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Research report

Help-seeking behaviour, barriers to care and experiences of care among persons with depression in Eastern Cape, South Africa

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ABSTRACT

Background: Little is known about the help-seeking behaviour and barriers to care among people with depression in poor resource settings in Sub-Saharan Africa.
Methods: This is a cross-sectional population-based study including 977 persons aged 18-40 living in the Eastern Cape Province in South Africa. The prevalence of depression was investigated with the help of a questionnaire (the Mini International Neuropsychiatric Interview). Several socio-economic variables, statements on help-seeking and perceptions of earlier mental health care were included. Data collection was performed from March to July 2012.
Results: The prevalence of depression was 31.4%. People aged 18-29 and those with no or low incomes were less likely to seek help. Promotive factors for help-seeking included having social support and tuberculosis comorbidity. Of all people with depression in this sample, 57% did not seek health care at all even though they felt they needed it. Of the variety of barriers identified, those of most significance were related to stigma, lack of knowledge of their own illness and its treatability as well as financial constraints.
Limitation: Recall bias may be present and the people identified with depression were asked if they ever felt so emotionally troubled that they felt they should seek help; however, we do not know if they had depression at the time they referred to.
Conclusions: Depression is highly prevalent among young adults in the Eastern Cape Province, South Africa; however, many do not seek help. Health planners should increase mental health literacy in the communities and improve the competence of the health staff.

1. Introduction

Depression lowers quality of life, affects socio-economic prosperity, education and employment (Lund et al., 2010) and affective disorders are prevalent in 59% of suicides (Cavanagh et al., 2003), contributing to a substantial proportion of global morbidity and mortality(Bertolote and Fleischmann, 2002). Despite the pervasive effects of depression, little attention has been given to research and health planning in low and middle income countries (LMICs) which has resulted in a lack of detection, treatment and a shortage of trained staff (WHO, 2008a; Saxena et al., 2007; Saraceno et al., 2007). Since 2008, the World Health Organization (WHO) has increased its effort in addressing this unmet need (mhGAP) (WHO, 2008b), but the treatment gap is still large (WHA, 2012) and evidence-based studies on the availability of and barriers to health care is scarce (Lancet, 2007; WHO, 2008b). This paper explores the help-seeking behavior and barriers to care among persons with depression living in the Eastern Cape, South Africa.

1.1. The burden of depression and the unmet need

In the few population-based studies that have been published on depression in Sub-Saharan Africa (Nigeria, Ethiopia, Uganda and South Africa), prevalence rates vary greatly: lifetime prevalence 3.1–9.7% (Gureje et al., 2010; Herman et al., 2009; Kebede and Alem, 1999; Stein et al., 2008; Tomlinson et al., 2009), and current or 12-month prevalence 1.1–47% (Bolton et al., 2004; Gureje et al., 2010; Herman et al., 2009; Kebede and Alem, 1999; Mogga et al., 2006, Nyirenda et al., 2013; Ovuga et al., 2005; Rochat et al., 2011, Stein et al., 2008; Tomlinson et al., 2009). In the South African Stress and Health (SASH) study performed between 2003 and 2004, the lifetime prevalence of depression was 9.7% and the 12-month

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prevalence was 4.9%. (Tomlinson et al., 2009; Herman et al., 2009; Stein et al., 2008) and only 8.2% of those with a lifetime prevalence of depression had consulted a psychiatrist during the last year (Tomlinson et al., 2009). In the Eastern Cape, the lifetime prevalence of mood disorders was 8.3% (Herman et al., 2009). Seedat et al. (2009) found in another SASH study by that only 6.6% of men 18.5% of women with a 12-months mood disorder and 16.6% of men and 20.6% of with any 12- months DSM-IV disorder had used any health care (general medical health care or mental health care) within the last 12 months.

1.2. Perceived barriers to health care

Earlier studies from Africa have identified reasons as to why people do not seek health care when they suffer from a mental illness such as not being able to identify that the illness is a treatable disorder and beliefs that they would recover without treatment (Trump and Hugo, 2006), not knowing where to go or feeling embarrassed (Seedat et al., 2002) and beliefs that the mental illness is a somatic illness (Okello and Neema, 2007). Stigma and misconceptions about the cause and severity of mental illness (Corrigan, 2004; Sartorius, 2007) are common barriers especially in poor resource settings where local culture and religion have a profound impact on people's lives (Crawford and Lipsedge, 2004; Ae-Ngibise et al., 2010). Crawford and Lipsedge (2004) highlighted that Zulu people in South Africa found Western medicine useful for treating physical illness, but not mental illness since many mental health problems were considered to be understood only by traditional healers from their own culture.

