

Mental Health Advocacy in The Gambia, West Africa

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Abstract

Introduction: To promote mental health globally, including low-and middle-income countries, research and advocacy are essential. The Republic of The Gambia is one of the smallest countries in the world and is the focus of this research.

Purpose: This study examines social and cultural aspects of access to mental health treatment in The Gambia, West Africa.

Methodology: The population of focus consisted of adults over 18 living in The Gambia. The methodological approach was a qualitative phenomenological study involving semi-structured interviews conducted via Zoom, by a researcher from The Gambia.

Results: Data were collected from 17 participants living in The Gambia at the time of the study. A team of analysts with diverse backgrounds evaluated transcripts and identified five themes highlighting social and cultural conceptualizations of mental health and mental illness, sociocultural determinants of health, interventions, barriers to care, and legal frameworks to support mental health change.

Conclusions: The findings from this study are significant for mental health providers who seek to understand different perceptions of mental health and mental illness and the associated stigma. Furthermore, this study suggests several opportunities for mental health advocacy in The Gambia.

Keywords

mental illness, mental health, The Gambia, Africa, stigma

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Introduction

The Republic of The Gambia, commonly known as The Gambia, is a former British colony that gained independence in 1965. It features a democratic system of government consisting of three branches: the legislature, the judiciary, and the executive. The president of the republic is the head of the executive branch and is assisted by a vice-president and a cabinet of ministers. The Gambia is one of the smallest countries in the world, with an estimated population of 2.2 million people (World Health Organization (WHO), 2018). According to The Gambia Bureau of Statistics (GBOS, 2013), more than half of the population is female, and over 63% are youth. Moreover, approximately 50% of the population lives in rural regions, which comprise 60% of the country (GBOS, 2013). The Gambia is also one of the poorest countries in the world, with an estimated gross domestic product per capita of \$773 in 2020 (World Bank Group, 2022). The mental health services comprise one community mental health team and an in-patient unit called Tanka Tanka Psychiatric hospital (Kretzschmar et al., 2012).

The exact prevalence of mental illness in The Gambia is unknown. A situational analysis of mental health conducted by the Mental Health Leadership and Advocacy Program (MHLAP) in 2012 revealed that, of an estimated population of 1.478 million people, approximately 120,000 had a mental disorder (MHLAP, 2012). Since then, the size of the population has nearly doubled, but no recent studies have been conducted on the prevalence of mental illness in the country. Global Burden of Disease (GBD) statistics from 2017 indicated that more than 34% of Gambians have a depressive disorder and 35.9% have an anxiety disorder. Mental health stigma has been identified as a factor significantly affecting people with mental health problems in The Gambia.

Stigma is a pervasive condition that often discredits individuals and leaves them feeling lesser than others (Abdullah & Brown, 2011; Goffman, 1963; Monteiro, 2015). The plethora of emerging research on mental health stigma in low- and middle-income countries (LMICs) highlights the role of culture and cultural differences in conceptualizations and understandings of mental health (Amuyunzu-Nyamongo, 2013; WHO, 2012, 2014). In The Gambia, explanatory beliefs about the causes and attributions of mental illness and associated labels are stereotypical, isolating, discriminating, and stigmatizing toward those with mental health issues, which may result in

mental health stigma. Empirical studies have provided a foundational understanding of the scale, nature, and lack of access to necessary mental health services (Barrow, 2016; Barrow & Faerden, 2022; Coleman et al., 2002). These studies have mentioned the need for better information on the role, association, and impact of stigma on care-seeking attitudes and as a deterrent to service utilization. An investigation of lived experiences of mental health stigma would generate significant findings and serve as a resource for the Gambian government, which plans and implements services, and nongovernmental organizations and institutions that provide mental health services. Such an investigation could address the 90% treatment gap (MHLAP, 2012).

Given the multitude of needs, it is essential to prioritize those that are most fundamental to health, including access to treatment and addressing stigma. Although MHLAP (2012) indicated that it did not specifically examine mental health stigma, this factor likely influences service underutilization. Mental health in The Gambia is rooted in culturally nuanced concepts and understandings that significantly impact the social identity of people with mental health disorders. Furthermore, they define treatment pathways and modalities for mental health care and fuel the public stigmatization of mental health issues.

The globalization and decolonization of mental health in Africa have led researchers and scholars to call for action to extend the bio-psycho-social framework of mental health assessment, diagnosis, and treatment on the continent (Monteiro, 2015). The bio-psycho-social model has long been used in contextual approaches to mental health interventions in low to middle-income countries (LMICs) in response to the need to address factors that determine or improve mental health (Engel, 1977). Research has examined systemic and structural factors in mental health, such as lack of funding, limited healthcare infrastructure, lack of mental health policy and laws, and mental health stigma and discrimination (Akinsulure-Smith & Conteh, 2018; Becker & Kleinman, 2013; Monteiro, 2015). Although such a model has increased overall mental health status in LMICs, mental health remains a stigmatized and neglected area of health and well-being in these countries. Furthermore, due to the widespread prevalence of mental illness, it has been described as an epidemic in LMICs (Hohenshil et al., 2015; Monteiro, 2015). As an LMIC, The

Gambia shares similar systemic and structural problems as many other African countries with regard to the prioritization and delivery of mental health care (Akinsulure-Smith & Conteh, 2018).

