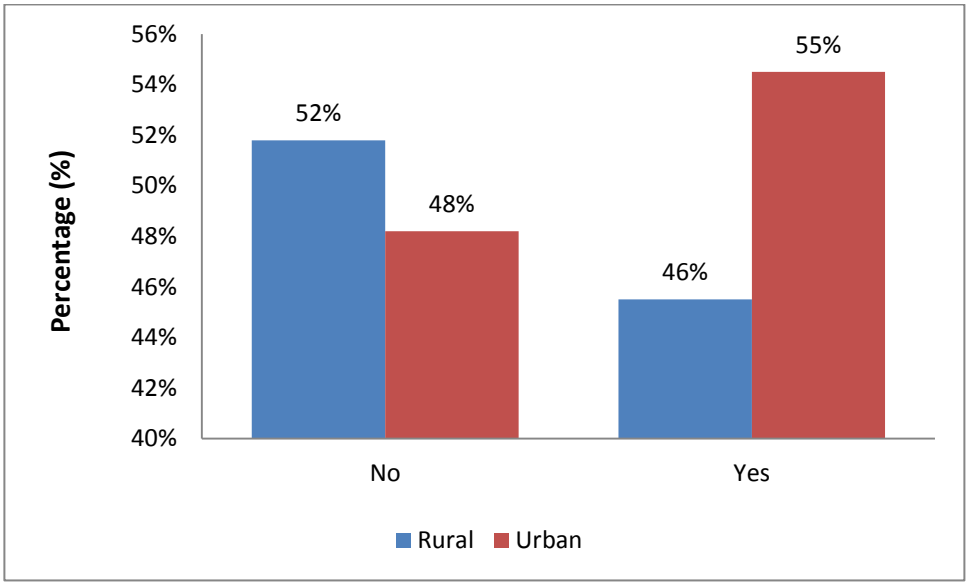

Figure 4.8: Mental health seeking behaviour by residence urban and rural

The results show that there were more people residing in urban areas (55%) that expressed positive behaviour towards seeking mental health treatment than those that resided in rural areas (46%). This means that majority of the people that seek mental health support/treatment are found in urban areas. This could be attributed to factors such as good medical facilities and access to awareness creation campaigns about mental health.

4.4.5 Wealth and mental health seeking behaviour

There was a slight difference in percentages of respondents with regular income and reporting if a member of the household had received all the treatment they needed. Accordingly, 65% participants reported they received regular income, while 35%

reported they did not. For both literacy and education, slightly lower percentages of those that were literate and those that had some formal education sought the health care. There seemed to be no disparity in health seeking tendencies among the different income brackets.

Table 4.6: Chi-Square Tests: wealth

	Value	***Df***	***Asymptotic Significance (2-sided)***
Pearson Chi-Square	*22.822*[a]	*4*	*.000*
Likelihood Ratio	*22.911*	*4*	*.000*
Linear-by-Linear Association	*21.033*	*1*	*.000*
N of Valid Cases	*4865*		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 162.29.			

4.5 DISCUSSION OF RESULTS

The main purpose of this cross-sectional study was to examine the health seeking behaviours among people who experienced mental health issues in Namibia. Further, the study sought to determine if the demographic factors and socio-econmic factors influences the health seeking behaviours of respondents who experienced mental health issues. The main purpose of this cross-sectional study was to examine the health seeking behaviours among people who experienced mental health issues in Namibia.

4.5.1 Help-seeking behaviours for mental health problems

According to the results of this study, people that experienced mental health issues in the age group 15-44 were more likely to seek medical care for mental disorders compared to

other age groups. It was found that more than one third of those suffering from mental disorders did not report any need for help and did not use any health care unit or informal help seeking. This is consistent with studies suggesting that most of young adults often do not seek help for a mental disorder[88].

According to the findings of this study, it was found that there is poor help-seeking behaviours among men comparing to their women equivalents. This might be explained by the masculinity traits in which ‘‘real men’’ are considered to be physically fit, careless of their health and self-sufficient[88] while young women are more perceived to be likely to make use of the most trusted people in their social environment to seek help, medical support and advice for mental health issues[89].