1.3. Lack of treatment and the effects on population health

Lack of evidence-based treatment increases the individual's suffering, risk for poverty and social exclusion (Prince et al., 2007). Furthermore, if depression is not treated it may increase the spread of infectious diseases, such as HIV and sexually transmitted infections through risky behavior such as alcohol and substance abuse and unprotected sex (Khan et al., 2009). The prevalence rate of HIV/AIDS in South Africa is as high as 17.8% among adults aged 15–49 (UNAIDS, 2012) and untreated depression among such people may be a risk for low adherence to antiretroviral treatment (ART) (Nel and Kagee, 2011). A recent review study from Sub-Sahara Africa found that the likelihood of good adherence to ART was 55% lower among persons with depressive symptoms compared to persons with no sign of depression (Nakimuli-Mpungu et al., 2012). In the Eastern Cape Province in South Africa, the HIV prevalence in the general population was approximately 10% in 2011 (SANAC, 2011) and among pregnant mothers aged 15–49 years, 28.1% in 2009 (Department of Health, 2010). Untreated depression among mothers may also affect the child's health through a lack of caring ability, leading to infections and malnutrition which affects the child's physical and mental health and cognitive development (Avan et al., 2010; Rahman et al., 2002).

1.4. Health care for people with mental illness—A human right

Although the right to health (an abbreviation for the right to the enjoyment of the highest attainable standard of physical and mental health) is a self-standing human right found in numerous legally binding international and regional human rights treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), the UN Convention on the Rights of Persons with Disabilities (CRPD) and the regional treaty of the African Charter on Human and People's Rights (Banjul Charter), there are numerous instances where people with mental illness have not received treatment and in many cases have been neglected and maltreated (Drew et al., 2011). Furthermore, although the comorbidity of physical and mental illness is high, mental illness has received very little attention from health and human rights authorities, especially in LMICs (Prince et al., 2007). South Africa is signatory to ICESCR and has ratified CRPD and the regional African treaty. Thus, South Africa has legally committed itself to respect, protect and fulfill this right and ensure that all South Africans, including people with mental illness, are able to realize this right to health. In order to fulfill this right evidence-based studies are needed to provide information on how the population with mental illness experiences their right to health. According to our knowledge, it has not previously been investigated as to how the population in the Eastern Cape Province, the poorest of the nine provinces in South Africa, experiences these issues. Therefore, we investigate among persons with depression, the prevalence, their help-seeking behavior, their barriers to mental health care and their experiences of previous health care visits; factors all related to the right to health.

2. Methods

2.1. Population and setting

This is a cross-sectional study performed in the Eastern Cape Province in South Africa. Included in this study are 977 men (52%) and women (48%) aged 18–40 years old. The age group was chosen since the onset of mental illness is generally during adolescence and young adulthood and has a profound impact on health and socio-economic prosperity if not treated (Patel et al., 2007). The study was performed in the Nelson Mandela Bay Metropolitan Municipality of the Port Elizabeth area (1005,780 inhabitants) and the Kirkwood area in the Cacadu District Municipality (412,000 inhabitants) in order to make urban and rural comparisons. Data collection ended July 2012 when the time limit was reached.

2.2. Sampling

A randomized sample of 1000 individuals was selected for this study. A sample size calculation with assumed life time prevalence of psychiatric disorders at 20% among unexposed, alpha value of 0.05 and power of 0.80 to detect an increase of 10 percent units in the exposed group resulted in a required sample size of 630 with equal number of unexposed-exposed. An additional 370 individuals were included to permit gender stratified analyses. A multi-staged sampling process was conducted as follows: *Stage 1: Selection of EAs*: For the purposes of the national census, the country has been divided into enumerator areas (EAs), each EA containing approximately 500 people. Port Elizabeth consists 1196 EAs and Kirkwood has a total of 13 EAs. These EAs were used as the basis for the sampling. EAs were randomly selected from Port Elizabeth and Kirkwood and based on regional distribution (urban, semi-urban and semi-rural) and race (Black, White and Coloured) to ensure a representative sample of the South African population. Randomisation of EAs was done by a professional statistical firm, using Hawth's Analysis Tools for ArcGIS (SpatialEcology, 2013) together with the support of population statistics estimates (Stats South Africa, 2011). The 1196 EAs were divided into three large racially dominant geographic areas and the 80 EAs selected resulted in a representative distribution of the demographic race profile of South Africa. In the Port Elizabeth area, 80% of the EAs were randomly selected from Black residential areas, 10% from White residential areas and 10% from Colored residential areas. Random sampling of the EAs in the Kirkwood area was unnecessary as there are only 13 EAs. In the Kirkwood area 20% of the sample was drawn from the urban area (the majority of which are White) and 80% was drawn from the