One way to conceptualize views of mental health in The Gambia is through the ecological systems theory of human development, which can be helpful for examining mental health care and access (Bronfenbrenner, 1977). Ecological systems theory considers the influences of multiple systems at different levels, which interact to influence individuals' lived experiences and the systems that surround them (Crawford, 2020). According to this theory, human development results from interactions between developing human organisms and environments at five significant levels: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem consists of a person's immediate environment and includes their personality, beliefs, and temperament. The mesosystem refers to the connection between different microsystems. For example, elements of the microsystem affect the individual's experiences (e.g., how school and home interact). Both the microsystem and the mesosystem must include the individual.

Systems that affect environments at the meso level but do not include individuals are the exosystem, which consists of microsystems interacting with each other. However, at least one of the microsystems does not include the individual at the center of the system. For example, a parent's workplace does not include the child, but the latter could be affected by characteristics of the parent's workplace (e.g., the parent is required to work long hours or stressed from work). However, because the child is not part of the parent's work environment, the workplace is not part of their microsystems or mesosystems. The macrosystem influences the characteristics of interactions between different systems; in other words, it influences the "social design" of the broader culture or subculture. For example, family culture develops within a family in the microsystem, which is influenced by the mesosystems and exosystems of each family member. All of these systems are then affected by broader society and culture. Bronfenbrenner emphasized the importance of cultures within groups and the exchange patterns within and among groups. This theory emphasizes the reciprocal effects of these different systems on personality development and social and psychological outcomes

(Crawford, 2020). Thus, ecological systems theory provides an essential perspective for investigating West Africa, access to mental health care, and associated stigma. This study begins by examining individual perspectives, then identifies themes through a phenomenological interpretive analysis. In the discussion of the findings, these themes are viewed through the lens of ecological systems theory to provide insight on how different levels of frameworks interact in the context of one's life.

The significance of this study cannot be underscored enough in the context of opportunities for mental health advocacy in The Gambia. First, as an LMIC, The Gambia should make mental health a public health priority. Mental health is a global pandemic, and the treatment gap for mental illnesses is between 76% and 85% in LMICs, compared to 35% to 50% in high-income countries (Barrow, 2016; Evans-Lacko et al., 2012). This wide treatment gap necessitates an investigation of factors that impact this disparity.

Second, Patel and Prince (2010) investigated the intersection of treatment outcomes and care-seeking behavior to bridge this treatment gap. They posited that current interventions utilized in African mental health care are ineffective without behavioral change. Furthermore, Summergrad (2016) underscored the need for early intervention to avoid secondary effects not only with regard to general health goals but also socio-economic development in particular. Therefore, qualitative and quantitative research are greatly needed to understand the nature and scale of the problem (Barrow & Faerden, 2022). With this in mind, the current counseling-, advocacy-, and social justice-focused research can provide a better understanding of how mental health is experienced and thus inform interventions.

Third, although the Gambian government has acknowledged mental health care as a priority, it has not yet implemented a framework for developing a viable system. Although The Gambia has developed a mental health policy for 2021–2030 and validated a mental health bill in 2019 to legislate mental health laws, this has not yet been implemented or enacted. Extant mental health legislation consists of the Lunatic Act (1964). Therefore, the findings from this study could inform mental health policy development and bring The Gambia in line with its obligations under the Convention on the Rights of Persons with Disabilities (2008), which it ratified.

Fourth, mental health care interventions must be decolonized in The Gambia. The current counseling and social justice research aim to reflect cultural and social understandings of the research phenomena and facilitate closer understanding, empathy, and more interactions with people with mental illness. This study is well-situated for this facilitation through its inquiry into the social and cultural factors that impact mental well-being. To approach a study with cultural humility, a term coined by Tervalon and Murray-Garcia (1998), health practitioners must exercise restraint in applying previously acquired cultural knowledge to avoid perpetuating power imbalances in the therapeutic setting (Zhu et al., 2021).

Purpose

This qualitative phenomenological study aims to explore and understand experiences of mental health and the role of mental health stigma among adults in The Gambia. To this end, two research questions were developed for the study. The first research question is, "What are the lived experiences of mental health among adults in The Gambia?" The second research question is, "What is the lived experience of mental health stigma among adults in The Gambia?" No hypotheses were developed due to the qualitative nature of the study.