There is a finding which appears to show that there was no statistically significant difference between people who resided in urban areas and those who resided in rural areas. Rural residents were more likely to seek medical care than town dwellers [58]. Even in Namibia, the results show that this inescapable difference can be caused by people who reside in urban areas suffering more from mental health issues than those caused by mostly economic factors. Those who reside in rural areas do not like to seek medical help and are thus prone to mental health issues.

In general, people living in financial hardship are at increased risk of mental health problems and lower mental wellbeing. The relationship operates in two directions: being poor can bring about mental health problems (most commonly anxiety and depression), but mental health problems can also lead people into poverty due to discrimination in employment and reduced ability to work.

In addition, it was found that people in the lowest socioeconomic groups have worse health than those in the middle groups, who in turn have worse health than those in the highest. This ‘social gradient’ means that mental health problems are more common further down the social ladder.Importantly, it has been argued that the greater the income inequality in a society, the worse the social outcomes for that society as a whole. The social gradient is not a purely economic term, as it is compounded by cultural, relational and environmental influences.

4.5.2 Demographic factors

Having lower educational achievement has been associated with mental health problems in adulthood. Women with low levels of literacy are five times more at risk of depression than those with average or good literacy skills[96]. Similarly, dropping out of education has been associated with substance misuse, mood disorders and suicidal ideation[96].

Education is an important determinant of health-seeking behavior including factors such as treatment course completion, self-medication, when to visit a doctor. Studies have shown that implementing a behavioral model and educating people, significantly reduces the rate of mental health disorders. This study shows thatin Namibia, the more educated a person becomes, the less likely he/she has mental disorders. As expected, education was significantly associated with tendency to seek medical help. The study shows that participants with higher education qualifications (64%) had more compliance than the other groups. In this study, however, it is those with secondary education that were more likely to seek medical attention in comparison to other educational levels. Further, this

study identified a significant relationship between education and health seeking behaviour among respondents in Namibia. There is a strong evidence that students who have experienced school-age perpetration, victimisation, and/or witnessing of bullying behaviour will have an increased risk of experiencing a mental health problem. In fact, the evidence supports a causal association between exposure to bullying and victimisation in children and adolescents and adverse health outcomes including anxiety, depression, poor mental health, poor general health, non-suicidal self-injury, suicidal ideation and suicide attempts[73]. The relationship between education level and inattention to treatment was a negative one as well; showing educated people to be more concerned about their health probably because of better knowledge of the consequences of not receiving the appropriate treatment.

In the aggregate level data for the overall survey population in this study, gender was shown to have a significant influence on health care seeking behavior among people who have mental health issues in Namibia. For individuals overall, women were significantly more likely than men to report being sick and seeking treatment, once all other variables had been controlled for. Although most women are prone to mental disorders, they tend to seek mental health treatment more often than men. The causes of mental challenges encountered by women could be due to merit, relational issues, or abuse from the opposite sex. Gender based violence is rife in Namibia which may account for the majority of mental disorders in women.

Place of residence was found to have an impact on people's health-seeking behavior in Namibia. Villagers in the northern part of Namibia sought medical attention for illness

more often than urban populations. They self-medicated less than urban residents and had less inattention to treatment. In studies that showed more self-medication in rural people, the tendency to go for traditional medicine was noted[89]. This pattern was also detected in this study as city residents in Namibia visited drugstores as the main way of self-medication while village residents used herbal medicine instead. The difference observed between city and village residents in Namibia in terms of self-medication may reflect the difference in educational and economical status between these groups.

4.5.3 Socio-economic factors

The study shows that there is a statistical relationship between economic status and health seeking behaviour. The poor are more susceptible to mental disoders than the affluent. Those living in poverty or with financial insecurity need to be a priority group for preventative action. Not only can the stress and social problems attached to poverty and debt lead to mental health problems, but they can also worsen existing mental health problems and inhibit recovery. Education inequity can start at a very early age, with some young children being poorly prepared for the communication, social and emotional challenges of school and pre-school education. This can lead to a cumulative disadvantage in learning that has a lasting impact into adulthood.

The Health Survey for England has consistently found that people in the lowest socioeconomic class have the highest risk of a mental health problem[89]. Debt itself is an issue; people in debt are more likely to have a common mental health problems[89], and the more debt people have, the greater the likelihood[62. There is some evidence that problem debt (particularly housing debt) has a negative impact on mental wellbeing similar to that shown for marital breakdown and job loss[54].

