FACTORS INFLUENCING ACCESS TO HEALTH CARE SERVICES AMONG CHILDREN WITH MENTAL ILLNESS: A CASE OF ENDEBESS SUB-COUNTY, TRANS-NZOIA COUNTY-KENYA.

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A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN PROJECT PLANNING AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI

DECLARATION

This research project is my original work and has not been presented for a degree in any other University.

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L50/71763/2014

This research project has been submitted for examination with my approval as the Supervisor of the University of Nairobi.

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DEDICATION

This reach project is dedicated to all the children with mental illness whose plight has formed a subject of my study. Secondly to my father Honan Imbwaga and Mother Alice Kayeli; they highly contributed to this journey by taking me to school; I also dedicate this work to my beloved wife Jackline Isiji for her consistent financial, material and moral support; finally dedicate this study my child Gift Imbwaga; you are the greatest joy in my life.

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LIST OF ABBREVIATION AND ACRONYMS

CRPD: United Nations Convention on the Rights of Persons with Disabilities

HCS: Health Care System

KHHEUS: Kenya Household Health Expenditure and Utilization Survey

KNCHR: Kenya National Commission on Human Rights

MDGs: Millennium Development Goals

MI: Mental Illness

NAMI: National Alliance on Mental Illness

NGOs: Non-Governmental Organizations

SGDs: Sustainable Development Goals

UK: United Kingdom

UNICEF: United Nations International Children's Fund

WHO: World Health Organization

ABSTRACT

The purpose of this study was to determine the influence of different factors on accessibility to health services among children with mental illness in Endebes Sub-County, Trans-Nzoia County-Kenya. It focused on socio-economic factors, geographical factors, cultural factors and perception of parents on mental illness to establish the extent to which these factors influence access to health services. Descriptive survey research design was adopted with 381 respondents targeted through snowball sampling technique. Questionnaires were used to collect data. The instruments validation exercise was done by the supervisor. Before the main study, Pilot testing was done targeting 34 respondents from Kwanza Sub-location within Kwanza Sub-county. Reliability of the instruments was determined through a pilot study where Cronbach alpha co-efficient of 0.79 was obtained indicating that the instruments were highly reliable. Data was analysed using descriptive statistics. The results were presented in form of tables and percentages. The findings were broadly discussed, conclusions drawn and recommendations made. The study established that socio-economic, cultural, geographical and parents perception on mental illness influences access to health care services among children with mental illness. The researcher finally compiled final report for final presentation to the University of Nairobi.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

With the entry into force of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), disability is increasingly understood as a human rights issue. However, people with disabilities still comprise a significant portion of the world's marginalized population.

According to the World Report on Disability (2011) by The World Health Organization (WHO) and The World Bank (WB), it is estimated that one billion people are living with some form of disability and of these 200 million are children. The World Health Organization report (2001), estimated that about 10% of the adult and child population at any given time suffer from at least one mental disorder. In addition, at least 2% of all patients seen by primary health care professionals have one or more mental disorders.

WHO (2002), found out that mental health disorders are one of the leading causes of disability worldwide and that three out of ten leading causes of disability in people between ages of 15 to 44 are mental disorders. Estimates showed that mental illness accounted for up to 14% of the global burden of disease with approximately 450 million people worldwide having some type of mental disorder. Most importantly, report notes that people with disabilities are by the poorest of the poor, and do not have equal opportunities and equal access regarding employment, health and education. Consequently there rights are violated more so in low income countries and those living in the poorest quintile of the world's population. This means that disability is compounded by social

disadvantage which may lead to a cycle of health inequalities and disparities.

Reality of inequalities particularly for children with disabilities are depressing; almost all of the children with disabilities in developing countries do not attend school translating to low literacy levels, a third of the world's street children are living with some form of disability and social marginalization and limited access to social services (UN-DESA 2007, UNICEF 2008). There is evidence that nine out of ten children with disabilities will not survive past age of 20 years and the mortality rate for children with disabilities has been recorded as high as 80% in countries where the general mortality rate for under-five is 20% (UNICEF 2008). Not only are children with disabilities at a greater risk of impairments due to their low social-economic status, but their rights to health has been disregarded.

Although health care needs for persons with disabilities are similar to others, they however also require services which are specific to their impairments such as health related rehabilitation and appropriate specialist care (Scheer et al. 2003). Many children with disabilities have a greater need for health care than the non-disabled population. However, due to lack of appropriate services and failure to use primary health care services they often utilize emergency room services more often than non-disabled population (Drainoni et al. 2006).

Several studies have been conducted globally on access to health care by different categories of people, barriers to health care and prevalence of mental illness. Some are highlighted below:

Recent research show that people with disabilities are 3 times more likely to be denied health care, 50% more likely to have catastrophic health related expenditure, 50% of them cannot afford necessary care and are 4 times more likely to be treated badly in facilities (WHO 2013).

The Mental health Foundation (2005), estimated that 20% of children had a mental health problem in any given year, and about 10% at any one time. This was reported by Lifetime Impacts: Childhood and Adolescent Mental Health, Understanding the Lifetime Impacts, Mental Health Foundation, (2005). On the other hand, the National Alliance on Mental Illness (NAMI) found out that approximately 20% of youth aged 13-18 years and 13% of children aged 8-15 years in the USA experienced severe mental disorders in a given year and almost 50% of these children do not receive health services.

According to the United State of America's National Healthcare Disparities Report (2004), access to excellent health care is not evenly distributed in the US. Rural residents often face barriers to high quality care compared with their urban counterparts. Although 20 % of Americans live in rural areas only 9 % of the Nation's physicians practice there. Rural residents also face longer distances to reach health care delivery sites. While, Merikangas et al (2009) noted that although the prevalence of mental health problems is high, only about half of those with mental disorders in the US receive mental health treatment.

In 1993, Eisenberg et al. performed a study of health care utilization in the United States and found out that use of non-conventional medical care providers, such as herbal remedies, surpassed use of conventional medicine (i.e., medical doctors and doctors of osteopathy) by nearly 37 million visits. Although several of the treatments then identified as unconventional are now common within professional biomedicine, this study highlights the extensive use of alternative medicines not formally offered by biomedical practitioners. He concluded that understanding why people utilize alternative or conventional medicines is central to increasing health care utility and efficacy.

In UK, it is estimated that one in four people will experience a mental health problem each year, while one in six experience a neurotic disorder such as anxiety or depression. Anxiety disorders are also

estimated to affect 3.3% of children and young adults in the UK. Furthermore, one in ten children between the ages of one and 15 have a mental health disorder (National Statistics Mental health in children and young people in Great Britain, 2005).

In Australia, one in five (20%) of people aged 16-85 experience mental illness in any year with the most common mental illness being depression, anxiety and substance use disorder. However, 65% of people with mental illness do not access any treatment.

According to Canadian mental Health Association, Ontaria division, the most frequent cited misunderstanding about people with mental illness are that they are dangerous or violent (88%), lack intelligence (40%0, are incurable (30%), are to blame for their illness (20%), are contagious (6%). (Health S 2003).

People with a significant mental illness are by the most excluded in society. Sayce (2001), for instance, has proposed that psychiatrists should directly embrace social inclusion and recovery as treatment goals. They should also indirectly contribute by engaging in the wider social policy debate, including for example issues relating to the disability rights agenda.

Babar et al. (2004) in a study on health seeking behaviour and health service utilization in Pakistan asserted that the factors determining the mental health behaviours may be seen in various Contexts: physical, socio-economic, cultural and political. Therefore, he concluded that the utilization of a mental health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions, and the disease pattern and health care system itself.

In Africa, 5% of the population suffers from mental illness and the number is expected to rise to 15% by the year 2030 (WHO: 2012).

Despite this alarming statistics, mental health remains by the most under-resourced areas of health in developing countries. Mental health services in low-income countries are typically hospital based and confined to only metropolitan areas. this is According to a review article, "prevalence of child mental health problems in Sub-Saharan Africa (Cortina et al, 2012); The growing awareness of the importance of mental health as a key component in child development has begun to shape global health initiatives during the past quarter of a century. It is increasingly recognized that improving children's psycho-social well-being is necessary to achieve MDGs.

In sub-Saharan Africa, rates of psychological disorders in adults are particularly elevated, and studies have shown rates of posttraumatic stress disorder, anxiety, and depression ranging from 20% to 60%. Adverse conditions during childhood largely interfere with children's fundamental physical, emotional, and social development and place them at risk for psychological problems i adulthood. There has been little research in child mental health in low-and middle-income countries, but the world health organization estimates that as many as 20% of the world's children and adolescents experience a mental disorder at some stage in their childhood. Cortina MA., Sodha A., Fazel M., Ramchandani PG (2012).

Like in most of Africa, children in Kenya are viewed as an asset, in that they not only carry on the family name, but they also are expected to assist the family especially their parents later in life when they have aged (Mungai, 2002; Munyere, 2004). In the past children who were born sick or with a disability were left to die because they were seen as a liability and a shame to their families. Most of the community members still believe witchcraft and curses attributed to disability (Kisanji, 1995). All this contribute to a feeling of fear that causes parents/guardians not to take their children with disabilities to existing services. Little will change in the lives of children with disabilities until attitudes by communities,

professionals, media and governments begin to change (UNICEF 2013: state of the world's children with disabilities p12).

According to an article in the international journal of environment research and public health, Prevalence of common mental disorders in rural district of Kenya, and socio-demographic Risk Factors (2012), the prevalence rate of mental disorder at household level is 10.8%.Health care services are not accessible to all populations in Kenya, according to the 2003 Kenya Household Health Expenditure and Utilization Survey (KHHEUS), 22.8% of those who were sick did not seek care. By those Kenyans who are ill and did not choose to seek care, 44% were hindered by *cost* and 18% were hindered by the long distance to the nearest health facility. Alliance Health Care (2015)

There was inadequate data and information on prevalence of mental and behavioural disorders in Kenya. It is estimated that up to 25% of the out patients and up to 40% of the in-patients in health facilities suffer from mental conditions KNHCR (2011). The concerns of mental disorders/illness in Kenya continue to draw attention of the media with its worse forms being manifested through suicides, homicides and violence at household level. Traumatic events such as sexual violence against children by other forms of violence against children and lack of adequate counselling services has significantly led to mental illness through development of post-traumatic disorders, anxiety and depression.

There is a huge treatment gap in Kenya for those with mental illness; currently Kenya has 81 psychiatrists for a population of over 40 million people. Most psychiatrists operate in private practice meaning their services are unaffordable to the majority of Kenyans. Only about 25 psychiatrists are in the public sector and most of these are situated in Nairobi, leaving a major gap in service delivery in rural areas. While, not all mental disturbances require psychiatric intervention, most do require intervention through psychologists, professional counsellors and psychotherapists, who are also scarce in rural areas (Mental Health Research Centre concept paper in Kenya, 2011).

Several global health initiatives have continuously advocated for health equality for all, especially for vulnerable members of the community. The World Health Organization has been on the forefront advocating for equitable access to health care and promotion of health equality. This evidenced by its constitution of 1946 which states that everyone has the right to enjoy the highest attainable standard of physical, mental health and social well-being but at the same time should not merely be considered as the state of absence of disease or infirmity (WHO 1946). And by Alma Atta "Health for All" declaration 1978, which expressed the need by all governments to protect and promote health of its entire people through the primary health care (PHC). Perhaps the most important development that has taken place is effecting of the UN-CRPD which most African countries have signed and ratified these conventions and have adopted legislations and policies to remove barriers which prevent the utilization of primary health care services by the vulnerable social groups (Maulick and Darmstadt 2007, Mji et al. 2009). Similarly the CRC (1989) contains two articles which specifically mention children with disabilities. Article 2 has elements of non-discrimination as a general principle and obliges states to provide inclusive services without discrimination to children with disabilities. Article 23 is comprehensive in its statements for the rights of the child. It encompasses children with disabilities rights to a life of dignity, the provision of services such as health care which must be provided free of charge according to available resources and the dissemination of evidence based treatment for the prevention of disabilities.

1.2 Statement of the problem

While the right to health has been recognized as a fundamental human right for all persons, this right is far from being realized in most developing countries. Children with disabilities continuously face barriers to accessing health services. These access barriers have far reaching consequences on their lives such as; increased number of preventable

impairments and disabling conditions, disempowerment, lack of necessary social capital, lack ability to assert rights and greater risk exposure to poor living conditions (UNICEF 2007, Groce et al. 2001 and UNICEF 2013). For children with disabilities having access to health care that treats their condition when the need arises and that prevents them from a disease, and that promotes and maintains their health is a fundamental right.

Several researches have been conducted on mental illness especially in the west and only few of them conducted in Africa.

Lawrence and McCulloch (2001) reviewed the barriers that older adults, specifically those in rural areas face when in need of mental health care. They noted that stigmatization, migration, economic conditions, and informal social support inhibit elders in rural communities from seeking mental health services.

Babar et al. (2004) in a study on health seeking behaviour and health service utilization in Pakistan asserted that the factors determining the health behaviours may be seen in various contexts: physical, socio-economic, cultural and political.

A study on people with epilepsy in rural Ghana, found that spiritual beliefs surrounding epilepsy influenced health and seeking of treatment. While a study in rural areas of the Gambia reported that only 16% of 380 people with epilepsy knew that preventive treatment was possible; 48% of people with epilepsy had never used treatment, 70% did not know that clinics offered treatment for seizures.

Wang et al (2004) present interesting information about the frequency and lengthy delays in receiving treatment experienced by many individuals after the onset until the first contact with a general medical doctor and 11 years until the first contact with a psychiatrist. Even though more severe mental disorders were associated with shorter delays, the average delay between onset and first treatment contact for even the most severe disorders was five years.