Methodology

Study design

The philosophical ideals that underpin this study are grounded in phenomenology and social constructivism, which assume that absolute realities do not exist. Instead, realities are constructed through subjective experiences shaped by the environment and social interactions (Moustakas, 1994). A phenomenological approach recognizes the subjectivity of participants through their interpretation of the truth, not what is attributed to or imposed on them by the researcher (Moustakas, 1994). Therefore, several steps were followed to gather qualitative data after the institutional review board granted approval for the study. No intervention was undertaken, as this study is qualitative in nature and focuses on participants' lived experiences. For the purposes of the study, mental health was defined as a state of optimal well-being that incorporates physical and mental health (WHO, 2014). Mental health stigma is a socially constructed identification that "a social group

creates of a person or group of people based on some physical, behavioral, or social trait perceived as being divergent from group norms" (Goffman, 1963, p. 54).

Participants

The population of focus consisted of adults over the age of 18 in The Gambia. A convenience sampling strategy and snowball sampling technique were used, and participants were recruited through various means (e.g., email and social media). Additionally, the informed consent, demographic questions, and interview process required an eighth grade-level understanding of English.

Data sources and collection

To collect data, a recruitment message was shared with potential respondents, including a link to SurveyMonkey. On SurveyMonkey, interested individuals were asked to review the informed consent form and demographic questions. The latter included the following:

- *Do you live in The Gambia?*
- *Which age range do you fit into?*
- *What is your gender?*
- *What is your marital status?*
- *What is your level of education?*
- *How many people live in your household?*
 - *What best describes your religious or spiritual beliefs?*
 - *Which dates and times would you be available for a 30-minute Zoom interview regarding mental health in The Gambia?*

Once a suitable date and time for the Zoom interview was determined, the primary researcher contacted the participant via email to confirm these. During the interviews, the researcher followed a script with a set of open-ended questions. At the beginning of the interview, the participant was reminded that it would be audio recorded. Next, they were informed of the purpose of the study, then asked the open-ended questions. The interview questions included the following:

- *What do you know about mental health or mental illness in The Gambia?*
- *How do you think people feel about mental health/illness in The Gambia?*
- *What is your understanding of how people see mental health?*
- *What is the meaning of mental health in your language/cultural group?*

- *How might people get help for their mental health issues in The Gambia?*
- *What is your experience with seeking local and traditional healing for mental health?*
- *What is your opinion about why mental health services might be underutilized in The Gambia?*

Upon completion of the interviews, participants were thanked for their time. The audio recordings were transcribed, and any identifying information was removed. The recordings were then stored on a password-protected computer for the duration of the study.

Data analysis

The demographic data were evaluated with descriptive statistics using JASP, a statistical analysis program. Then, the qualitative data were analyzed after the transcription of the interviews. In phenomenological studies, researchers are expected to bracket their feelings, assumptions, biases, and judgments about the phenomenon to arrive at the true essence and a deeper understanding of participants' lived experience (Moustakas, 1994). Bracketing allows researchers to process the identification of the research questions, data collection, data analysis, and understanding of the essence of the lived experiences (Creswell, 1998). Furthermore, as a practice, bracketing is used to enhance trustworthiness. All three researchers identified as female and were aged 33 to 52. Moreover, two researchers identified as Black and African, while the third identified as White and of European descent. During the bracketing process, it was determined that two researchers had related lived experiences, while one had methodological experience. Potential biases and positionality included the fact that all three researchers had an interest in mental health in the population of interest, were concerned about stigma, and were aware of the impact of colonization.

Verbatim transcripts of data collected from the interviews were analyzed. First, a team of three analysts, including the principal researcher, developed an understanding of the data through reading and note-taking. The data were then coded, and a matrix was utilized to chart identified commonalities across analysts. The primary researcher also collaborated with available participants to review the data and its interpretation to achieve triangulation and saturation and

provide some checks and balances. Throughout the study, the American Counseling Association Code of Ethics was referenced (ACA, 2014), and permission was obtained from the institutional review board to conduct this research.

Results

Data were collected from a total of 17 participants living in The Gambia at the time of the study. This section presents demographic information about the study sample and reports results from the research, including direct quotations from participants.

Demographic information

A control question about residence was asked to ensure that all participants met the criteria for participation; 100% of participants indicated that they lived in The Gambia. In terms of age ranges, one person was 18–19 years old, three participants were 20–29 years old, 10 participants were 30–39 years old, one was 40–49 years old, one was 50–59 years old, and one was 60–69 years old. Regarding gender, 70% of participants were male and 30% were female. In addition, 65% of participants were married and 35% were single. Regarding level of education, five participants had a high school degree or equivalent, seven attended college but did not obtain a degree, two had an associate degree, and three had a graduate degree. When asked how many people lived in their household, three participants indicated three to four people, four participants indicated five to six people, four participants indicated seven to eight people, four participants indicated nine to 10 people, and two participants indicated 11 or more people. Finally, with regard to religious or spiritual beliefs, 88% of participants responded that they were Muslim and 12% responded that they were Protestant Christian.