However, a causal link is not yet proven[92], and the relationship can probably work both ways: personal debt may lead to some mental health problems, while mental health problems may also lead to being in debt. The risk to mental health of economic hardship starts early in life.

The inequalities that influence mental health can be the environmental factors related to income, and not the income itself. Further, these include factors such as parental education, neighbourhood violence and family benefit status. At country level, higher national levels of income inequality are linked to a higher prevalence of mental health problems. As countries become richer, but the distribution of this wealth remains unequal, the rates of mental ill-health increase. In Namibia, there is a need to narrow the economic gap between the rich and the poor through governmental initiatives.

Overall, research on mental health help-seeking behavior among people who have experienced mental health issues and stigma has demonstrated that stigma is a critical barrier to care equally at adult and youth ages. In particular, more recent studies conducted around the world on stigma and help seeking have focused on the roles of perceived stigma towards mental illness in one's social network and self-stigma in explaining help seeking intentions and behaviors.

4.6 Summary

The findings and discussion of results related to demographic and socioeconomic factors impacting mental health seeking behavior among Namibians who experienced mental health disorders was covered in this chapter. According to the findings of this study, men demonstrated weaker help-seeking behaviors than their female counterparts. The study looked at a wide range of variables related to aspects of seeking medical attention:

socio-economic factors and demographic characteristics that includes medical service accessibility. The next chapter will discuss the conclusion and recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of results

In this chapter the results were discussed, recommendations were given, and conclusions were drawn. In this study, the health-seeking behaviours of individuals with mental disorders were examined. The results of the information gathered show many similarities across the population who have experienced mental health issues. Over all regions, women were more likely than men to seek formal health care treatment. The older the participant, the less likely they were to seek medical care. If participants had regular income, a member of their household was more likely to seek treatment.

It was found that the medical seeking behaviour of people who experienced mental health issues tend to be dependant on both demographic and socio-economic factors such as age, gender, place of residence, educational level, region from which the respondent comes from and employment status among other factors. Women are more likey to develop mental challenges than men. However, women are likely to seek medical care than men. Although the age group from 15-44 is more susceptible to encounter mental health challenges, they tend to seek medical attention than those from age 45 and above. Rural resopndents are more likely to seek medical care compared to urban dwellers. The other finding from this study is that individuals in the poor and poorest wealth quintiles were less likely to seek treatment. Rural areas especially in developing countries are also often distinguished for their lower rates of literacy and education, and often lower income.

In Namibia, there are many barriers to accessing mental health services and these barriers need to be removed to ensure that every resident can access the services. It is important to focus on tackling barriers at the personal and environmental level and on removing barriers encountered at the interface between service user and healthcare provider. The barriers to accessing mental health services include but not limited to economic (financial resources), social, educational and geographical location (political regions). Incentives to remove barriers may include raising awareness of mental health and reducing stigma; raising awareness of services and access pathways. Raising awareness of mental health can reduce stigma and help individuals to recognise symptoms. To add,this may encourage health seeking behaviour at an earlier stage of presentation, including talking therapy.

Namibia is comprised of peoples of different ethnic; socialization; social class; geographic zones and culturalization, and this accounts for a difference in belief systems and health behaviours. This disparity must be taken into consideration when designing public health programmes.

5.2 Conclusions

The current study highlighted the importance of medical care seeking behaviours, especially for people who experienced mental health issues in Namibia.. Further, the study intended to establish how the medical care seeking behaviours and/or seeking medical care is influenced by demographic factors and socio-economic factors. Besides, this project helped bring knowledge and better understanding of barriers to health care seeking behaviours.

These analyses were conducted in hopes of influencing policy and practice relating to making mental health care accessible even to the most remote-dwelling people, using the most flexible form of health care delivery.

Respondents' characteristics such as level of education, age group, gender, belonging to higher socio-economic status quarntile, place of residence and region from which the respondent comes from were significantly associated with health care seeking behaviour. The knowledge generated can be used in providing good services, affordability of such services and proximity were considered the most important service characteristics in seeking health seeking behaviour. The quality of care provided at health facilities also requires attention as mentoring, supportive supervision and other measures could be embarked upon in order to improve quality of care.