In Kenya, studies on psychiatric morbidity have clearly been demonstrated the illness burden, Ndetei and Muhangi in (1979). They

studied 140 rural walk-in clinic patients and found that 20% suffered psychiatric illness; especially depression. Sebit (1996) assessed 186 patients attending primary health care facilities and found out an overall prevalence rate of psychiatric disorders at 0.43%. Further, a hospital based study was carried out by Omar (2003) found out that negative opinions about mental illness were widely held by relatives of mentally ill patients and concluded that this could be higher in the general population. Knowledge on mental illness treatment was remarkably high with 96% of respondents believing that medical treatment is necessary, 80% believed that mentally ill patients will improve if treated and 62.7% believed that mentally ill patients will eventually recover. A research conducted in Baringo by Benjamin Mwasi (2010), aimed at identifying the major barriers to health service access for the people living in that area. The study identified, distance, time and cost as the strongest barriers to health care access. While distance was the single most important factors affecting the choice of facility attended.

In spite of this significant burden of mental ill health, there is a scarcity or lack research on factors influencing access to health services by children with mental illness. Since the current initiative in mental health services provision in Kenya is decentralization and integration in primary health care. It is important that scientific information on the community's mental health treatment seeking behaviour, attitude and practice is available to planners and policy makers since one important component of primary health care service provision is that the services have to be accessible by the target population. This study seeks to add to existing knowledge regarding the factors which influence access to health care services by people with mental illness.

1.3 Purpose of the Study

The purpose of the study was to establish the factors influencing accessibility to healthcare services by children with mental illness in Endebes Sub-County of Trans-Nzoia County.

1.4 Objectives of the study

The study will be guided by the following objectives;

1. To examine the socio-economic factors influencing access to mental healthcare services by children with mental illness in Endebes Sub-County

2. To determine geographical factors influencing access to mental healthcare services by children with mental illness in Endebes Sub-County

3. To examine cultural factors influencing access to mental healthcare services by children with mental illness in Endebes Sub-County

4. To establish the influence parents perception on access of mental healthcare services by children with mental illness in Endebes Sub-County.

1.5 Research questions

The researcher sought to answer the following questions during the study;

1. How do Socio-economic factors influence access to health care services by children with mental illness in Endebes Sub-County?

2. How do geographical factors influence accessibility to health care services by children with mental illness in Endebes Sub-County?

3. How do cultural factors influence access to health care services by children with mental illness in Endebes Sub-County?

4. How do the parents' perceptions on mental illness influence access to mental health care services by children with mental illness in Endebes Sub-County?

1.6 Significance of the study

The need to have equitable health services is a global goal which every country seeks to fulfil. This study would be of substantive value to the children with mental illness especially by highlighting the factors which influence their accessibility to health care services. It would also help the Ministry of health in making policies that would enhance access to health services for children with mental illness.

1.7 Basic Assumptions of the study

The assumptions of the study were that, the respondents would cooperate and provide the required data accurately and honestly, and that the instruments chosen for the study was the most appropriate and it would give the required results.

1.8 Limitations of the study

The limitations included the poor road network within Endebes sub-county. The researcher was also faced with resource and time limitations. However proper planning enabled the researcher to overcome these challenges.

1.9 Delimitation of the study

The study was delimited to Endebes Sub-County in Trans-Nzoia County-Kenya. Three locations namely Endebes location, Matumbei and Chepchoina locations were included in the study. Whereas there were adults with mental illnesses, the study was only delimited to factors influencing access to health care services by children with mental illness. Despite the topic being wide, the researcher narrowed it down to four

objectives namely; socio-economic, geographical factors, cultural factors and the parents' perception on the status of the illness and how they influence access to health services by children with mental illness in Endebes Sub-county. The target population was the parents of children with mental illness in Endebes Sub County.

1.10 Definition of significant terms used in the study

Socio-economic factors: are the social and economic experiences and realities that help mound one's personality, attitudes, and lifestyle: Includes; financial resources or income, occupation and level of education.

Cultural factors: are the established beliefs, values, traditions, laws and languages of a nation or society. Cultures develop norms, values, and behaviours that are suited to that environment. Each culture further comprises of various subcultures such as religion, age, geographical location, gender (male/female), status etc.

Perception: has been used in this context to refer to parent's inability to identify children's needs for mental health services, denial of the severity of a mental health problem, or belief that the problem can be handled without treatment. Perceptions about mental health services e.g lack of trust in or negative experience with mental health providers, lack of children's desire to receive help, or stigma related to receiving help may also affect the willingness to seek treatment (Owens et al, 2002)**.**

Mental illness: According to Mayo clinic, mental illness refers to a wide range of mental health disorders that affect your mood, thinking, and behaviour. Examples of mental illness in children include depression, anxiety disorders, aggressive behaviour or defiance, hyperactivity, impulsivity or substance use. Many people have mental health concerns from time to time, but mental health concerns becomes illness when on-going signs and symptoms cause frequent stress and affect one's ability to function. In most cases, mental illness symptom management is by a combination of medication and psychotherapy.

1.11 The organization of the study

This Research Project is organized in Five Chapters. Chapter one is the opening of the study. It gave a brief overview of the Project by discussing the Background of the study, the Problem that the Project was attempting to address, the Objectives of the study, states the Research questions, Significance of the study, Basic assumptions of the study, Limitations of the study, Delimitations of the study and Definition of significant terms.

Chapter two took a critical look at the existing Research Literature that is significant to the work that the Researcher was carrying out. It consisted of current Literature reviews with information from Articles, Scholarly journals, Theses and Dissertations, Government documents, papers presented at conferences, Books, Abstracts and the internet which are relevant and connected to the Research topic. It was based on the discussion of the Objectives of the study. The Theoretical and Conceptual frameworks were used to show the interaction and relationship of the Research variables and their accompanying indicators. This Chapter concluded with summary of Literature Review and showed gaps to be filled by the study.

Chapter three of the Project dealt with the description of the methods that were applied in carrying out the Research study. The various sub-topics this chapter included Research Design, Target Population, Sample size and Sampling procedure, Data collection instruments, Pilot testing of the instruments, Validity of the instruments, Reliability of the instruments, Data collection procedures, Data analysis and Ethical considerations.

Chapter four covered data analysis, presentation of the findings, interpretation of the findings and discussions while chapter Five covered summary of the research findings, conclusions and recommendations.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

The literature review guided the researcher to gain insight on the project topic by analysing the works of other scholars on the same topic. The researcher focused on the dependent and independent variables of the research topic respectively. The researcher focused on each of the four objectives of the project namely; to investigate how various factors namely socio-economic, geographical, and cultural and parents' perception on mental illness influences their access to health services among children with mental illness.

2.2 Concept of mental health in children

Good mental health is integral to human health and well-being. A person's mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. It is of major importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages, and through to older age. Action throughout these life stages would provide opportunities for both improving population mental health, and for reducing risk of those mental disorders that are associated with social inequalities. While comprehensive action across the life course is needed, there is a considerable evidence base and scientific consensus that action to give every child the best possible start in life will generate the greatest societal and mental health benefits. In order to achieve this, action needs to be universal, across the whole of the social distribution, and it should

be proportionate to disadvantage in order to level the social gradient and successfully reduce inequalities in mental disorders.

Comprehensive strategies at the population level to address these societal determinants are likely to improve mental health in the population and reduce inequities, because such strategies focus on improving the conditions in which people are born, grow live, work, and age. Life-course: Prenatal, Pregnancy and prenatal periods, early childhood, adolescence, working and family building years, older ages all related also to gender; Parents, families, and households: parenting behaviours/attitudes; material conditions (income, access to resources, food/nutrition, water, sanitation, housing, employment.

2.2.1The prenatal period

The prenatal period has a significant impact on physical, mental, and cognitive outcomes in early life and throughout life. A mother's maternal health is particularly important and poor environmental conditions, poor health and nutrition, smoking, alcohol and drug misuse, stress, and highly demanding physical labour can all have a negative effect on the development of the fetus and later life outcomes. Joint Commissioning Panel for Mental Health. (2013) Guidance for commissioning public mental health services - Practical mental health commissioning. (2013). Children with poor mothers are more likely to be disadvantaged even before birth, for example, with an increased likelihood of poor nutrition during pregnancy and low birth weight and exposure to stress, poor working conditions, and demanding physical labour. Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: World Health Organization, 2013. A systematic review and meta-analysis of 17 studies on maternal depression or depressive symptoms and early childhood growth in developing countries showed that children of depressed mothers were a greater risk of being underweight and stunted, low birth weight is itself an increased risk factor for depression in later life32Surkan PJ, Kennedy

CE, Hurley KM, Black MM. Maternal depression and early childhood growth in developing countries: systematic review and meta-analysis. Bull World Health Organ. 2011; 89(8):608-15

A systematic review of studies in low- and middle-income countries estimated prevalence of common prenatal mental disorders among women to be 16% before birth and 20% postnatal. Fisher J. et al (2012). They further explain that Risk factors for common prenatal disorders include socioeconomic disadvantage; unintended pregnancy; being younger; being unmarried; lacking intimate partner empathy and support; having hostile in-laws; experiencing intimate partner violence; having insufficient emotional and practical support; in some settings, giving birth to a female, and having a history of mental health problems. Protective factors include having more education; having a permanent job; being of the ethnic majority and having a kind, trustworthy intimate partner. A large body of research has emphasized the importance of maternal education for a wide range of outcomes for children, with lower maternal education relating to increased lower cognitive scores and mental health problems and infections Gleason MM, Zamfirescu A, Egger HL, Nelson CA, Fox NA, Zeanah CH (2011).

2.2.2 The early years

Adverse conditions in early life are associated with higher risk of mental disorders. Family conditions and quality of parenting have a significant impact on risk of mental and physical health. The Institute of Health Equity conducted a recent review of literature on factors influencing early childhood and found that “lack of secure attachment, neglect, lack of quality stimulation, and conflict, negatively impact on future social behaviour, educational outcomes, employment status and mental and physical health”. This concurs with. Fryers T, Brugha T. (2013) who agrees that, Children’s exposure to neglect, direct physical and psychological abuse, and growing up in families with domestic violence was particularly damaging. Parental mental health plays a key

role in outcomes for children as children of mothers with mental ill-health are five times more likely to have mental disorders. This is according to a study carried out by Melzer D, Fryers T, Jenkins R, Brugha T, McWilliams B. (2003) Poverty, and particularly debt, can increase maternal stress. Moreover, conflict between parents also carries risks for children. Exposure to multiple risks is particularly damaging as effects accumulate. Children in lower socioeconomic groups are less likely to experience conditions to allow optimal development Schady N. (2011). Social gradients in social and emotional difficulties have been shown among children as young as three years. Analysis from the United Kingdom showed that family income was inversely related to socio-emotional difficulties in children at ages 3 and 5. However, impact can be offset by protective parenting activities, such as good social and emotional interactions. These inequalities in early years' development are potentially remediable through family and parenting support, maternal care, and child care and education. Wider family and strong communities can also act as buffers and sources of support to ameliorate impact of mental illness.

2.2.3 Later childhood

While the early years of brain development are highly significant for later life outcomes, continued and appropriate forms of support are needed throughout childhood and adolescence. Education is important in building emotional resilience and affecting a range of later life outcomes that raise the risks of mental disorders – such as employment, income, and community participation. Schools are also important as institutions capable of delivering upstream, preventive programmes to young people. As with infancy and early childhood, children and adolescents from poorer backgrounds are likely to have greater exposure and experience of poor environments and stressful family contexts, there is therefore a need for a proportionately greater focus on those most at risk. Poverty makes it more difficult to provide home environments conducive to learning, for

instance overcrowding and unhealthy conditions Marmot Review Team (2011). Parents' access to employment not only reduces poverty, but also improves family routines, and ensures children grow up understanding the role of employment in adult lives. Schools can play a key role in working directly with children; they can also work with other services to provide parents with support and advice on parenting strategies and potentially support them with readiness for work or skills training. As children grow into adolescents, they become more interested in taking risks, including substance misuse Campion J. (2013). It is important to ensure that adolescents have the knowledge to make informed decisions, and that they have protective factors including social and emotional support and positive interactions with peers, family, and the wider community. Depressive symptoms among adolescents are associated with their history of adverse childhood experiences as well as their current experiences. Wickrama KA, Conger RD, Lorenz FO, Jung T. (2008)

2.3 Influence of Socio-economic factors of parents on the access to mental health services by mentally ill children

Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live. Social inequalities are associated with increased risk of many common mental disorders. Taking action to improve the conditions of daily life from before birth, during early childhood, at school age, during family building and working ages, and at older ages provides opportunities both to improve population mental health and to reduce the risk of those mental disorders that are associated with social inequalities.(WHO 2012).

A population study carried out in England, Wales, and Scotland found out that the more debt people had, the more likely they were to have mental disorders. Jenkins R, Bhugra D, Bebbington P, Brugha T, Farrell M, Coid J, et al (2008). A review of population surveys in

European countries found that higher frequencies of common mental disorders are associated with low educational attainment, material disadvantage and unemployment Fryers T, Melzer D, Jenkins R, Brugha T. (2005), and for older people, social isolation. The pattern of social distribution of common mental disorders is observed as a social class gradient, more marked in women than in men. McNamus S, Meltzer H, Brugha T, Bebbington P, Jenkins R. (2007.).Studies on the distribution of positive mental health in Europe have also been undertaken. Results from the Euro-barometer survey in 2002 showed significant variation in population mental health between countries, and between men and women within countries Lehtinen V, Sohlman B, KovessMasfety V. (2005). He further reported that poorer mental health was found in women, poorer groups, and among those who reported weak social support.