Themes

Five themes were identified during the data analysis: social and cultural conceptualizations of mental health and mental illness, sociocultural determinants of mental health/mental illness, mental health care interventions and bio-psycho-social interventions, barriers to mental health care, and legal frameworks to support mental health change.

Theme 1: Social and cultural conceptualizations of mental health/mental illness

Constructions of mental health and mental illness differ across cultures and communities. One participant said, *"I want to clarify something, and I can see that the question has made a distinction between mental health and mental illness. Here in The Gambia, there is not a distinction between the two."* Regarding etiology, one participant stated, *"Others tend to say that they steal from people; that is why they are taken to the marabout and the marabout put a charm on them."* Another participant said, *"Some people feel like they are possessed by demon(s) or things like that, you know. The public will run away from them because it's believed that these people are cursed, an evil spell from the Devil or wicked spirit."* Another participant shared that mental health was also seen as something that could be inflicted: *"To some people, it's just a problem that is prompted by a jinn. It's more common here that people see it as something that is being inflicted from the spiritual world."* While many participants believe that the spiritual world inflicts mental illness, a participant stated, *"My understanding of the whole thing from people's perspective is mental illness is not God's doing. It's not God's doing."* Another participant said, *"Those ones are the ones that are mentally imbalanced. Like one of their senses is lacking."* Another participant added, *"They lack self-esteem. That's what they lack. Self-esteem and common sense."* One participant explained that *"mental health or illnesses have some interesting classifications, ranging from drug abuse related, absent-mindedness either by drug addiction or affliction by black magic."* Participants also believed that disease is a cause of mental health/mental illness. For instance, one participant said, *"Epilepsy is also believed to be part of the problem. Yeah, a gradual process that can send somebody crazy."* Another participant stated, *"Some believe, for example, that cerebral malaria causes (mental illness)."*

Many participants questioned whether there is a cure for mental illness. For example, one participant explained that, *"in The Gambia, mental health is something that is not easily curable. It's not easy for people that have mental health to recover from the mental illness in (the) Gambia."* Another participant also discussed suffering related to mental illness: *"Since I was a child to now over 40 years old, people that I know that had mental illness are still suffering from it."* Another participant said, *"Traditionally, you cannot be healed when you have mental health (issues)."*

You cannot be healed by traditional means. Something is lacking in your brain, or your system is lacking something, so a marabout cannot heal you."

The participants also expressed concerns about helping those with mental health issues. One participant explained, *"People fear them thinking that they might attack them."* Another participant noted, *"Some people even go to the extent of chasing them away because they think when people are near the mentally affected, that they themselves might also contract the mental illness."* One participant said, *"So, because they don't understand it, they have a concept, a prevalent belief system in the society, a belief that when you touch them the thing that is affecting him or her will fight you."* The participant further shared, *"I've seen that. It's like when you start helping the person, for example, even by simply escorting the person to a healer, like, for example, the hospital or even the traditional healer, you will start seeing strange things happening to you."*

Theme 2: Sociocultural determinants of mental health/mental illness

The second theme focuses on sociocultural determinants of mental health/mental illness. Regarding this topic, one participant said, *"Personally, from my own point of view, I think mental illness, if it's not caused by society, then society will exacerbate it."* Another participant stated, *"In fact, to be possessed doesn't always mean you have to be mad. However, even with the lack of access to opportunity here, many would believe the person is possessed."*

Respondents also suggested that poverty plays a role in mental illness. One participant said, *"Society now believes that you have to have money in order to be a human being. Once you don't have money, which means you have mental problem."* Another participant stated, *"The majority of members of the society feels that once you are poor, then there's something happening to you. Some may call it bewitching, like the guy in Bewitched; that is why he is poor. The person cannot have opportunity."* Another participant said,

In fact, 79 of the patients at Tanka Tanka, when I asked them, they said their condition is directly related to poverty. They traveled to look for money in Europe or America. And, when deported, it's like they have no purpose living any longer. They said that their

parents sold all compound or cattle; they had to send them through back way to Europe. If they don't reach or they are deported, they have nothing left.

A prominent subtheme was migration or failed migration. Participants discussed various issues related to this topic. One person stated, *"They see their friends are finally sending money back home, taking care of their families. And here they sit, unable to do the same. Some people actually do go insane just because of this."* One participant shared, *"We have a saying over here. We say, 'Nerves.' We say, 'This boy is nerves.' What that means is that this person wants to go abroad so bad that they're starting to go crazy."* Another participant associated deportation with mental health/mental illness: *"What aggravates the problem of these people is mostly when they are deported back to their native land. There is this stigma that goes with it when they come back."* One participant also stated, *"People see them as failures. They went to search for money and opportunity but ended up being sent back with nothing."*

Another subtheme related to the labels and names that are used to describe and refer to people with mental illness. Participants shared meanings associated with mental health/illness in some of their languages and cultural groups. For example, one participant said, *"Yes, we call them Nymatou in Mandinka. In Wolof, they call them Duff; in Jola, also, they call them Ahnymatou. These mean crazy or mad person."* Another participant said, *"If you call somebody who is not mad, you call them kangardo, they will not like that. You are abusing them."*