The results add to the body of evidence, suggesting that for common mental disorders, it is important to consider dependent factors when considering influences on help-seeking, but also to find ways to remove barriers to service accessibility. The current study revealed that health behaviour is a function of socio-demographic variables. Poverty which is synonymous to rural areas influences people choice in visits to health care facilities. An interesting consideration of rural residence with those than residents of other geographic zones is the culture and its influence on health care-seeking behaviour and other such decisions. The findings of this study suggests that health service professionals need to increase awareness about the benefits of purchasing prescribed medication, and that this must be more so for rural and urban residents.

Research is needed to understand how and to what extent knowing someone with a mental illness can change help-seeking behaviours. For example, whether these behaviour are mediated by increased mental health-related knowledge, more positive attitudes towards psychiatric treatment, or a change in perceived social norms regarding help-seeking. This understanding is important, since population level anti-stigma programmes have to decide whether to try and promote familiarity by encouraging discussion among people already familiar with each other, and/or whether to encourage well known role models with personal experience to disclose this in a way that effectively mimics the impact of personal familiarity.

From the above conclusion, it can be seen that the first objective, which is to determine the demographic factors that influence the medical care-seeking behaviour of people who experience mental health issues in Namibia, and the second objective, which is to determine the socioeconomic factors that influence the medical care-seeking behaviour of people who experience mental health issues in Namibia, were both sufficiently answered by this study.

5.3 Recommendations

In order for the care of people with mental health problems to be effectively implemented, attitudes and behaviours towards these conditions must the transformed. Practices such as using community health workers and peer-based support to refer and monitor less severe mental illnesses may offer effective, efficient and sustainable solutions to improving on the significant lack of trained psychiatric specialists in Namibia.

The study recommends the following:

- Thus, policy formulation and implementation by the Ministry of Health and Social Services (MoHSS) and relevant stakeholders such as the World Health Organization (WHO) should be directed towards improving access to mental healthcare services. This can be done by increasing the number of mental health facilities in under-served areas.
- A cross-cultural approach that takes into account the requirements such as cultural diversity and those of individual communities should be applied by the stakeholders such as MoHSS, including other health stakeholders. In the end, it should include both local ways of doing things and the local languages people use to talk about their mental health needs.
- Mental health issues and services should be promoted as a priority through Mental Health Champions (MHC) to ensure a wide dissemination of consistent and coherent messages about mental health in the regions in Namibia. This responsibility lies in the hand of MoHSS, Non-Governmental Organizations (NGO's) and the media for extensive coverage.
- The MoHSS, media and other relevant stakeholders should address stigmatisation of mental health problems through increased awareness, greater prioritization of treatment, and enhanced support and health and/or mental health education.
- The MoHSS and academic institutions should offer training of health care workers to recognise common forms of mental illness, especially at the first point

of contact, and the provision of necessary interventions should be a prioritized health investment in Namibia.

- The government of the Republic of Namibia should play a vital role and take steps forward to improve mental health status of the people. It should conduct regular surveillance to collect the data regarding the prevalence, type of mental illness and conduct surveys for accessibility of mental health services in the different regions of the country, so that accurate services can be developed and implemented.

5.4 Direction for future research

Taken together, the results of the study suggest that future research consider other factors such as stigma when studying help seeking behaviours for mental health issues, particularly common mental disorders. For example, a recent quantitative systematic review of attitudinal barriers to medical-care seeking behavior among people who have experienced mental health issues identified the meaning that individuals ascribe to such symptoms as important. Other work has highlighted practical barriers to access due to work-force shortages or cost, including in countries where health systems are well developed [93].

A further implication for research on help-seeking for mental health problems is the need to distinguish between mild and common problems versus those that are less common and more severe, as the influences on help-seeking for each may differ [94]. To add, this may include the effect of stigma and the influence of peer behaviour. Further, it is important to study whether these influences are changing over time, and whether help

seeking for mild and common disorders versus severe mental illness is becoming easier or harder as a result of the overall combination of influences.