While comprehensive action across the life course is needed, scientific consensus is considerable that giving every child the best possible start will generate the greatest societal and mental health benefits. However, these Actions need to be universal and across the whole of society, and proportionate to need in order to level the social gradient in health outcomes. Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender. Disadvantage starts before birth and accumulates throughout life. A significant body of work now exists that emphasizes the need for a life course approach to understanding and tackling mental and physical health inequalities. This approach takes into account the differential experience and impact of social determinants throughout life. There is firm consensus on known protective and risk factors for mental disorders. In addition, a growing body of evidence exists, not only from high-income countries but growing in low- and middle-income countries, that shows effective actions can be successfully

implemented in all countries at all stages of development. Marmot Review Team (2011).

Systematic inequalities between social groups that are judged to be avoidable are inequitable and unfair, so systematic differences in mental health by gender, age, ethnicity, income, education, or geographic area of residence are inequitable and can be reduced by action on the social determinants. There is good evidence, for example, that common mental disorders are distributed according to a gradient of economic disadvantage across society Campion J, Bhugra D, Bailey S, Marmot M. (2013) and that the poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences.

Patel V, Kleinman A. (2003) in his systematic review of the l literature on common mental disorders and poverty in low and middle-income countries found that of the 115 studies reviewed over 70% reported positive associations between a variety of poverty measures and common mental disorders. A two-way relationship exists between mental disorders and socioeconomic status: mental disorders lead to reduced income and employment, which entrenches poverty and in turn increases the risk of mental disorder. Patterns of inequity in social distribution emerge before adulthood. A study found that the prevalence of depressed mood or anxiety was 2.5 times higher among young people aged 10 to 15 years with low socioeconomic status than among youths with high socioeconomic status. Lemstra M, Neudorf C, D'Arcy C, Kunst A, Warren LM, Bennett N.R. (2008).Among children as young as three and five years of age, socio-emotional and behavioral difficulties have been shown to be inversely distributed by household wealth as a measure of socioeconomic position Kelly Y, Sacker A, Del BE, Francesconi M, Marmot M. (2011)A dominant hypothesis linking social status and mental disorders focuses on the level, frequency, and duration of stressful experiences and the extent to which they are buffered by social supports in the form of emotional, informational, or instrumental resources

provided by or shared with others, and by individual capabilities and ways of coping. Those lower on the social hierarchy are more likely to experience less favourable economic, social, and environmental conditions throughout life and have access to fewer buffers and supports. These disadvantages start before birth and tend to accumulate throughout life, although not all individuals with similar exposures have the same vulnerabilities; some are more resilient or have access to buffers and supports to mitigate the potential mental health effects of disadvantage and poverty. A multilevel framework for understanding social determinants of mental disorders can be applied to strategies and interventions to reduce mental disorders and promote mental well-being.(Bell R, Donkin A, Marmot M. 2013.) These areas are important for two reasons: they influence the risk of mental disorders; and they present opportunities for intervening to reduce risk.

Limited access to mental health care increases patient and family suffering. Unmet mental health needs have a negative effect on poverty reduction initiatives and economic development. Untreated mental conditions contribute to economic loss because they increase school and work absenteeism and dropout rates, healthcare expenditure, and unemployment. Addressing unmet mental health needs will require development of better mental health infrastructure and workforce and overall integration of mental and physical health services with primary care, especially in the developing nations.

In Kenya, the economic loss associated with institutionalization of mental and behavioural disorders is about $13 million. According to Kirigia & Sambu, (2003), a large amount in a country where over half of the population live on less than a dollar per day and have no safe drinking water (UNDP, 2010),Unmet mental health needs can create social problems (e.g. unemployment, substance abuse, poverty) that may increase crime and political instability. He further observes that there is plenty of evidence that unemployment has many far-reaching effects other than loss of income, including psychological harm, loss of work

motivation, skill and self-confidence, increase in ailments and morbidity, disruption of family relations and social life, hardening of social exclusion and accentuation of racial tensions and gender asymmetries' (Sen, 1999, p. 94). In many developing nations these social problems are further compounded by poor governance, corruption and social morbidity due to natural and manmade disasters (e.g. wars) which increase mental health problems, erode social cohesion and capital, and limit economic growth (Dewa& Lin, 2000; Njenga, 2002; WHO, 2002).

2.4 Influence of Cultural factors on access to health care services by children with mental illness in Endebes Sub-County

Culture and society play pivotal roles in mental health, mental illness, and mental health services. Understanding the wide-ranging roles of culture and society enables the mental health field to design and deliver services that are more responsive to the needs of all human beings. Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). It refers to the shared attributes of one group. Anthropologists often describe culture as a system of shared meanings. The term "culture" is as applicable to whites as it is other races. The dominant culture for much of United States history focused on the beliefs, norms, and values of European Americans. But today's America is unmistakably multicultural. And because there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation, or profession), many people consider themselves as having multiple cultural identities.

With a seemingly endless range of cultural subgroups and individual variations, culture is important because it bears upon what all people bring to the clinical setting. It can account for variations in how consumers communicate their symptoms and which ones they report. Some aspects of culture may also underlie culture-bound syndromes - sets of symptoms much more common in some societies than in others. More often, culture bears upon whether people even seek help in the first

place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness. All cultures also feature strengths, such as resilience and adaptive ways of coping, which may buffer some people from developing certain disorders. Consumers of mental health services naturally carry this cultural diversity directly into the treatment setting.

Culture is a concept not limited to only patients. It also applies to the professionals who treat them. Every group of professionals embodies a "culture" in the sense that they too have a shared set of beliefs, norms, and values. This is as true for health professionals as it is for other professional groups such as engineers and teachers. Any professional group's culture can be gleaned from the jargon they use, the orientation and emphasis in their textbooks, and from their mind set or way of looking at mental illness. Health professionals in the United States and the institutions in which they train and practice are rooted in Western medicine which emphasizes the primacy of the human body in disease and the acquisition of knowledge through scientific and empirical methods. Through objective methods, Western medicine strives to uncover universal truths about disease: its causation, diagnosis, and treatment. Its achievements have become the cornerstone of medicine worldwide.

To say that physicians or mental health professionals have their own culture does not detract from the universal truths discovered by their fields. Rather, it means that most clinicians share a worldview about the interrelationship between body, mind, and environment informed by knowledge acquired through the scientific method. It also means that clinicians view symptoms, diagnoses, and treatments in ways that sometimes diverge from their clients' views, especially when the cultural backgrounds of the consumer and provider are dissimilar. This divergence of viewpoints can create barriers to effective care. The culture of the clinician and the larger health care system govern the societal

response to a patient with mental illness. They influence many aspects of the delivery of care, including diagnosis, treatments, and the organization and reimbursement of services.

Clinicians and service systems, naturally immersed in their own cultures, have been ill-equipped to meet the needs of patients from different backgrounds and, in some cases, have displayed bias in the delivery of care. The main message of this Supplement is that "culture counts." The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated and they do count. Cultural differences must be accounted for to ensure that minorities, like all Americans, receive mental health care tailored to their needs.

The burden of mental disorders in developing countries is compounded by high rates of stigma and discrimination, which are major obstacles in the provision and utilization of mental health services (Horwitz, Roberts, & Warner, 2008; Okasha, 2002; Onyut et al., 2009; Ssebunnya, Kigozi, Lund, Kizza, &Okello, 2009). Research documents increasing social distance and stigmatization of people living with mental disorders in sub-Saharan Africa (Adewuya & Makanjuola, 2005, 2008) even among mental health providers (Ndetei et al., 2009). The stigma, myths and misconceptions surrounding mental illness contribute to much of the discrimination and human rights violations experienced by people with mental disorders (Ndetei et al., 2007a). The laws, practices and social norms in many nations give extensive powers to guardians of people with mental disorders to decide where they live, their movements, their personal and financial affairs, and their care including their commitment to mental hospitals (Ndetei et al., 2007a).

Research, however, shows that clinicians and others, including family members, inaccurately judge what patients value (Gerhart, Koziao-McLain, Lowenstein, & White neck, 1994; Laine et al., 1996; Roberts et al., 2003; Roberts, Warner, Anderson, Smith peter, & Rogers, 2004a; Roberts, Green Hammond, Warner, & Lewis, 2004b), resulting in unnecessary restrictions in the rights to work, education, marriage and participation in community or family functions.

Limited knowledge of the causes, symptoms and treatment of mental illness often leads to common but erroneous beliefs that these conditions are caused by individuals themselves or by supernatural forces, possession by evil spirits, curse or punishment following the individual's family or is part of family lineage (Mohit, 2001). Disturbingly, physicians in training in some developing or economically disadvantaged countries hold these same beliefs, even after undergoing psychiatric training (Roberts, 2010). For example, 23–40% of Nigerian medical students in one study endorsed supernatural causes of mental illness, such as charms, evil spirits, and witchcraft (Aghukwa, 2010). These beliefs increase stigma, discrimination, and social isolation of individuals living with mental illness and limits resources for their care. Without effective diagnosis and treatment options, mental disorders are seen as untreatable, resulting in patients being undervalued and perceived as not able to contribute to society. In developing nations and in some communities in developed nations, the limited availability of modern mental health services and providers is offset by reliance on traditional and faith healers (Beals et al 2005). Although these alternative healers play a critical role, they often lack the necessary training and skills to provide effective care for people with serious mental illness.

A study on people with epilepsy in rural Ghana, found that spiritual beliefs surrounding epilepsy influenced health and seeking of treatment. While a study in rural areas of the Gambia reported that only

16% of 380 people with epilepsy knew that preventive treatment was possible; 48% of people with epilepsy had never used treatment, 70% did not know that clinics offered treatment for seizures.

2.5 Influence of geographical factors on the access to health care services by children with mental illness

The geographical factors taken into consideration by patients or their family before utilization of services include distance, time taken to travel and the geographical location. Several researches have been conducted on how each of the factors has influenced access to health care services.

The distance to health facilities is taken into consideration before utilization of services. Distance affects the mode of transport utilized and the time taken to reach a health facility. Several studies under review showed that travelling to a health centre was challenging for children with disability. These studies were conducted in South Africa (Saloojee et al. 2006, Barrat and Penn. 2009, Grut et al. 2012, Maart and Jelsma 2013); Mozambiques (Ravim and Handicap International), Namibia (Coorner, 2012) and in Malawi (Munthali et al. 2013). The authors in all these studies noted that the high cost of transportation, unreliability and its unavailability as the main obstacles to accessing health care services. The high cost was related to the price persons with disability had to pay for the service and also for extra charges.

Munthuli et al (2013b) conducted a study based on the living conditions surveys done by Sintef in Malawi. Their study however focused on only persons suffering from epilepsy. According to their results the respondents in the study who had to travel a distance of at least 50 kilometres to the nearest health facility reported that this was time consuming and not economically viable as they could be engaging in other productive activities.

However Coomer (2012) reported that in Namibia the distance from the health facility to the residence of the child with disability did not pose a barrier as most health facilities in the Khomas region where on average 5 kilometres away. However, disabling condition of the child made it impossible to walk on foot. She also noted that cost benefit ratio of paying for expensive transport and getting a poor service at the health centre is usually the main obstacle and not necessarily the transport itself.

The same concept of cost benefit ratio was observed by Saloojee et al (2006). They conducted a qualitative study in a poor residential are in Soweto, Johannesburg, South Africa. Most of the key informants in the study were unemployed or living in single headed households where the farther rarely supported the child with disability. Therefore their socio-economic status dictated whether they would prioritize paying for hospital and transport fees or use the resources for other needs. Therefore the non-compliance with use of health services could be understood as a rational choice.

Lawrence and McCulloch (2001) reviewed the barriers that older adults, specifically those in rural areas face when in need of mental health care. They note that stigmatization, migration, economic conditions, and informal social support inhibit elders in rural communities from seeking mental health services. According to him, migration patterns indicate that younger people are leaving rural areas to seek professional type careers in urban areas. This leaves rural communities depleted of the resources that younger people may contribute. This is because, Younger people, who may be more open minded to mental health care, are thus leaving rural areas. This depleted part of the social network on which elderly community members may rely. According to them, these tend to propagate the stigma that mental health issues are not important to address.

Goetz & Freshwater (1997) indicated that the incidence of poverty is higher among rural families and for women and children residing in rural, female-headed household than for those living in urban areas and cities. In his findings rural dwellers had 12% to 19% fewer financial resources than their urban counterparts (McLauglin, 1998). This meant there were fewer resources in rural areas and fewer individuals being able to afford what services are available. When a choice was to be made between mental health care or medical care, few choose mental health. This shows that even if services were available, rural folks, who live at or below the poverty level, cannot feasibly access them. Fears about the unknown relationships between mental health professionals and clients may also create stigma. As noted, participants surveyed believed that professional mental health care would probably be useful, but they were unsure of how relationships would be built between their children and the professional. This uneasiness contributed to an avoidance of seeking out care. It also appeared that older people in rural areas may hold onto out dated notions regarding what mental health and illness actually are. As younger people migrate out of rural areas, the older residents are left with little to replace these ways of thinking.

Garfinkel and Goldbloom (2000) depicted stigma surrounding mental health as originating in fear, lack of knowledge, and ingrained moralistic views that have persisted since antiquity. Rural cultural philosophy tends to exacerbate this stigma. Kelleher, Taylor, and Rickert (1992) postulate that certain characteristics of rural residents such as a high regard for autonomy and self-help propagate this stigma even more.

Weinert and Long (1987) conducted a qualitative/quantitative study regarding health care needs of rural Montanans. Contradictory to current data that suggests equivalent rates of mental illness in rural and urban populations, the Weinert and Long study indicated fewer indices of depression in rural Montana than in urban counterparts. Suggested rationales for this outcome, however, were the possibilities of rural

peoples not recognizing symptoms of depression as such, or not seeking help for this symptomology. This study also illuminated the importance of self -help as described by the rural participants.