A third subtheme was stigma, discrimination, social isolation, and labeling. One participant explained that *"the stigma around mental health is very high. This is one of the reasons why even with the awareness creation that we are doing at the moment, many people are still reluctant to come out to local services."* This participant also said, *"There's this common statement that we say, a crazy person can never be well again (Duff due musa wayri)"* and *"if you have any mental problem, you will never recover from it."* This statement alone is very powerful in stigmatizing an individual. One participant also shared, *"Whenever there is talk of somebody being mentally disturbed, the first thing people do is try to stigmatize the person. Yeah, that's stigma, that will start even from the immediate family members, most of the*

time." Another participant also stated, *"Instead of taking you for services, they might even lock you in the house because of stigma that can follow the family."* One participant stated, *"It's like when people feel that one is mad, they will not eat with the person. They will not sit with the person in one place. So, total isolation and discrimination."*

Theme 3: Mental health care and bio-psycho-social interventions

A significant theme addressed is mental health care pathways in The Gambia. A subtheme of mental health care and bio-psycho-social interventions was local and traditional healing. For example, one participant stated, *"In most cases, many people tend to go to (a) traditional healer or a marabout rather than medical."* Another participant stated, *"Traditional healers, but mostly religious, like they normally cure with the Quran, such as Ruqya. Yeah, I've personally seen that, using methods from the Quran and some, you know, Arabic textbooks, Islamic textbooks to cure them."* One participant clarified, *"I've experienced the Muslim way of treating the problem aside from (the) medical way of treating. There is this religious formula that they use called Ruqya. Ruqya, I think is exorcism in English."* Another participant shared, *"People believe when you successfully cure a mentally ill person, that disease or that mental problem will transfer to you. If it cannot do anything to you as the healer or as the traditional doctor, it will transfer to the family."*

When discussing additional treatment options, the participants emphasized a lack of support. One person said, *"Normally, lots of family people here cannot afford to take their mental illness people to the medical sector for them to be treated, so they lack support."* Another participant shared, *"As you can see, there is only one center in The Gambia where they normally take these mad people. They shove them in one place, that is Tanka Tanka."* One participant said, *"The medical side, they only give them medication to tame them, if the person is violent, but not actually to treat the person."* One participant described this treatment pathway as follows: *"Mental health in The Gambia is more chemotropic. When I say chemotropic, I mean the use of drugs (medication). They look at every mental illness or issue as being treated only with the use of drugs."*

In terms of counseling services, one participant shared, *"Just recently, people are becoming aware of counseling and*

psychosocial support. And I think that one is more related to people who are mentally distressed." Another person said, "Many of the deportees may know about Western treatment because they are coming from detention camps. I understand that they give them counseling when they are at those camps." Another participant stated, "As for counseling and psychotherapy, they are new innovative treatment(s) but are not known. Some Europeans are starting it here. They need to sensitize the public."

Theme 4: Barriers to mental health care

The participants mentioned several subthemes under the theme of barriers to accessing mental health care: mental health literacy, awareness, and affordability. They discussed increasing access to mental health services and shared relevant experiences. One participant recounted, "We have succeeded in decentralizing the outpatient services in every region ... there is one in Basse, one in Bansang, Soma, Farafeni, and Esau. But for the in-service mental health facility, we have not succeeded in the same capacity yet." This participant continued,

For the community mental health team, previously, they used to go around the country quarterly, every three months, they will take around all their equipment, and then they will announce their outreach dates. But recently, also due to gross lack of finance or lack of a sponsor in (the) mental health sector, such services (have) been truncated in such a way that it is only available within (the) greater Banjul area. And even the greater Banjul area, it's only few communities that are benefiting from that community mental health services. Mobility is a problem ... they used to visit prison, every month. But that also has not been possible as we are speaking.

Another person stated, "They should build more health places to have those that are mentally ill." In addition, one participant expressed the need to "sensitize people on the use of the drugs and order stuff and taking care of our children in our own place."

On the issue of counseling awareness, one participant stated, "And, to me, the idea of going for counseling is still not widely spread. There needs to be awareness, and people need to accept it. It's new, and people don't trust it yet." Another participant emphasized, "People may not realize the kind of behavior that the person is indicating, or the kind of

signs that will warn them that this person is developing certain things." Another participant added, "We need to create more health awareness, educate people about health, make them know about mental health issues, especially people that don't know about mental health, the illiterates will be taught (about) mental health and what to do with a person with mental health."