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APPENDIX

Appendix A: Ethical Cleareance Certificate from the University of Namibia

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: OSHAC /593/2020 Date: 19 November, 2020

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Demographic And Socio-Economic Factors Influencing Medical Care Seeking Behaviour Among People Who Experienced Mental Health Issues In Namibia

Researcher: TJIMUINE *KUARA*

Student Number: *200828835*

Supervisor: *Dr A P K Shilunga*

Campus: Oshakati Campus

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the HREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the HREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by HREC.
(d) The HREC retains the right to:

(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research;
(iii) Cognizance and the observation of Namibia's Research Science and Technology Act, 2004 which makes it compulsory for Non-Namibian based researchers to obtain the compulsory Research Permit from the National Commission on Research Science and Technology (NCRST), FIRST, BEFORE the research can commence.

HREC wishes you the best in your research.

Dr. J.E. de Villiers HREC Chairperson

Ms. P. Claassen: HREC Secretary

Appendix B: Application to the Ministry of Health and Social Services to conduct research project.

February 23, 2021

Office of the Executive Director
Ministry of Health and Social Services,
Directorate of Information System and Research,
Windhoek

RE: Application to conduct research project under the title: DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS INFLUENCING MEDICAL CARE SEEKING BEHAVIOUR AMONG PEOPLE WHO EXPERIENCED MENTAL HEALTH ISSUES IN NAMIBIA

Dear Dr. Ben Nangombe, **Executive Director** – Ministry of Health and Social Services

I am Kuara Tjimuine, a Public Health Master student from the University of Namibia. To fulfill the requirement of my degree, it is expected of me to conduct this study. I am writing to your office applying to conduct a research project titled: DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS INFLUENCING MEDICAL CARE SEEKING BEHAVIOUR AMONG PEOPLE WHO EXPERIENCED MENTAL HEALTH ISSUES IN NAMIBIA. The study will require the NDHS 2013 secondary data that I hope will benefit the Ministry and possibly the entire community of Namibia.

My research is based on the behaviours regarding the usage of mental health services in Namibia. I'm conducting this research with the interest of learning more about the factors that in any way affect the search for mental health services in Namibia. The purpose of this study is to develop and implement community-based education programmes on mental health and enhance the development of a sense of psychological need in Namibia. The results of this study will be released in a thesis.

The choice for NDHS 2013 secondary data was based on that although the NDHS 2013 provided the prevalence and distribution of mental health symptoms and indicated that a large segment of people with mental illness symptoms did not seek medical care, it did not do further analysis to explain why medical care seeking is very low, at least on the basis of the variables that the survey collected data on. NDHS 2013 data will be analysed with the hope of learning more about concerns influencing the use of mental health services in Namibia.

Any identifying details will not be required, but only averaged information. No names will be recorded anywhere in the study, and no link will be traced to any individual who participated in the survey. Only the researcher and his supervisor(s) will have access to the unlinked information. All individual information will remain confidential.

If the Ministry feels the need to talk to me after I access the data and/or after the analysis of such data, the Ministry can contact me on this number: +264 81 349 3018 (Namibian cell phone number). After completion of this study, I would like to come back and give feedback about my study results and future actions.

I believe my application to conduct this study will be kindly considered by your esteemed Office. Looking forward to hearing your Office.

Yours sincerely,

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Mr Kuara Tjimuine
Master of Public Health (UNAM)
Email: ktjimuine@yahoo.com
Cell: +264 81 349 3018

Appendix C: Permission letter from the Ministry of Health and Social Services.

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE EXECUTIVE DIRECTOR

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 17/3/3/KT
Enquiries: Mr. A. Shipanga

Date: 10 March 2021

Mr. Kuara Tjimuine
PO Box 41143
Ausspannplatz
Windhoek

Dear Mr. Tjimuine

Re: Demographic and socio-economic factors influencing medical care seeking behavior among people who experienced mental health issues in Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   - 3.1 The data to be collected must only be used for academic purpose;
   - 3.2 No other data should be collected other than the data stated in the proposal;
   - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   - 3.5 Preliminary findings to be submitted upon completion of the study;
   - 3.6 Final report to be submitted upon completion of the study;
   - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

BEN NANGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director.