Buor (2005) in his study “the determinants of utilization of health services by women in rural and urban areas in Ghana’’ it was also found out that in-come and family size affect the rural areas in Ghana during utilization while education and marital status affect those in urban areas. The influence of education on use of health service was also been examined It further appeared that respondents had negative biases regarding the stigma of accessing treatment and were unsure about ways in which positive therapeutic relationships could be built. He pointed out the need for educating potential clients regarding the therapeutic process and alleviating the negative viewpoints that often accompany the realization that mental health services may be necessary or beneficial.

According to the World Bank report (1996b), one in every three women from rural areas in Africa lives more than 5 kilometres from the nearest health facility. The scarcity of vehicles especially in remote areas, and poor road conditions can make it extremely difficult for women and other vulnerable groups to reach even relatively nearby facilities. Walking is also the primary mode of transportation, even for women in labour (Williams et al., 1985, World Bank, 1994).

Henson, Sadler, and Walton (1998) defined distance as "a degree of separation between two or more entities" and added that "the nature of that entity may be in space, time, or behaviour" (p. 51). Distance can be measured in various ways including linear distance on a map, road distance, travel time, perceived distance, perceived travel time, and distance to the nearest provider (Arcury, Gesler, Preisser, Sherman, Spencer & Perin, 2005). Distance is comprised of three attributes including mileage, time, and perception (Henson, Sadler, & Walton, 1998).

Accessing health care in rural areas is confounded by such varied problems as an insufficient health infrastructure, the press of chronic diseases and disabilities, socioeconomic barriers, and physical barriers (Ricketts, 2001). Many rural dwellers must travel formidable distances to obtain even the most basic of health care services. Distance issues may be further affected by accessibility of transportation, the inability to drive, lack of a driver's license, physical and mental impairments that may impact the use of public transportation, and severe or inclement weather (Bushy, 1993). One major reason for limited engagement by parents is their lack of knowledge of local services and how they could help (Gibbons and Thorpe, 1989; Henrickson, 2002). For example, Bhabra and Ghate (2004) reported on the evaluation of Parent Information Point (PIP), a pilot project that aimed to provide parents with a one-off session in schools to give them information about parenting and inform them of local services. Marmot Review Team (2011).They found that per cent of non-participants have never received information about the event, and that knowledge levels of both attenders and non-attenders was very low. Physically accessing a service can also prove challenging. Parents dependent on public transport to travel to a service have to take account of the cost of travelling to the service as well as practical considerations such as push chairs or transporting babies. There are also groups of parents prevented from accessing services because of time pressures – a particular issue for single parents and parents in employment (Johnson, 2003). Disabled parents face physical barriers to accessing services (Ellis, 2003; Olsen and Wates, 2003; Morris, 2004a, 2004b). Morris (2004a) points out that in addition to physical barriers, some disabled parents are challenged by factors such as lighting and colour contrasts, which can affect visually impaired parents. The geographical location of a service has a significant influence on parents' ability to attend.

Smith (1996) argues that even 'universal' services supposedly open to all parents, are restricted in reality by their geographical location. Many parents cannot access mental health care. Barriers to inclusion can

realistically be expected to attend services unless they are conveniently located in their own community or neighbourhood.

In the UK, Frost (2001) explored family support services in rural communities and found that many families were failing to engage in services because they were physically inaccessible. He argues that these families are slipping through the net because of policy-making assumptions that families in need live in urban environments. The Countryside Agency (2003) similarly found that the main challenges facing effective service delivery in rural areas included the different perceptions of need between disparate communities, the lower expectations of service availability, lower levels of resources and trained staff and a lack of suitable premises. The additional time and cost of providing services coupled with the risk of attracting low numbers of participants created further disincentives.

However, Kissane (2003), who interviewed poor female parents living in Philadelphia about their use of social services, found that the physical distance of a service from the neighbourhood they lived in was not important as long as it was accessible by public transport. The perception of an area as ‘safe’ in terms of crime was also influential in decisions about whether a service is used. This indicates that physical accessibility must be seen in the context of the type of community served by the service, rather than purely as an issue of geographical distance.

A study among Mru indigenous people in Bangladesh shows that distinctive geographical location and long distance to the service Centre from their place of residence is a determining factor for their low access to health facilities, antenatal care and postnatal care visits (Islam, 2010). Research on accessing community health services; challenges faced by the poor with disabilities in rural communities of South Africa. With new health centers established in rural areas, it had been thought that it would have presented a new opportunity for majority to access health services.

However, in order to receive health services some community members had to walk over hours. Public transport in form of small pickups was available on main roads. Because a person with disability had to be accompanied, parents have to plan for extra transport. In rural Tanzania, 84% of women who gave birth at home intended to deliver at a health facility but did not due to distance and lack of transportation (Bicego et al., 1997).

In Kenya, research conducted in Baringo by Benjamin N. Mwasi (2011) aimed at identifying the major barriers to mental health care service access for the people living in that area. The study identified, distance, time and cost as the strongest barriers to accessing mental health care access. While distance was the single most important factors affecting the choice of facility attended.

If you live in a city, you're more likely to be able to access health care than people who live in rural areas, according to (Fort & Voltero 2010) his findings revealed that.in many cases, doctors choose not to practice in rural settings because of financial constraints or due to lack of resources in rural areas. Often, these areas have deficits in specialists or hospital facilities. As a result, patients may need to drive long distances to attend medical appointments.

2.6 Influence of Parents' perception on mental health on the access to health care services by children with mental illness

Perception in this context is defined as parent's inability to identify children's needs for mental health services, denial of the severity of a mental health problem, or belief that the problem can be handled without treatment. Perceptions about mental health services e.g lack of trust in or negative experience with mental health providers, lack of children's desire to receive help, or stigma related to receiving help may also affect the willingness to seek treatment (Owens et al, 2002)

National association of Mental Illness carried out a Major survey on the following: healthcare-provider experiences, health insurance and managed care, the fall-out of inaccessible treatment and services, school-system experiences, abuse of children and adolescents in various systems, and the toll on families. While some families reported some positive experiences in each domain, the overall picture is that, there are major barriers to mental health care for the children and the families .NAMI (1999) The findings reported that; Only 34 percent of respondents agreed that their primary care physicians routinely evaluated mental, emotional, and behavioural issues and development; of the respondents, 56 percent of the responding parents stated that their children's primary care physician did not recognize their serious mental illnesses. Sixty-six percent of responding parents reported a lack of health insurance parity, with nearly half-49 percent-saying lack of parity impeded needed care. Nearly half of the respondents, again 49 percent, indicated that managed care organizations limited or denied access to needed treatment for their children to the detriment of their children's health. Twenty-three percent of respondents reported having been told that they will have to relinquish custody of their children to get needed services; 20 percent said that they did so to get care. Fifty percent of the responding parents reported agreeing or strongly agreeing with the statement, "I worry that my child will not get needed treatment and will become physically aggressive or violent." More than one third of the parents who responded to the survey 36 percent reported that their children were placed in juvenile justice because needed services were not available. Nearly half of the responding parents-46 percent-felt that schools resisted identifying children with serious mental illnesses; 68 percent said that their children must fail before services are put in place in schools. Only seven percent of respondents said that school professionals are adequately trained and prepared to deal with serious mental illness in children and adolescents. Nearly half of our survey respondents felt shunned by neighbours and friends because of their children's illnesses-and half said they are blamed for their children's conditions. In more than half the families, 55 percent,

one of the parents had to change jobs or quit to take care of the ailing offspring. Fifty-nine percent said they felt like they were pushed to the breaking point. Seventy percent reported that their marriages had been severely stressed by the experience of caring for a sick child; and in 80 percent of the responding families, siblings were negatively affected.

Kleinman (1980) carried out a study in Taiwan where he found out that if an individual's family had knowledge of an effective home remedy the person would often attempt that treatment before utilizing professional health care services. In Kleinman's study, families in Taiwan provided social resources, specifically knowledge, of which a lone ill person may not have been aware. The rapidly-evolving literature concerning stigma towards psychiatric illnesses among Chinese groups has demonstrated pervasive negative attitudes and discriminatory treatment towards people with mental illness. Yang L.H (2007).

A study on people with epilepsy in rural Ghana, found that spiritual beliefs surrounding epilepsy influenced health and seeking of treatment. While a study in rural areas of the Gambia reported that only 16% of 380 people with epilepsy know that preventive treatment was possible; 48% of people with epilepsy have never used treatment, 70% do not know that clinics offered treatment for seizures. In rural Tanzania, 84% of women who gave birth at home intended to deliver at a health facility but could not due to distance and lack of transportation (Bicego et al., 1997).

As such, belief in the efficacy of treatment, influenced by cultural categories of illness, can shape adherence to prescribed treatment and ultimately the use of health care services. Beyond faith in efficacy, cultures can have differing notions of the self which may influence health services utilization. For instance, in the United States as well as many other western nations, there are two main conceptions of self, one that is autonomous and one that is heteronomous (Gaines, 1992). If an individual is a member of a culture that considers the self as

heteronomous, they are likely to have their course of treatment determined by people within their networks.

According to the study by Coorner (2012), the negative experiences at the health centers ranged from not having a consistent physician and having to explain the child's health history many times, and to not finding a physician when they visited the health center and being treated by a student nurse instead.

The ACPF (2011b) report states that having to wait in a long queue is a challenge for a child with celebral palsy who needs medication to control their spasms. Due to their poor record and filling systems respondents reported that they had to wait at the hospital for a number of hours before their child's health records could be found (Barrat and Penn. 2009).

Socially there is still a lack of knowledge and acceptance for persons with disability in the community. This is usually the case in the rural areas where disability is still being viewed as an illness which is communicable, a shame, a result of witchcraft, a punishment from the ancestors for some wrong doing of the parent or extended family on a sign of promiscuity by the mother of the child (Ravin and Handicap International. 2010).

2.7 Theoretical Framework

The researcher relied on three theories to support this study. The theories described are Parsons' sick role, Mechanic's general theory of help seeking and Suchman's stages of illness and medical care.

2.7.1 Parson's sick Role theory (1951)

According to this theory, when an individual is sick, they adopt a role of being ill. This sick role has four main components: the individual

is not responsible for their state of illness and is not expected to be able to heal without assistance; the individual is excused from performing normal roles and tasks; there is general recognition that being sick is an undesirable state; and to facilitate recovery, the individual is expected to seek medical assistance and to comply with medical treatment. Parsons' theory attempted to identify typically seen behaviour in individuals who are ill. However, while ground breaking, the sick role failed to account for variability in illness behaviour. As a result, scholars have proposed multifaceted models and theories which identify factors influencing health care seeking (Wolinsky, 1988a).

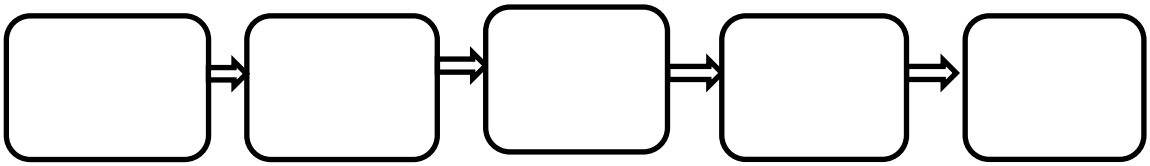
2.7.2 Mechanic's general theory of help seeking (1978)

The Mechanic's (1978) general theory of help seeking takes a psychological approach to health care utilization. The theory incorporates ten decision points which determine illness behaviour: the salience of deviant signs and symptoms; the individual's perception of symptom severity; the disruption of the individual's daily life as caused by the illness; the frequency of symptoms and their persistence; the individual's tolerance of symptoms; the individual's knowledge and cultural assumptions of the illness; denial of illness as a result of basic needs; whether or not response to the illness disrupts needs; alternative interpretations of symptom expression; and treatment availability via location, economic cost, psychological cost (stigma, humility, etc.), and treatment resources. Beyond these ten points, Mechanic's theory allowed for illness response to be influenced by either the individual or a person who makes decisions for the individual (Wolinsky, 1988b). Thus, as expressed in the illness behaviour theory, autonomy and heteronomy influence health care utilization.

2.7.3 Suchman's stages of illness and medical care (1965)

The Suchman's stages of illness and medical care (1965) indicates five stages of the individual's decision process in determining whether or not to utilize health care: the individual's symptom experience, including pain, emotion, and recognition of experience as symptomatic of illness; the individual's assumption of a sick role. During this second stage, the individual also explores his or her lay referral system for validation of the sick role and for exploration of treatment options; medical care contact. During this stage the individual seeks a professional health care system. However, the pace at which a person enters this stage is determined by their membership within parochial and cosmopolitan social networks. If a person's social network is parochial, they will tend to delay medical care contact by continuing the first two stages for longer than a person who is a member of a cosmopolitan network; the assumption of a dependent-patient role via acceptance of professional health care treatment. It is possible for this stage to be disrupted if the individual and the professional health care provider have differing opinions of the illness; the individual's recovery from illness. The individual recovers upon relinquishing their role as patient. However, if an illness is not curable, a person may assume a chronically ill role (Wolinsky, 1988b).