Theme 5: Legal frameworks to support mental health change

A subtheme concerned human rights. One participant described human rights violations against people with mental illness who seek traditional healing:

When they reach that place, if the craziness has deeply entered inside the person's system, they might chain the person. They might put a chain on the legs to avoid misbehaving, and the marabout there will have a lot of men, big men, strong men that would help him when he is reciting and doing the healing. There are some healers that will chain some of the patient(s) that then are quite aggressive to make sure that they are in one place. And some will even include beating them. So, yes. In providing these services, they are also abusing the people, which is also against their human rights. Human right violations. That's (the) downside of the traditional healing.

Participants further discussed the need for comprehensive mental health policies and legal frameworks for mental health. One participant noted, "We have a mental health bill that has been validated in 2019. But unfortunately, it has not yet been enacted. We are pushing very hard, but yeah, it has not been enacted yet." They clarified, "The law that we are going by is the Lunatic Act. It's the law of the land, which does not provide any rights to a person with (a) mental disorder. And it's very vague." One participant also expressed interest in attempting to "train non-mental health specialists to be able to assess, diagnose, and make simple interventions for common mental health problems. ... to train the general health care personnel, to make sure that mental health services can be accessed at every facility, irrespective of where you are." One participant also expressed, "So, of recent, what we have started developing is to incorporate mental

health services into the primary health service, that is the existing health services.”

Discussion

The current phenomenological investigation aims to understand the phenomena of mental health and mental health stigma among adults living in The Gambia. The findings from the study demonstrate the role of culture in people’s understanding of mental health. These perceptions significantly impact the social identity of people with mental health issues, the limited access to treatment pathways and modalities for mental health care, and the public stigmatization of mental health/illness.

The first theme identified in the data analysis was social and cultural conceptualizations of mental health/mental illness. Given that 90% of Gambians identify as Muslim, it was surprising that cultural norms featured more prominently than religious beliefs in the participants’ conceptualizations of mental health. The causes of mental health/illness were seen as spiritual and beyond the human realm and attributed to many explanatory forms, such as mysticism, possession by jinns or demons, and even revenge on healers or family members from responsible agents for healing or helping a person with mental illness. The transgression of norms by a person or their family member were also identified as a cause of mental health/illness. Mental illness was seen as retaliation, either from spiritually unseen forces or a wronged individual who took revenge by inflicting the condition through spiritual means. These beliefs are so long-standing that they have contextualized how people experience mental illness and are labeled, stereotyped, and discriminated against (Galvin, 2021). To foster improvements in mental health, the population must be educated on the etiology of mental health, treatments, and possibilities for care that have been identified elsewhere. Unless this education is provided, the treatment gap and mental health stigma will remain.

Firdos et al. (2021) conducted a community-based study on beliefs about mental illness in different populations in Al-Ahsa. The sample consisted of Muslim participants with similar beliefs about the causes of mental illness as the participants in this study. This study is crucial for understanding how similar Muslim countries conceptualize and experience the research phenomenon. Cultural beliefs are key to

addressing mental illness in The Gambia. To contend with the gap in treatment, psychoeducation for both the awareness and treatment of mental health concerns must consider the context of beliefs that impede treatment at both the individual and systemic levels. For mental health providers, developing cultural humility necessitates continual learning and openness toward their clients’ diverse cultural experiences and beliefs (Zhu et al., 2021).

The second theme identified in this study was sociocultural determinants of mental health/mental illness. The Gambia is a LMIC; as in many similar countries, there is inherent economic inequality. This affects people’s self-concept in terms of lifestyle choices. In addition, social issues such as poverty impact the majority of the Gambian population. The participants in this study discussed substance abuse and poverty as causes of mental illness and factors that deter people from accessing treatment. They also noted family support in the form of providing financial assistance to obtain treatment and purchase medication. The findings from this study align with those of a recent foundational study on mental health in The Gambia (Barrow & Faerden, 2022), which significantly discussed poverty as a factor that impedes positive mental health outcomes and cited the high costs of treatment, prescription injections, and medications as a frequent barrier to accessing care. Barrow and Faerden (2022) also found that the cost of consulting traditional healers was approximately \$187 and that the cost of biomedical interventions for injections and medications ranged from \$9–12. These high costs and disparities are significant barriers to accessing services (Barrow & Faerden, 2022). Barrow and Faerden (2022) also noted that reducing the factors that contribute to mental illness would significantly reduce the prevalence of mental health issues and help close the treatment gap, which is consistent with the findings from this dissertation.

In addition, participants in this study referenced failed migration as a social issue that leads to the displacement of Gambian youth. They noted that globalization has led many Gambians to seek better lives and improve their family’s living conditions. Since opportunities are not available in their own country, they look to distant shores. One way of seeking opportunity is through the “back way” by illegally migrating through the Sahara Desert and the Atlantic Ocean and entering Europe. Although this approach has proven fruitful for some, participants noted that

widespread illegal migration has led to more control and repatriation agreements, which have made it somewhat easier for migrants to be held in detention centers and eventually deported. Participants also shared that, when people plan to leave The Gambia, their families often incur debt or sell land and resources to ensure that their children will succeed and be able to support them and augment the family's status. Conversely, entire families may suffer when people do not successfully migrate, are detained for many years, and eventually deported or returned, as stigma is also attached to these deportations. As described by participants, returnees are viewed as having lost an opportunity and mitigated to a life of poverty. This can result in stress, depression, and traumatic conditions, which may be compounded by stigma and limited access to professional counseling services.