Appendix D: Permission letter from ICF to access and use DHS secondary data

May 27, 2021

Kuara Tjimuine
University of Namibia
Namibia
Phone: +264813493018
Email: ktjimuine@yahoo.com
Request Date: 05/26/2021

Dear Kuara Tjimuine:

This is to confirm that you are approved to use the following Survey Datasets for your registered research paper titled: "DemoDEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS INFLUENCING MEDICAL CARE SEEKING BEHAVIOUR AMONG PEOPLE WHO EXPERIENCED MENTAL HEALTH ISSUES IN NAMIBIA":

Namibia

To access the datasets, please login at: https://www.dhsprogram.com/data/dataset_admin/login_main.cfm. The user name is the registered email address, and the password is the one selected during registration.

The IRB-approved procedures for DHS public-use datasets do not in any way allow respondents, households, or sample communities to be identified. There are no names of individuals or household addresses in the data files. The geographic identifiers only go down to the regional level (where regions are typically very large geographical areas encompassing several states/provinces). Each enumeration area (Primary Sampling Unit) has a PSU number in the data file, but the PSU numbers do not have any labels to indicate their names or locations. In surveys that collect GIS coordinates in the field, the coordinates are only for the enumeration area (EA) as a whole, and not for individual households, and the measured coordinates are randomly displaced within a large geographic area so that specific enumeration areas cannot be identified.

The DHS Data may be used only for the purpose of statistical reporting and analysis, and only for your registered research. To use the data for another purpose, a new research project must be registered. All DHS data should be treated as confidential, and no effort should be made to identify any household or individual respondent interviewed in the survey. Also, be aware that re-distribution of any DHS micro-level data, either directly or within any tool/dashboard, is not permitted. Please reference the complete terms of use at: https://dhsprogram.com/Data/terms-of-use.cfm.

The data must not be passed on to other researchers without the written consent of DHS. However, if you have coresearchers registered in your account for this research paper, you are authorized to share the data with them. All data users are required to submit an electronic copy (pdf) of any reports/publications resulting from using the DHS data files to: references@dhsprogram.com.

Sincerely,

Bridgette Wellington

Bridgette Wellington
Data Archivist
The Demographic and Health Surveys (DHS) Program

Appendix E: Secondary Data Extraction Form

			Demographic and Socio-economic factors inflencing medical-care seeking behaviour among people who experienced mental health issues in Namibia							
Variables/Background Characteristics										
Record Number	CASEID	Sex - Male/Female	Age in years	Place of residence - Rural/Urban	Region	Education	Wealth Quantiles	Mental Health Symptoms	Experienced Symptoms	Sought medical care
1	aa	Male	15-19	Rural	Zambezi	No education	Lowest	Ever seen/heard things that are actually not there.	Yes	Yes
2	bb	Female	20-24	Urban	Erongo	Primary	Second	Felt seriously worthless, hopeless, or wished to be dead in the past 12 months.	No	No
3			25-29		Hardap	Secondary	Middle	Ever felt that you had a little interest or pleasure in doing things in the past 2 weeks.		
4			30-34		//Karas	More than secondary	Fourth	Ever felt low in energy, been in a bad mood, or been sad all of the time.		
5			35-49		Kavango		Highest	Ever sought any medical care.		
6			50-54		Khomas					
7			55-59		Kunene					
8			60-64		Ohangwena					
9					Omaheke					
10					Omusati					
11					Oshana					
12					Oshikoto					
13					Otjozondjupa					
n=	ab									
Definition of variables:										
1. Record Number - Serial number constituting the number of participants from participant number to the last partcipant.										
2.CASEID - A case identification used to uniquely identify each respondent in the study.										
3. Sex - Relates to the biological categorization based on reproductive potential as used in the study.										
4. Age - Categorization of participants into age groups from 15 years as youngest partcipant and 64 years as oldest participanyt according to the study.										
5. Place of Residence - Refers to place residence where participants live as categorized by the study as urban or rural.										
6. Region - Areas or zone on which participants were organized or lived in the country.										
7. Education - Level of education of participants in the study.										
8. Wealth quantiles - Holdhold wealth of partcipants according to the study.										
9. Mental Health Symptoms - The mental health symptoms the participants indicated to have experienced.										
10. Number of Symbtoms - Number of mental health symptoms participants ever experienced.										
11. Sought Medica Care - Whether participant ever sought medical care for the symptoms experienced.										