Figure 2.1 Suchman's stages of illness and medical care (1965)

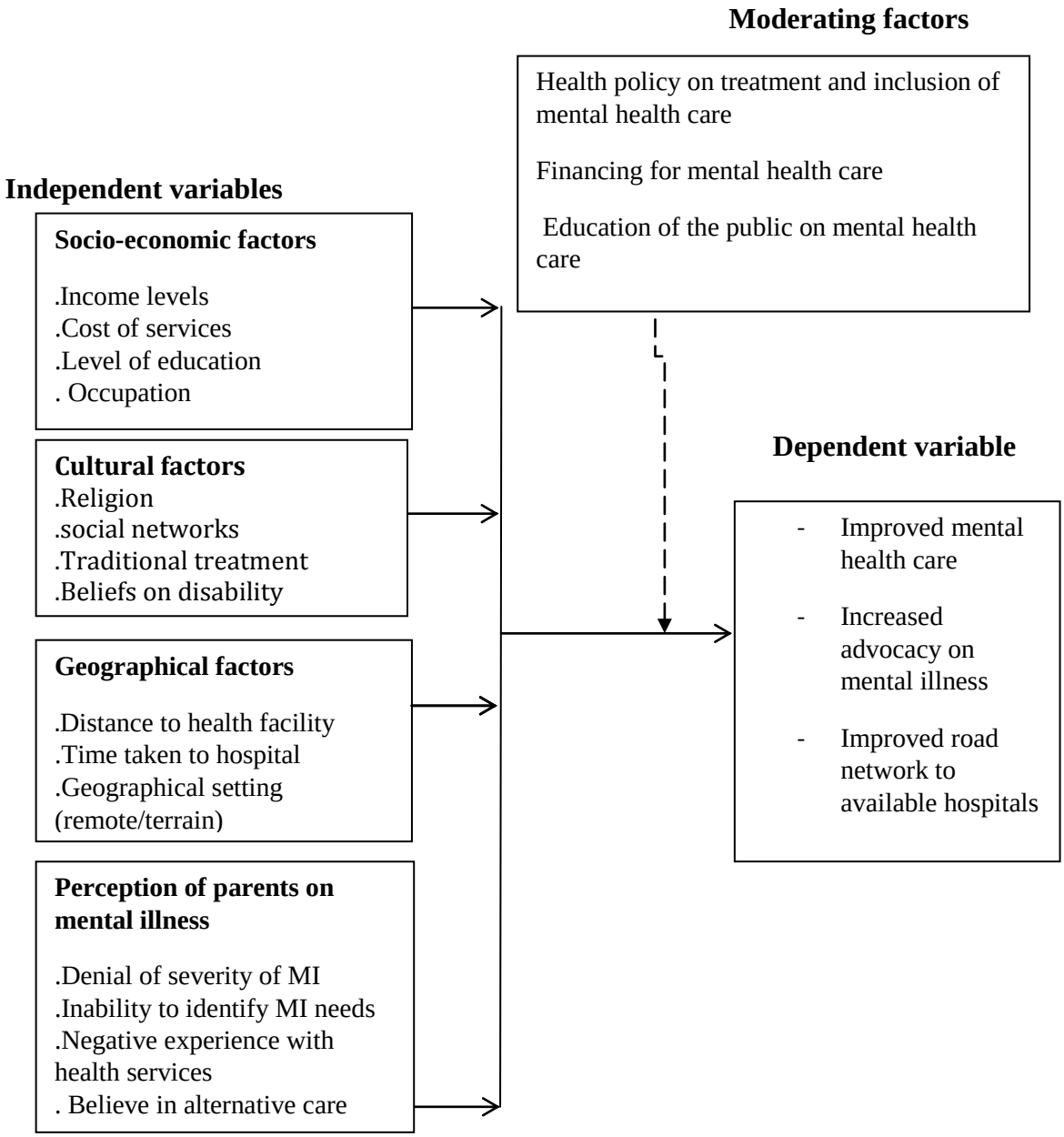


2.8 Conceptual Framework

The researcher conceptualized that, independent variables were the socio-economic, cultural, geographical and parents perception and tried to show the relationship they influence the dependent variable of access to health care for children with mental illnesses. However, in the presence of moderating factors such as Health policy, Financing,

Inclusion and Education can improve the situation and ensure that many affected families seek medical help for their children at an early age hence increasing the chances of healing.

Figure 2.2: Researcher's conceptual framework of the linkages between variables in the study.



2.8 Knowledge gap

This study sought to fill the following knowledge gaps:
Different scholars had conducted studies on prevalence of mental illness, influence of mentally ill parents on the children. No research had been conducted on factors influencing access to health care services among children with mental illness. However, in this study, the researcher looked at factors influencing access to health care services among children with mental illness. Since, No such study had been carried out in Endebes Sub-County, therefore the findings will be used for future references.

For the few researches that had carried out on mental health, they had been based in the urban areas. The researcher focused on the rural areas hence bringing new knowledge by filling these knowledge gaps. The table below analyses the knowledge gaps that the researcher sought to fill in each objective.

Variable	Source	Finding	Gap
Socio-economic factors	Campion J, Bhugra D, Bailey S, Marmot M. (2013)	In their study, they found out that common mental disorders are distributed according to a gradient of economic disadvantage across society and that the poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences	They however did not look at how the low socio economic status influences access to mental health care. Hence the researcher sought to determine how low socio economic status influenced access to mentally ill children.
Geographical factors	Kelleher, Taylor, and Rickert (1992)	Postulated that certain characteristics of rural residents such as a high regard for autonomy and self-help propagate this stigma even more.	They looked at the rural area as places where stigma was high and hence had an influence on whether they sought for treatment or not. The researcher however looked at the influence of rural roads and unavailability of health facilities as an impediment to access to mental health care.
Cultural factors	(Roberts, 2010).	He found out that, physicians in training	The researcher looked at how

		in some developing or economically disadvantaged countries held the same beliefs that , that these conditions are caused by individuals themselves or by supernatural forces, possession by evil spirits, curse or punishment following the individual's family or is part of family lineage after undergoing psychiatric training	these same beliefs influenced the access to medical facilities by parents who had children suffering from mental illnesses. This was to help in determine the factors that influence access to children with mental illnesses.
	Perception of parents on mental illness	Yang L.H (2007)	In his study, he found out that rapidly-evolving literature concerning stigma towards psychiatric illnesses among Chinese groups has demonstrated pervasive negative attitudes and discriminatory treatment towards people with mental illness	The researcher looked at how these negative perceptions and beliefs would influence the ace to mental health care by parents with mentally ill children

2.10 Summary of the Literature Review

The literature reviewed covered factors influencing access to health care services among children with mental illness in Kenya. The literature was reviewed on four objectives of the study. Socio-economic factors influencing access to health services were level of income, education level and cost of health services were the main some of the socio-economic factors found to influence access to health care services. On geographical factors, geographical location and distance to health care services were the key factors which influence access to health services. The cultural factors were reviewed and its influence on access to health care services established. Perception of the health status also influences access to health services.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter was mainly concerned with the method and plan to be used in carrying out the study. These included the research design, the target population, sampling procedure, research instruments, methods of data collection, methods of data analysis and ethical issues.

3.2 Research Design

A research design is the structure of research that is said to be the glue that holds all the elements of the study together. Kothari (2004), describes it as "the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure". In this study, a descriptive survey design was used. According to Mugenda (2003), Descriptive research design allows description of the behaviour of a subject in its unchanged natural environment. According to Orodho and Kombo (2002), Descriptive survey is a research design in which Questionnaires and Interview Schedules are administered to a Sample of respondents in order to collect data about the characteristics, actions, opinions or attitudes of a large group of People. The purpose was to answer questions concerning the current status of the subjects being studied. The design was used to get the opinion of the respondents on factors influencing access to mental health care services among children with mental illness in Endebes Sub-County.

Descriptive statistics such as frequencies and percentages were used to summarize and describe the data. The appropriate inferential statistics were used to draw inferences from the sample population.

3.3 Target Population

According to Orodho (2005), target population is a large population from which a sample population is selected. According to 2009 census results Endebes sub-county has a population of 91,192 people. The adult-children population ration is 50-50. The researcher further estimates that there are about 5,000 parents/guardians of children with mental illness in Endebes sub-county. The target population is therefore 5000.

3.4 Sample size and Sampling procedures

3.4.1 Sample size

A sample is a set of respondents selected from a larger population for the purpose of a survey. (Kothari 2004) confirms that a sample size is part of the population that took part in the study.

Using Kreijcie and Morgan's (1970) tables, the sample population is 381 as the population is 5,000 (appendices 1)

Table 3.1: Sample size

Respondents	Target population	Sample size
Parents	5000	381
TOTAL	5000	381

3.4.2 Sampling procedure

Sampling is the process of selecting number of individuals from the population such that the selected group contains elements representative of the characteristics found in the entire group called a sample. (Kothari 2004) consequently samples can be selected by a sampling design. The sample was drawn from a target population of 5,000, using Krejcie and Morgan table (1978), a sample size of 381 was arrived at. Since the researcher did not know where the respondents live,

a snowball sampling procedure was used. Through volunteer children's officers leaders of existing parents groups of children with mental illness were identified. The leaders led the researcher to each of their members and they consequently referred the researcher to other parents. The use of local community health workers made it easier to identify the parents who did not belong to any group.

3.5 Data collection instruments

Data collection instruments are tools used to collect data from respondents. Questionnaires were therefore used to solicit data from the respondents. This instrument is preferred because it up holds confidentiality, saves on time, lack interviewer bias and enables collection of data from a large sample and from various regions of the study.

3.5.1 Piloting of the Instrument

A pilot study to test the research instruments were carried out in Kwanza Sub-county, a neighbouring sub-county which has similar characteristics with Endebes Sub-county. This brought to a total of 34 respondents during pilot study. This is done to determine the validity and reliability of the instrument.

3.5.2 Validity of the Instruments

Validity is the extent to which differences found with a measuring instrument reflect true differences among those being tested. Kothari (2004); there are three types of validity. Content validity is the extent to which a measuring instrument provides adequate coverage of the topic under study. Criterion-related validity relates to the ability to predict some outcome or estimate the existence of some current condition. The researcher made a pre-visit to the study area in order to familiarize oneself with the location. On the other hand Construct validity is the

degree to which scores on a test can be accounted for by the explanatory constructs of a sound theory.

After constructing the research instruments, the researcher shared the instruments with his supervisor and colleagues in the Department of Extra-Mural studies of the University of Nairobi as recommended by Mutai (2000), to ascertain it's constructive and face validity. According to Gall (1989), content validity improved through expert Judgment. The instruments were then restructured and clarified questions that were not clear.

3.5.3 Reliability of the Instrument

The reliability of an instrument is the degree of consistency with which a research instrument measures whatever it is intended to measure and yields consistent results. It refers to the extent to which findings can be replicated by another researcher (Silverman 2005). To test the internal consistency of the items listed on the instrument used, the Cronbach alpha coefficient was computed. Cronbach's alpha is a statistic coefficient (a value between 0 and 1) that is used to rate the reliability of an instrument such as a questionnaire. This method randomly splits the data set into two and a score for each participant calculated from each half of the scale. If a scale is very reliable, respondents get same scores on either half of the scale so that, correlation of the two halves is very high. The advantage with using Cronbach's alpha is that the data is split into every possible way and the correlation coefficient for each split computed. The average of these coefficients is the value equivalent to this alpha (Cronbach, 1951). Thus Cronbach's alpha was used to test reliability of the questionnaires used in the study. A reliability correlation coefficient of 0.79 was achieved which indicated a high degree of internal consistency among the data collected and hence was used for data collection of the final study (Kathuri & Pals, 1993).

3.6 Methods of data analysis

The quantitative data were analysed using statistical methods and expressed in the form of tables, frequencies and percentages.
After data analysis, the researcher compiled a final report and presented the same for approval by the Faculty Board upon completing of defence.

3.7 Ethical Consideration

Permission to conduct the study was sought from Research and Ethics Committees of the University of Nairobi and consequently obtained a permit and authorization letter from the National Council of Science and Technology, Ministry of Education Science and Technology Permission was sought from the Endebes sub county administration for entry into the research area. There was no coercion of any nature to the respondents e.g. promising what the researcher could give to the respondents and Consent would be sought from all the participants after explaining the aims, methods, anticipated benefits and potential hazards if any. Participants were then assured that data collected from the study would be kept confidential and used only for purposes of this study. This was also on voluntary basis and participants were free to withdraw from the study at any time. Any information sought would not reveal the identities of the participants

3.8 Operational Definition of Variables

Table 3.2 Operationalization of variables

Objectives	Variable	Indicator	Measure	Scale	Type of analysis
Socio-economic factors	Independent	-levels of income -level of education	-Amount earned -Level attained	Nominal	Quantitative
Cultural factors	Independent	Increased advocacy	-Number reached	Nominal	Quantitative
Geographical factors	Independent	Distance to hospitals -Location of residence	Distance travelled Number of hospitals -Rural or urban	Nominal	Quantitative
Parents' perception	Independent	Denial of severity of MI -Inability to identify MI -Negative experience with health services	Acceptance of MI Identification of MI Positive experience	Nominal	Quantitative
Improved mental health care	Independent Variable	Availability of specialist medical officers	Early detection	Nominal	Quantitative
Increased advocacy	Independent Variable	Increased knowledge on	Early treatment	Nominal	Quantitative

on mental illness		mental illness			
Improved road network to available hospitals	Dependent Variable	Good road network	Regular maintenance	Nominal	Quantitative

3.9 Summary of Research methodology

Chapter three is the final chapter in a research proposal and it highlights how the data was collected, coded and analysed to give information that was filled in the gaps that were identified in chapter two during the literature review.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter involves presentation, interpretation and discussion of findings. In this chapter of the research report, the researcher presented the data from the field and the data analysis procedures employed to answer the research questions that guided the study questions below.

1. How do Socio-economic factors influence access to health care services among children with mental illness in Endebes Sub-County?

2. How do geographical factors influence accessibility to health care services among children with mental illness in Endebes Sub-County?

3. How do cultural factors influence access to health care services among Children with mental illness in Endebes Sub County?

4. How does the parents' perception on mental illness influence access to mental health care services among children with mental illness in Endebes Sub-County?

Discussions are then formed to help assess the contribution of the data collected to the body of knowledge.