The understandings, descriptions, and labels attached to mental illness reflect the highest level of public stigma. Stigma is socially constructed and permeates all aspects of Gambian society. Research on mental health stigma has posited that language shapes perceptions and can significantly influence psychological or cognitive processes (Granello & Gibbs, 2016). The terms that participants used to describe mental health did not reflect linguistic relativity (Wolf & Holmes, 2011) or align with "people-first" language (Granello & Gibbs, 2016). Instead, they used stereotyping and portrayed mental illness as a permanent, incurable condition that affects the self-esteem and social identity of affected people. A prevailing sentiment among participants was that people do not associate with those who suffer from mental illness. Globally, there is evidence that public stigma is a deterrent to seeking treatment for mental illness, which aligns with the findings from the present study. Participants shared that many people would lock up a family member with a mental illness rather than face public stigmatization. Women from families with mental illness are particularly affected, and their marriage prospects are limited due to the negative connotations attached to their family history of mental health (Amuyunzu-Nyamongo, 2013).

The third theme identified in the data analysis was mental health care and biopsychosocial interventions. The prevailing belief among participants was that local, traditional, or faith-based healing is the most popular and accessible type of intervention. In a seminal study on mental illness in The

Gambia, Coleman et al. (2002) found that approximately 80% of the population resorts to local and traditional pathways. These are more aligned with people's understandings of mental health, as they are rooted in local and cultural beliefs. Biomedical services in The Gambia are the mainstream conventional system of treating mental health in terms of legal services. There is limited access to outpatient services; currently, there is only one inpatient facility in the country. The participants shared that, as a result, people must find the finances to travel to the region or not go at all. The findings from this study also suggest that there was previously a community mental health team that traveled around the country every three months to provide greater access. However, this program has been challenging to maintain. Thus, a lack of funds significantly impacts community services that could enhance access to medical and mental health care.

From a multicultural standpoint (Ratts et al., 2016; Bharti et al., 2021; Sue, 1994), it is essential to recognize that counseling is an emerging field in The Gambia. Although some nongovernmental organizations are working to increase services, a lack of awareness of mental health issues in communities is a risk factor for their sustainability. Given the importance of the globalization and internationalization of mental health counseling in African countries, there have been significant intersectional challenges related to contextual factors such as stigma, lack of awareness, and lack of infrastructure (Amuyunzu-Nyamongo, 2013). Multicultural counseling may also involve certain ideals, such as decolonizing concepts. Due to people's beliefs about mental health, it is difficult to demonstrate the potential healing capacity of Western counseling. Acknowledging current beliefs while showing the possibilities of mental health care requires balance, which a multicultural counseling approach might be able to help with.

The traditional healing system of treatment includes local, traditional, spiritual, and faith-based pathways. Participants shared that these are the most available and accessible forms of treatment; they are grounded in local belief systems and accepted by many people as their first choice of treatment. Other regional studies have also highlighted this alignment with local cultural beliefs and the accessibility of treatment. Furthermore, the World Health Organization Alma-Ata Declaration (1978) recognized the role of traditional medicine in the primary healthcare

sector. The participants in this study empathized with this treatment modality. Findings from the subregion also showed that 80% of people who seek mental health treatment in Ghana rely on the abovementioned system of care (Krah et al., 2018). Findings show that, although The Gambian health sector is relatively small-scale, it is moving toward full integration of mental health care. This provides an opportunity to foster the integration of traditional healing into delivery and multicultural counseling into mainstream biomedical services or collaboration with local and traditional healers. The Gambian government could also help with the integration of multicultural counseling and psychoeducation.

The fourth theme identified in this study was barriers to mental health care. All participants suggested poverty was a social factor that immensely impacts mental well-being. They described poverty as a barrier to mental health treatment and a cause of mental illness. Therefore, reducing the circumstances that cause economic inequality could be a prime policy matter for the government. Since around 60% of the population consists of youth, the government could support training and skills development of projects to alleviate poverty among young people. Furthermore, a lack of funds to pay for medication or daily meals can impact mental health and well-being. The current research did not examine mental health among youth and women, which are two groups significantly affected by poverty; however, this area needs attention.

In addition, there is a need for mental health literacy in The Gambia while also respecting long-held traditions and values. Local people could be trained to know about mental health practices that promote wellness. Some efforts are already underway in this area, which could promote access to services. As participants shared, community mental health services could also improve access. Although such programs have been implemented in the past, they were cut due to a need for more funding. This sentiment was highlighted in a study by Kutcher et al. (2016), which aligns with the findings from the present study. For communities to benefit from counseling, adequate training from qualified professionals is required. These professionals could work within the guidelines of multicultural counseling practice and ethical standards. So far, no known counselor training programs or institutions exist in The Gambia. The training of paraprofessionals could be

helpful, but they would only partially replace professionals. Professional associations could also provide counseling in underdeveloped nations. Furthermore, the field of mental health counseling must be regulated to ensure that professionals who treat people have an appropriate clinical background.