4.2 Response Return rate

A total of 381 questionnaires were sent out to the respondents in the study area to fill. This sending out more questionnaires was to give some allowance since some questionnaires would have not come back.

Of these questionnaires, 354 were returned for analysis. However, 37 questionnaires were incomplete and therefore could not be analysed. The remaining 317 questionnaires accounted for 83% response rate. According to Mugenda and Mugenda (1999) a response rate of 70% and above is sufficient and hence it allowed for data analysis.

4.3 Background Characteristics of respondents.

Information about background characteristics of respondents of Endebes Sub County had varied backgrounds. The researcher found it necessary to analyse this data. It includes gender, age, education level and, position in society.

4.3.1 Gender of respondents

The study found it necessary to analyse the gender of respondents as there were need to demonstrate the heterogeneity of the respondents.

Table 4.1 Gender of respondents

Description	Frequency	Percentage
Male	162	51
Female	155	49
Total	317	100

Table 4.1 indicates that 162(51%) of the respondents were male while 155 (49%) were female. This implies that both sexes were adequately represented in the study and that the samples were heterogeneous. The researcher believes that the findings of this study present the views of all genders (male and female) from Endebes sub-county.

4.3.2 Age bracket of respondents

The study found it necessary to analyse the age brackets of respondents. The data is represented in the table below.

Table 4.2 Age bracket of respondents

Description	Frequency	Percentage
18-28	85	27
29-39years	111	35
40-50 years	95	30
50-60	19	6
Above 60	7	2
Total	317	100

Regarding the age of respondents, Table 4.2 indicates that 85(27%) of the respondents were in the age group of below 18-28 years while 111(35%) of the respondents were 29 – 39 years of age. Another 95 (30%) of the respondents were 40-50 years of age, 50-60 had 19 (6%) of the respondents and 7(2%) of the respondents were above 60 years. This implied that all the target respondents were adults.

4.3.3 Level of education of respondents

Table 4.3 Level of education of respondents

Response	Frequency	Percentage
Never gone to school	10	03
Primary	143	45
Secondary	130	41
Tertiary	28	09
University	6	02
Total	317	100

The findings revealed that 10 (3%) of the respondents had never gone to school, 143 (45%) had attained primary education level, while 130 (41%) had been to a secondary school. . 28(09%) had been to tertiary institution whereas 6 (2%) had attained University education level This is

important as it can be used to further assess how education influences peoples choices on whether to use health care services. Education is also a very important socio-economic indicator.

4.3.4 Respondents' understanding of mental illness

The respondents were asked to confirm if they understood what mental illness is. The responses are presented in the table below.

Table 4.4 Respondents' understanding of mental illness

Description	Frequency	Percentage
Yes	241	76
No	76	24
Total	317	100

When asked to state whether they understood what mental illness is, 241 (76%) replied with YES while 76 (24%) said NO. This show that majority of respondents believed that they knew what mental illness is. However, as to what extent to which they understood would not be confirmed since they were not meant to define. This could be verified with the preceding questions.

4.3.5 Symptoms of mental illness

The respondents were asked to list some of the symptoms of mental illness that they knew. This being an open question the respondents gave varied respondents. This question was analysed in two categories with those who said they understood mental illness (YES) in previous question on one hand and those who said they did not understand what mental illness was (NO) on the other hand.

Interestingly, 21 (9%) out of 241 who had said they understood mental illness would not give any correct symptom. Under this category, Some of this respondents listed deafness, speech problem, and loose

neck, not able to hear and slow growth which were symptoms of associated to others forms of disabilities. Surprisingly some respondents thought diarrhoea, vomiting and fever were symptoms of mental illness. While 139 (58%) out of 241 gave two correct symptoms out of the four they listed. Despite giving two correct responds, the other symptoms given either related to other forms of disabilities while others would not relate to any disability. Only 102 (42%) of the 241 who had earlier said they knew what mental illness listed four correct symptoms. The symptoms associated to mental illness according to this respondents were; violent, aggressiveness, stress, depression, anxiety disorders, hallucinations and post-traumatic stress disorders.

4.3.6 Causes of mental illness

The researcher needed to determine if the respondents understood the causes of mental illness. After analysis, the researcher found out that 265 (84%) respondents listed various causes of mental illness while 52 (16%) said they did not know any cause of mental illness. Further analysis indicated that 44 (14%) of the respondents mentioned witchcraft and curses as causes of mental illness; this is alarming bearing in mind that mental illness is treatable if detected and reported early. A total of 221 (70%) of them listed varied causes of mental illness including Family inheritance, Accidents, drug abuse/alcoholism, illness, traumatic experiences like abuse. In summary, it can be concluded that 30% of the respondents were either misinformed or unaware of the causes of mental illness while 70% were aware of the actual causes of mental illness.

4.3.7 Respondents were asked if mental illness is treatable

When the respondents were further asked if mental illness is treatable or not and the results recorded in the table below;

Table 4.5 Respondents views on treatability of mental illness

Responses	Frequency	Percentage
Yes	259	82
No	58	18
Total	317	100

The finds indicated that some 259 (82%) believed that it was treatable whereas 58(18%) believed that it wasn't treatable. The opinion held by the parent as to whether mental illness is treatable or not is very significant as it determines whether the parent or a guardian would choose to take the child to hospital for mental health care or not. In this case 82% of the respondents believed that the disease is treatable and therefore if the barrier factors are addressed they would seek medical services for children with mental illness. However, 18% would still be locked out of the services even if barriers to services were addressed and would therefore require different interventions to help them change their opinion.

The researcher further analysed how the respondents who had associated mental illness responded to this question; 14 (32%) out of the 45 said that mental illness can be treated while 16 (36%) believed one would be healed by witchdoctors, 6 (14%) believed only prayers would heal. Surprisingly 2 (5%) believed counselling would help one heal while 5 (11%) believed mental illness could be treated at the hospital.

4.3.8 Rating of the level of access to health services

Respondents were asked to rate the level of access to health services among children with mental impairment in their area. The responds are presented in the table below.

Table 4.6 Rating of the level of access to health service

Responses	Frequency	Percentage
No Access	138	44
Low Access	159	50
Moderate	17	05
High Access	03	01
Total	317	100

The findings revealed that 138 (44%) believed that there was no access to health care despite it being treatable, while 159 (50%) believe that there was low access to health care services among children with mental illness. However, 17 (5%) believe that there was only moderate access to mental health services whereas 3 (1%) believe there was high access to the mental health care services. This statistics are worrying bearing in mind that earlier analysis showed that 76% of respondents believed that mental illness is treatable.

4.4 Influence of Social-economic factor on access to mental healthcare for children

The respondents were asked about social economic factors influencing access to mental healthcare services. These factors include, level of education, employment, their monthly income and the factors which prevent parents from taking their children with mental illness to seek medical attention. The findings were as follows;

4.4.1 Employment status of respondents

Table 4.7 Employment status of respondents

Description	Frequency	Percentage
Formal employment	87	27
Self employed	66	21
Not employed	164	52
Total	317	100

The findings showed that 87 (27%) of respondents were in formal employment, 67 (21%) were self-employed while 166 (52%) were unemployed. The high level of unemployment among the respondents could highly be explained by their level of education and possibly lack of appropriate skills to engage in any income generating activity. Despite saying they were unemployed, some of the respondents said that they engage in farming while others provided causal labour and earned some income for their families.

4.4.3 Families monthly income

Table 4.8 Families' monthly income

Description (Shs.)	Frequency	Percentage
Below 5000 per month	136	43
5001-15000	119	38
15000-30000	39	12
Above 30000	23	07
Total	317	100

The findings revealed that 136(43%) earned below 5000 shillings per month, 119(38%) earned between 5001-15000 shillings per month while 39(12%) earned between 15001- 30,000 shillings per month; only 23 (7%) of the respondents earned above 30, 000 Kenyan shillings. This analysis shows that most of the residents of Endebes Sub County lives below the poverty line and definitely cannot afford to get all basic needs including health services. The case is even worse if they need to pay for transport to access any service regardless of its cost.

4.4 Socio economic factors that influence access to health care services by children with mental illness in Endebes sub-county

Table 4.9 Socio economic factors of respondents

Description		SD	D	UD	A	SA	TOTAL
When he / she does not have knowledge of the disease	Frequency	22	3	24	210	29	317
	Percentage	07	1	08	66	09	100
If the parent does not have formal education	Frequency	120	2	19	105	44	317
	Percentage	38	0	06	33	14	100
If the parent does not have means of transport to the hospital	Frequency	43	0	03	66	19	317
	Percentage	14	0	01	21	61	100
Has no time to go hospital due to other responsibilities	Frequency	160	7	14	25	44	317
		51	2	04	08	14	100
Does not know the child is affected by mental illness	Frequency	73	1	12	77	30	317
	Percentage	23	3	04	24	10	100

Do not know if the mental health services exist	Frequency	104	9	13	73	35	317
	Percentage	33	2	04	23	11	100
It is expensive to treat mental illness	Frequency	10	3	21	98	15	317
	Percentage	03	1	07	31	49	100

The respondents agreed that one was likely not to take the child to the hospital for mental healthcare if they did not have knowledge of the disease. Analysis indicates 239 (75%) agreed with 210 (66%) agreeing while 29 (9%) strongly agree. However 17% of the respondents disagree to the same. The implied holding other factors constant, parents who are having knowledge of the illness would take their children to hospital. Since the respondents held a view that most children with mental illness do not access health care services, then it is implied that the parents who fail to take their children to hospital lack basic knowledge of determining whether a child was sick or not.

With regards to formal education as a factor, 120(38%) of the respondents strongly disagree, while 44(14%) strongly agree, 105(33%) agree while 29 (9%) disagree. The 47% who disagree believe that lack of formal education would not influence a parent not to take a mentally ill child to hospital. On the other hand, the 47% who agree that lack of formal education would influence the parent not to take the child to hospital for mental healthcare.

A total of 150 (82%) of respondents believed Lack of means of transport influences parents decision on whether to take their children for health services or not with only 54 (12%) disagreed with the same.

Further, 234 (74%) disagree with the notion that sometime parents lack time to take their children to hospital. Perhaps this is because most of the respondents are not employed and therefore are available to take care of their children. It also implies that the parents are able to create time to take to provide care to their children but are limited by other factors. Disagreeing could also imply that the parents know that it is their obligation to take care of their children and therefore would not publicly declare that they lack time to provide care for their children. Interestingly, 69 (22%) supported lack of time as a reason not to take their children to hospital. This is alarming, as it could imply that they either leave their children unattended which exposes them to abuse or hide their children which increases the vulnerability of the children even further.

As to whether the parent/guardian not knowing the child was affected by mental illness influences access to health care services, the researcher analysed respondents and found out the following; 198 (62%) disagreed, implying that most parents would detect mental illness in their children. While 107 (34%) believed that this was a reason, this implies that a significant number of parents as well would not detect that their child was affected with mental illness. As regards to the cost of treatment, 254 (80%) of respondents believed that it was expensive to treated mental illness with only 42 (13%) disagreeing while 21 (7% were undecided.

4.5 Cultural factors influencing access to mental healthcare by parents with mentally ill children

The researcher identified cultural influences as some of the factors that may prevent parents from seeking mental health care for the mentally ill children. Below are the results from the analysis. Below are some of the questions that the researcher used to bring to the fore the information on cultural influences on the access to mental health care for children with mental illnesses.

4.5.1 Knowledge of presence of mental illness by respondents

Table 4.10Knowledge of mental illness by respondents

Response	Frequency	Percentage
YES	300	95
NO	17	05
	317	100

When the respondents were asked if they had ever heard about mental illness, 300 (95%) responded with yes while 17(05%) said No.

4.5.1.1 Sources of information about mental illness

Table 4.11 Sources of information about mental illness

Sources	Frequency	Percentage
Radio	79	25
Television	23	7
Chiefs Baraza	44	14
Church/Mosque	53	17
School	85	27
Family/friends	33	10
Total	317	100

75 (24%) had heard about mental illness over the radio while 23 (07%) heard over the television, 43 (14%) on chief Baraza, while 53 (17%) had heard either in church or in mosques and lastly 35 (11%) said they heard from family and friends. The source of information is significant in the sense that it shows various sources of information within the community which can be relied upon to sensitize the community on mental illness.

4.5.2 Summary of Cultural factors that influence access to health care services among children with mental illness

The table below summarized an analysis of cultural factors that prevented parents from accessing mental healthcare for their mentally ill children. The analysis revealed that 147 (60%) disagree to parents being embarrassed about having a mentally ill child. 70 (28%) however agreed to parents being embarrassed about mentally ill children. a lack of knowledge was also analysed and 77 (31%) disagreed to the parents lacking knowledge on mental illness. 147 (59%) agreed that a lack of knowledge contributed to not taking the children to hospital for mental health care. On witchcraft, 163 (66%) disagreed that parents believe its witchcraft. However, 79 (32%) agreed that parents believed its witchcraft. A further 73 (30%) disagreed that the parents trusted on the gods for the children's' healing. But 159 (65%) agreed to parents depending on the gods for their children's healing of mental illnesses. On the other hand, 165 (76%) disagreed that parents believed that mental illness cannot be treated. Only 72 (29%) agreed to the same. 144 (58%) disagreed that parent looked for traditional methods to heal mental illnesses. 91 (37%) agreed to parents looking for traditional methods of healing the disease.

Table 4.12 Cultural factors influencing access to health care services

		SD	D	UD	*A*	SA	TOTAL
When the parent is embarrassed to have a child with mental illness	Frequency	70	62	29	79	77	317
	Percentage	22	20	09	25	24	100
When he or she does not have knowledge of the disease	Frequency	22	31	24	210	30	317
	Percentage	07	10	08	66	10	100
Believing that it is witch craft	Frequency	70	93	15	100	39	317
	Percentage	22	29	05	32	12	100
Trusting in the gods to heal the child	Frequency	22	51	15	171	58	317
	Percentage	07	16	05	54	18	100
Believe that mental illness Cannot be treated	Frequency	90	75	10	66	76	317
	Percentage	28	24	03	21	24	100
Looking for traditional methods of healing the disease	Frequency	69	95	12	51	90	317
	Percentage	22	30	04	16	28	100

4.4.4 Reaction of parents on realization that their child could be suffering from mental Illness

The Parents react differently on the realization that their children suffered from mental illness. The table below presents the findings;

Table 4.13 Reaction of parents on their children suffering from mental illness

	Frequency	Percentage
Seek prayers from religious leaders	41	13
Seek help from witchdoctors	17	05
Take child to hospital	152	48
Seek advice from community health workers	28	09
Hide the child to avoid shame	61	19
Other	18	06
Total	317	100

Respondents were asked about the first action they suspected their child was suffering from mental illness; 41 (13%) said they would seek prayers first before taking any other action, while 17 (5%) would consult a witch doctor and 152 (48%) would take the child to hospital while 61 (19%) would hide the child and 18 (06%) would take other unspecified action. For the parents who choose to hide the child, they do so due the feeling of shame and fear of stigmatization associated with mental illness. While those who seek prayers first is due to strong religious believes, trusting in Gods miracle as the first reaction. This group could be associating mental illness with curses or evil spirits while those who seek help from witch doctor could be because they believe mental illness is caused by witchcraft.

4.6 Influence of geographical factors on access to mental health services for parents with mentally ill children

4.6.1 Residence of respondents

The study found it necessary to analyse the residence of respondents

Table 4.14 Residence of respondents

	Frequency	Percentage
Rural	286	90
Urban	31	10
	317	100

The findings revealed that a large number of residents live in the Rural areas 286 (90%) while a small number of respondents 31 (10%) live in the urban centre at urban townships. This implied that they may have a difficult time getting to the urban centre where the medical facilities are located.

4.5.2 Geographical factors which prevent parents from taking their children with mental illness to hospital

Table 4.15 Geographical factors

	Description	**SD**	**D**	**UD**	**A**	**SA**	**Totals**
The hospital is far from home	Frequency	64	17	28	54	154	317
	Percentage	20	5	9	17	49	100
When it takes long time to reach the hospital	Frequency	31	100	7	135	44	317
	Percentage	10	32	2	43	14	100
When the parents stay in remote areas with bad terrain	Frequency	15	67	5	101	129	317
	percentage	5	21	2	32	40	100

The table shows that majority of respondents agreed that the hospital is far from home 208 (66%). This was in agreement to (Fort & Voltero 2010) whose findings revealed that in many cases, doctors choose not to practice in rural settings because of financial constraints or due to lack of resources in rural areas. They further said that often, these

areas have deficits in specialists or hospital facilities. As a result, patients may need to drive long distances to attend medical appointments.81 (25%) however disagreed to the same. Kissane (2003), who interviewed poor female parents living in Philadelphia about their use of social services, found that the physical distance of a service from the neighbourhood they lived in was not important as long as it was accessible by public transport. Endebes sub-county is faced with the challenge of poor road network and therefore limits the use of public transport in all areas forcing people to walk for long distances in order to either access services or access the means of transport. The poor families cannot afford to use motorbike which is expected to serve as the easiest means of transport in the region. In Kenya, research conducted in Baringo by Benjamin N. Mwasi (2011) aimed at identifying the major barriers to mental health care service access for the people living in that area. The study identified, distance, time and cost as the strongest barriers to accessing health care services. While distance was the single most important factors affecting the choice of facility attended.

179 (57%) also agreed that it took long to reach the hospital while 131 (42%) disagreed to the same this implied that perhaps this group would afford transport cost and hence use lesser time. The same applies to the once who said that it takes longer time, this could imply that they walk to hospitals and therefore take longer time. This agrees with Buor (2003) who found that distance is the most important factor that influences the utilization of health services in the Ahafo-Ano south district of Ghana. The effect of travel time on utilization reflects that of distance and utilization.

Further, 230 (72%) of the respondents agreed that staying in rural areas with a bad terrain would influence decision to go for health care services. This is further supported by finding from other studies; a study among Mru indigenous people in Bangladesh shows that distinctive geographical location and long distance to the service centre from their place of residence was a determining factor for their low access to health facilities, antenatal care and postnatal care visits (Islam, 2010). In rural

Tanzania, 84% of women who gave birth at home intended to deliver at a health facility but did not due to distance and lack of transportation (Bicego et al., 1997). However, 82 (26%) disagreed with the same.

4.7 Parents' perception on the mental health condition

4.7.1 Parents' perception of Conditions associated with mental illness

Table 4.16 Conditions associated with mental illness

	Frequency	Percentage
Depression	76	24
Extremely violent behaviours	28	09
Suicidal thoughts	45	14
Addiction to drugs	64	20
Difficulties in making and keeping Friends	26	08
Post-traumatic stress disorder	17	05
Anxiety disorders	30	09
Mood disorder	31	11
Total	317	100

From the analysis the respondents recognized that most of the above were symptoms of mental illness. However, depression, suicidal thoughts and abuse of drugs were the most ticked symptoms of mental illness.

4.7.2 If child has suffered from any of the above conditions?

Table 4.17 symptoms of mental illness

		Yes	No	Total
Depression	Frequency	25	292	317
	Percentage	08	92	100
Extremely violent behaviours	Frequency	23	294	317
	Percentage	07	93	100
Suicidal thoughts	Frequency	29	288	317
	Percentage	09	91	100
Addiction to drugs	Frequency	52	265	317
	Percentage	17	83	100
Difficulties in making and keeping Friends	Frequency	06	311	317
	Percentage	02	98	100
Post-traumatic stress disorder	Frequency	13	304	247
	Percentage	04	96	100
Anxiety disorders	Frequency	11	306	247
	Percentage	04	96	100
Mood disorder	Frequency	17	300	247
	Percentage	05	95	100

The respondents were asked if their children had suffered symptoms associated with mental illnesses. The results were as below 25 (08%) said their children had suffered from depression, 23(07%) extremely violent behaviour, 29 (09%) suicidal thoughts ,52 (17%) addiction to drugs and 06 (02%) difficulties in making friends, 13 (04%)

had post traumatic disorder, 11 (04%) had anxiety disorders while 17 (05%) had mood disorder. Interestingly majority of the respondents who said their children had suffered from the above symptoms had earlier said that their children had never suffered from mental illness. This implies that lack of knowledge on the disease highly influences choice to use health services.

When asked if they sought medical care they responded as follows;

Table 4.18 if medical help was sought

		Yes	No	Total
Depression	Frequency	15	10	25
	Percentage	60	40	100
Extremely violent behaviours	Frequency	7	16	23
	Percentage	30	70	100
Suicidal thoughts	Frequency	06	23	29
	Percentage	13	87	100
Addiction to drugs	Frequency	09	43	52
	Percentage	17	65	100
Difficulties in making and keeping Friends	Frequency	00	06	06
	Percentage	00	100	100
Post-traumatic stress disorder	Frequency	00	13	13
	Percentage	00	100	100
Anxiety disorders	Frequency	05	07	11
	Percentage	36	64	100
Mood disorder	Frequency	05	12	17
	Percentage	29	71	100

Of the 25 children that showed depression, 15 (60%) sought medical help whereas 10(40%) did not seek medical advice. On extremely violent behaviour, 07 (30%) sought medical help while 16 (70%) did not seek medical help, 09 (17%) that had addiction to drugs sought medical help. Perhaps the parents who did not seek medical services believed that it was a minor problem or they did not imagine it would be a mental health issue.

4.7.3 Parents perceptions influences access to health care services among children with mental illness

Table 4.19: Respondents views on different parents perceptions

Perceptions		SA	A	UD	D	SD	TOTAL
When the Parent doesn't think the child was suffering from mental illness	Frequency	131	107	06	40	33	317
	Percentage	41	34	02	13	11	100
Lack of child's desire to receive help/child refuses to go to hospital	Frequency	127	101	30	30	59	317
	Percentage	40	30	03	08	19	100
Believe that mental illness could be handled without treatment	Frequency	53	50	17	107	91	317
	Percentage	15	16	06	34	29	100
If the parents feels it is not severe	Frequency	157	98	12	30	22	317
	Percentage	49	31	03	09	07	100
Believe that children with mental illness were not handled with respect at the hospital	Frequency	112	94	22	58	32	317
	Percentage	35	30	07	18	10	100
Bad experience during previous visit with the health services	Frequency	114	96	17	68	35	317
	Percentage	36	30	05	21	11	100

Respondents agreed to 5 factors while they disagreed on one. The five factors which influence access to health care services include; 238 (75%) of respondents agree that when parents don't believe that child is suffering from mental illness then they won't take them to hospital. 228 (70%) believe that access to health services is influenced by the child's lack of desire to receive services or refusal to go to hospital. 255(80%) thought said when parents feel that the condition is not severe while 201(66%) it could be due to bad experience. 103 (31%) believed agree that believe that the problem can be healed without treatment could affect while 198 (63%) disagree with this factor.

This findings agreed with (Owens et al, 2002) whose findings showed that Perceptions about mental health services like lack of trust in or negative experience with mental health providers, lack of children's desire to receive help, or stigma related to receiving help may also affect the willingness to seek treatment. This implies that parent's perception is a key factor in which influences access to health care services among children with mental illness.

When the respondents were asked to generally list the factors that prevented parents from taking children with mental illness to hospital, they gave the following reasons; lack of knowledge from parents, poor road network, poverty, ignorance from parents, lack of proper personnel at the hospitals to deal with mental illness, inadequate income to deal with mental illness, parents ashamed of the mentally ill children and lack of awareness. This agreed with (Owens et al, 2002) whose findings showed that Perceptions about mental health services e.g lack of trust in or negative experience with mental health providers, lack of children's desire to receive help, or stigma related to receiving help may also affect the willingness to seek treatment.

4.7.5 Institutions and persons to aid with the solution

Below are some of the solutions that the respondents suggested

Table 4.20 Institutions and persons to aid with the solution

Proposed solution	To be implemented by who?
Repair of roads	County government
Education to parents	Social workers
Guiding and counselling	Social workers
Employment of more psychiatrists	County government
Advocacy on mental illness	Health workers
Early diagnosis	Health practitioners

4.7.6 What is your position on the following statements?

Table 4.21 The views of respondents on proposed solutions

	Description	SA	A	UD	D	SD	TOTAL
The government should establish tough laws to compel parents to take children with mental illness to hospital	Frequency	117	127	09	19	45	317
	Percentage	37	40	03	06	14	100
Provide free medical care including consultation and registration fees for children with mental illness	Frequency	114	130	06	32	35	317
	Percentage	36	41	02	10	11	100
Educate parents on importance of health care services	Frequency	112	75	12	55	64	317
	Percentage	35	23	04	17	20	100
Conduct mental health screening to identify cases	Frequency	114	120	10	32	41	317
	Percentage	36	38	03	10	13	100
Employ Psychiatric doctors to be based at Endebes District hospital	Frequency	131	113	09	19	45	317
	Percentage	41	36	28	07	14	100
Nothing can be done to correct these situation	Frequency	112	68	15	58	64	317
	Percentage	35	21	05	18	20	100

NAMI (1999) found out that the overall picture is that, there are major barriers to mental health care for the children and the families. Consequently, the implication was that all factors constant, the children's access to health facilities was impeded by so many factors. This could be related to the fact that children were helpless and always had to depend on parents and guardians for all aspects of their lives including health care.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter discusses summary, conclusion, recommendations, contribution to the body of knowledge and suggested areas for further research in the following sub themes

5.2 Summary of findings

Based on the data and other information obtained and analysed to answer the research questions of the study, a number of research findings were presented in chapter four. The findings are summarized in this section:

All genders were adequately represented among the 317 respondents where 162 (51%) of the respondents were male while 155 (49 %) were female.

Regarding the age of respondents 108(34%) of the respondents were in the age group of below 18-28 years while 105(33%) of the respondents were 29 – 39 years of age. Another 82 (26%) of the respondents were 40-50 years of age, 50-60 had 13(4%) of the respondents and 10(3%) of the respondents were above 60 years. This implied that the majority of the respondents were at a child barring age and is better informed about mental illness in children**.** On socio-economic factors, the findings revealed that 10 (3%) of the respondents had never gone to school, 143 (45%) had attained primary education level, while 130 (41%) had been to a secondary school. . 28(09%) had been to tertiary institution whereas 6 (2%) had attained University education level This is important as it can be used to further assess how education influences peoples choices on whether to use health care services. Education is also a very important socio-economic indicator.

The findings also showed that 87 (27%) of respondents were in formal employment, 67 (21%) were self-employed while 166 (52%) were unemployed. The high level of unemployment among the respondents could highly be explained by their level of education and possibly lack of appropriate skills to engage in any income generating activity. Despite saying they were unemployed, some of the respondents said that they engage in farming while others provided causal labour and earned some income for their families. The findings revealed that 136(43%) earned below 5000 shillings per month, 119(38%) earned between 5001-15000 shillings per month while 39(12%) earned between 15001- 30,000 shillings per month; only 23 (7%) of the respondents earned above 30, 000 Kenyan shillings. This analysis shows that most of the residents of Endebes Sub County lives below the poverty line and definitely cannot afford to get all basic needs including health services. The case is even worse if they need to pay for transport to access any service regardless of its cost.