The fifth theme identified in the study was legal frameworks to support mental health change. The Gambia has stated its stance on mental health: to promote it. To this end, greater attention should be paid to mental health policy, laws, facilities, and access to services. In addition, there has been a call to meet United Nations conventions. For instance, it addresses the rights of people with disabilities. The Gambia has an opportunity to identify well-trained, experienced mental health professionals and collaborate with them to improve services and policies. It is important to have a mental health policy in place to guide mental health regulations and access. Other studies have mentioned the need for protection for people with mental illness. For example, Lund et al. (2011) argued that legislation and policies are required to optimize mental health services in LMICs. The Gambia alludes to this in its mental health policy for 2021–2030.

With regard to policies, the ministry could begin by revising practices in the existing facility and increasing standards of care. For instance, only one facility offers substance abuse treatment and conventional mental health care. A lack of halfway houses was also noted in this study. Furthermore, it is essential to address the financial burden of family caregivers, if possible. Currently, a risk factor is that the government does not regulate traditional healing practices, which sometimes entail physical beatings and other human rights violations that can further exacerbate mental illness. There has also been a call to ensure access to food, housing, employment, safe living and working conditions, gender equity, and mental health (Cosgrove et al., 2021). Collaboration between traditional healers and counseling professionals could result in the identification of common ground to uphold human rights.

Limitations of the Study

While a qualitative data analysis yields descriptive data, it needs to be more generalizable and show the exact prevalence of issues and needs in The Gambia. Additionally, this study was conducted in English, which only sometimes

accommodates local dialects. It also excluded many people who needed to speak English. Furthermore, the data were collected via Zoom, which required an internet connection. Another limitation was that this study did not focus on women and children, who are the most widely affected.

Future Directions

Many opportunities exist for further research on implementing mental health services in The Gambia while considering the challenges of an LMIC. Future research could utilize a quantitative approach to identify the prevalence of mental illness and the need for mental health services more accurately. Additionally, a quantitative approach might identify the specific needs of people with statistical data. Future research could also investigate opportunities for multicultural counseling professionals to collaborate with traditional healers and biomedical services. Furthermore, researchers could collaborate with the government to identify legislation and policies that promote mental health and well-being in the country. This also sets a framework for other LMICs to promote mental health globally.

Conclusions

There are many opportunities for mental health care and advocacy in The Gambia and beyond. Yet, it is also essential to recognize traditional healing practices and beliefs about mental health, as these can impact mental health stigma. While working with populations that are only beginning to explore mental health services, it is vital to recognize community-based resilience in The Gambia. For instance, people must become accustomed to independently seeking care. Instead, family members are typically tasked with caring for them. Furthermore, recognizing people's inherent worth, and acknowledging and accentuating their personal strengths can help provide a buffer against the impact of mental illness. This also challenges the idea that people are solely defined by their deficits, illnesses, or life circumstances; they are capable and resilient when connected to caring communities and systems (Ward & Reuter, 2011). This reiterates the importance of ecological systems theory and how different systems interact and have great importance.

Utilizing Bronfenbrenner's ecological systems theory, many people with mental health issues rely on the family system for care

and access to mental health care. Participants noted that families utilize pathways that align with their worldviews and cultural nuances since they are the decision makers for individuals who need mental health care. This reflects the family's vital role in a collectivist system. The mesosystem concerns the connections between peers and family. Sometimes, families fear sharing that a family member is struggling with mental illness because of prevailing beliefs about being possessed or cursed. This can cause isolation and stress for the family system. In addition, it is essential to recognize that, with some psychoeducation, communities might be able to unite for early intervention. The exosystem involves links between social systems that do not directly involve an individual (e.g., a family member's job requires travel). The macrosystem describes the overarching culture, such as the challenges of socioeconomic status and poverty in The Gambia. Finally, the chronosystem involves beliefs embedded in the Gambian culture that can be passed down from generation to generation, such as the assumption that all people with mental illness are dangerous, cursed, and often incurable. As evidenced by the results from this study, there is also a widely held belief that little can be done to support the health of people with mental illness beyond attempts to use traditional methods of healing or institutionalization. However, some participants with a higher level of education recognized that there are opportunities to revise policies, systems, and care. In LMICs, mental health care cannot be one-dimensional, and financial needs must be addressed. In addition, cultural humility is vital to advocate for people in The Gambia. It is essential to help clients identify issues as they see them and focus on the specific needs of populations worldwide to promote mental health and well-being.

Conflict of interest

The authors declare that they have no conflicts of interest.

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