The respondents agreed that one was likely not to take the child to the hospital for mental healthcare if they did not have knowledge of the disease. Analysis indicates239 (75%) agreed with 210 (66%) agreeing while 29 (9%) strongly agree. However 17% of the respondents disagree to the same. The implied holding other factors constant, parents who are having knowledge of the illness would take their children to hospital. Since the respondents held a view that most children with mental illness do not access health care services, then it is implied that the parents who fail to take their children to hospital lack basic knowledge of determining whether a child was sick or not.

With regards to formal education as a factor, 120(38%) of the respondents strongly disagree, while 44(14%) strongly agree, 105(33%) agree while 29 (9%) disagree. The 47% who disagree believe that lack of formal education would not influence a parent not to take a mentally ill child to hospital. On the other hand, the 47% who agree that lack of formal education would influence the parent not to take the child to hospital for mental healthcare.

A total of 150 (82%) of respondents believed Lack of means of transport influences parents decision on whether to take their children for health services or not with only 54 (12%) disagreeing with the same.

Further, 234 (74%) disagree with the notion that sometime parents lack time to take their children to hospital. Perhaps this is because most of the respondents are not employed and therefore are available to take care of their children. It also implies that the parents are able to create time to take to provide care to their children but are limited by other factors. Disagreeing could also imply that the parents know that it is their obligation to take care of their children and therefore would not publicly declare that they lack time to provide care for their children. Interestingly, 69 (22%) supported lack of time as a reason not to take their children to hospital. This is alarming, as it could imply that they either leave their children unattended which exposes them to abuse or hide their children which increases the vulnerability of the children even further.

As regards to Cultural factors, Respondents were asked about the first action they suspected their child was suffering from mental illness; 41 (13%) said they would seek prayers first before taking any other action, while 17 (5%) would consult a witch doctor and 152 (48%) would take the child to hospital while 61 (19%) would hide the child and 18 (06%) would take other unspecified action. For the parents who choose to hide the child, they do so due the feeling of shame and fear of stigmatization associated with mental illness. While those who seek prayers first is due to strong religious believes, trusting in Gods miracle as the first reaction. This group could be associating mental illness with curses or evil spirits while those who seek help from witch doctor could be because they believe mental illness is caused by witchcraft. The analysis revealed that 147 (60%) disagree to parents being embarrassed about having a mentally ill child. 70(28%) however agreed to parents being embarrassed about mentally ill children. a lack of knowledge was also analyzed and 77 (31%) disagreed to the parents lacking knowledge on mental illness.147 (59%) agreed that a lack of knowledge contributed

to not taking the children to hospital for mental health care. On witchcraft, 163 (66%) disagreed that parents believe its witchcraft. However, 79 (32%) agreed that parents believed its witchcraft. A further 73 (30%) disagreed that the parents trusted on the gods for the children's' healing. But 159 (65%) agreed to parents depending on the gods for their children's healing of mental illnesses. On the other hand, 165(76%) disagreed that parents believed that mental illness cannot be treated. Only 72(29%) agreed to the same. 144 (58%) disagreed that parent looked for traditional methods to heal mental illnesses. 91(37%) agreed to parents looking for traditional methods of healing the disease.

Geographical factors significantly influence access to health care services among children with mental illness. The findings revealed that a large number of residents live in the Rural areas 286 (90%) while a small number of respondents 31 (10%) live in the urban centre at urban townships. This implied that they may have a difficult time getting to the urban centre where the medical facilities are located. Majority of respondents agreed that the hospital was far from home 208 (66%). 81 (25%) however disagreed to the same. Endebes sub-county is faced with the challenge of poor road network and therefore limit the use of public transport in all areas forcing people to walk for long distances in order to either access services or access the means of transport. The poor families cannot afford to use motorbike which is expected to serve as the easiest means of transport in the region. 179 (57%) also agreed that it took long to reach the hospital while 131 (42%) disagreed to the same this implied that perhaps this group would afford transport cost and hence use lesser time. The same applies to the once who said that it takes longer time, this could imply that they walk to hospitals and therefore take longer time. Further, 230 (72%) of the respondents agreed that staying in rural areas with a bad terrain would influence decision to go for health care services. The respondents were asked if their children had suffered symptoms associated with mental illnesses. The results were as below 25 (08%) said their children had suffered from depression, 23(07%) extremely violent behavior, 29 (09%) suicidal thoughts ,52 (17%)

addiction to drugs and 06 (02%) difficulties in making friends, 13 (04%) had post traumatic disorder, 11 (04%) had anxiety disorders while 17 (05%) had mood disorder. Interestingly majority of the respondents who said their children had suffered from the above symptoms had earlier said that their children had never suffered from mental illness. This implies that lack of knowledge on the disease highly influences choice to use health services. Of the 25 children that showed depression, 15 (60%) sought medical help whereas 10(40%) did not seek medical advice. On extremely violent behavior, 07 (30%) sought medical help while 16 (70%) did not seek medical help, 09 (17%) that had addiction to drugs sought medical help. Perhaps the parents who did not seek medical services believed that it was a minor problem or they did not imagine it would be a mental health issue.

Lawrence and McCulloch (2001) reviewed the barriers that older adults, specifically those in rural areas face when in need of mental health care. They noted that stigmatization, migration, economic conditions, and informal social support inhibit elders in rural communities from seeking mental health services. This explains why the parents in rural Endebes found it hard to access mental health care services. Buor (2005) Weinert and Long (1987); Garfinkel and Gold bloom (2000) in their finding emphasized stigma and self-help as a phenomenon of rural populations as the reasons for lack of access to mental health care. However, in Endebes Sub County, the findings revealed that the distance and poor terrain made it impossible to reach mental health care facilities. This is coupled by poverty, ignorance and cultural factors. The finding concur (Williams et al., 1985, World Bank, 1994). ‘’Walking is also the primary mode of transportation, even for women in labour ‘’ (Williams et al., 1985, World Bank, 1994). Other finding also concurred with the findings I rural Endebes Sub County. These were by (Ricketts, 2001), who found out that accessing health care in rural areas is confounded by such varied problems as an insufficient health infrastructure, the press of chronic diseases and disabilities, socioeconomic barriers, and physical barriers (Ricketts, 2001). He further

said that Distance issues may be further affected by accessibility of transportation, the inability to drive, lack of a driver's license. Another scholar in Baringo Benjamin N. Mwasi (2011) in his study found out that distance, time and cost as the strongest barriers to accessing mental health care access. While distance was the single most important factors affecting the choice of attending a medical facility.

Responding to question son parent's perception, the respondents agreed to 5 factors while they disagreed on one. The five factors which influence access to health care services include; 238 (75%) of respondents agree that when parents don't believe that child is suffering from mental illness then they won't take them to hospital. 228 (70%) believe that access to health services is influenced by the child's lack of desire to receive services or refusal to go to hospital. 255(80%) thought said when parents feel that the condition is not severe while 201(66%) it could be due to bad experience. 103 (31%) believed agree that believe that the problem can be healed without treatment could affect while 198 (63%) disagree with this factor. This agreed with (Owens et al, 2002) whose findings showed that Perceptions about mental health services e.g lack of trust in or negative experience with mental health providers, lack of children's desire to receive help, or stigma related to receiving help may also affect the willingness to seek treatment.

5.3 Conclusions of findings

Below are the conclusions drawn on the findings from the study by the researcher; this has been discussed based on the objectives.

The researcher concluded that the parents in Endebes Sub County had low socio economic status and hence this made it impossible for them to access mental health services for their children. Most of them had low levels of education and therefore worked in informal jobs. This did not allow them to earn lots of money to cater for all the basic need including medical health care.

The parents of Endebes Sub County have cultural beliefs that hinder them from accessing mental health care services for their mentally ill children.

From the findings, the researcher concluded that that geographically Endebes Sub County is a rough terrain and transport system not very reliable. Consequently it affects the ability of the parents to take their mentally ill children for mental health care services.

Parents' perception in Endebes Sub County hinders them from accessing mental health services for their mentally ill children. This is characterized by their actions where, Parents of have the perception that mental illness is not a medical condition but a result of human evil works. When symptoms of mental illnesses occur, they seek all other solutions but not medical conditions.

5.4 Recommendations

Leaders in Endebes Sub County should promote education for school going age children, vocational skills training for those who drop out in primary and secondary schools and support Agribusiness in order to improve the socio-economic status of the residence. By so doing the vulnerability of the people will reduce and they will be able to access many services including health services.

Health and child protection stakeholders should step up awareness sessions to demystify the misconception about mental illness which arise from cultural believes.

The health stakeholders should include mobile screening for mental health needs as a way of promoting early detection of mental illness before it worsens. This will also eliminate the distance covered by those who's who are far from services and therefore encourage the residents to seek medical help when needed. The county government on the other hand should invest in infrastructure to open up remote areas. This will increase the use of public transport in the areas and therefore easy movement from one place to the other.

Advocacy should be carried out highlighting symptoms of mental illnesses in children for early detection and treatment as opposed to self-treatment on the feeling that the medical professionals will not be of any help.

5.5 Contributions to the body of knowledge

Table 5.1 Contributions to the body of knowledge

Objectives	Contributions
Socio-economic factors influencing access to health services among children with mental illness in Endebes Sub-County	According to Campion J, Bhugra D, Bailey S, Marmot M. (2013) mental disorders are distributed according to a gradient of economic disadvantage where the poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences . The researcher found out that the in habitants of Endebes sub county had low socio economic status and he concluded that this contributed highly to their inability to access mental health care for their mentally ill children. This was evidenced by the level of education and the income levels.
To determine how geographical factors influence access to health services among children with mental illness in Endebes Sub-County	Benjamin N. Mwasi(2011) Found out that distance, time and cost as the strongest barriers to accessing mental health care access. While distance was the single most important factors affecting the choice of facility attended. The researcher found out that Endebes sub county had a rugged topography with a poor road network. Consequently, it took long for the patients to access medical facilities amidst much discomfort. These hindered accesses to the mental health care as majority of the inhabitants were rural dwellers. The hospital did not have specialists in mental health care hence compounding the problem. There was also has no psychiatrist in the only medical facility and this has made the condition worse for the parents with mentally ill children; hence the inability to access mental health acre.

To examine how cultural factors influence access to health services among children with mental illness in Endebes Sub-County	(Roberts, 2010). Found out that physicians in training in some developing or economically disadvantaged countries held the same beliefs that, that these conditions are caused by individuals themselves or by supernatural forces, possession by evil spirits, curse or punishment following the individual's family or is part of family lineage after undergoing psychiatric training. The researcher found out that the inhabitants of Endebes sub county are very cultural people and still believed that mental illness is was a result of witch craft and curses or punishment from the ancestors. He concluded that this contributed to the lack of access to mental health care services by parents with mentally ill children.
To establish how parents perception of mental illness influence the access of mental health services for their mentally ill children in Endebes Sub-County.	The inhabitants perceive mental illness as a condition that cannot be healed and that it is a waste of time ro seek medical services. They however revert to self-medication which may prove detrimental.

5.6 Suggested areas for further research

The researcher suggests the following further areas of research

1. The researcher suggests that a similar study be carried out in an urban Centre where parents have high socioeconomic status and there are better health care facilities to determine how the findings will differ

2. The researcher suggests that a study be carried out on the influence of advocacy on the access to mental health care services to rural populations.

3. The researcher further suggested that a similar study be carried out in a different sub county to determine if the findings will concur.

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APPENDIX 1: TABLE FOR DETERMINING SAMPLE SIZE FOR A FINITE POPULATION

N	*S*	*N*	*S*	*N*	*S*
10	10	220	140	1200	291
15	14	230	144	1300	297
20	19	240	148	1400	302
25	24	250	152	1500	306
30	28	260	155	1600	310
35	32	270	159	1700	313
40	36	280	162	1800	317
45	40	290	165	1900	320
50	44	300	169	2000	322
55	48	320	175	2200	327
60	52	340	181	2400	331
65	56	360	186	2600	335
70	59	380	191	2800	338
75	63	400	196	3000	341
80	66	420	201	3500	346
85	70	440	205	4000	351
90	73	460	210	4500	354
95	76	480	214	5000	357
100	80	500	217	6000	361
110	86	550	226	7000	364
120	92	600	234	8000	367
130	97	650	242	9000	368
140	103	700	248	10000	370
150	108	750	254	15000	375
160	113	800	260	20000	377
170	118	850	265	30000	379
180	123	900	269	40000	380
190	127	950	274	50000	381
200	132	1000	278	75000	382
210	136	1100	285	1000000	384

Note.—*N* is population size. *S* is sample size.

Source: Krejcie & Morgan, 1970

APPENDIX 2: INTRODUCTION LETTER TO RESPONDENTS

Dear Respondents,

My name is *Evelia Antony Imbwaga*, a student in the University of Nairobi undertaking Master's Degree in Project Planning and management.
As requirement of a master's degree, I'm conducting a study on factors influencing access to health care among children with mental illness in Endebes sub-county, Trans-Nzoia County, Kenya.

Findings of this project will guide service providers and local leadership to address the health care concerns among children with mental illness. In this regard, your response will assist me in understanding and providing a professional position on this issue.

All information will be kept confidential and to this extent all questionnaires will also be anonymous. Your honesty in answering questions will be highly appreciated and your decision to participate in the study is voluntary.

Thank you in advance for your consideration.

Yours faithfully,

Evelia Antony Imbwaga.

APPENDIX 3 : QUESTIONNAIRES

Dear respondent,

My name is Evelia Antony Imbwaga, a Masters student in the University of Nairobi. I'm conducting a study on factors influencing access to health care among children with mental illness in Endebes sub-county, Trans-Nzoia County, Kenya.

This research is meant for academic purpose only. You are kindly requested to provide answers to these questions as honestly and precisely as possible. The information provided will be kept confidential.

Collection of Personal Information

Please tick (√) all that apply

1. What is your Gender

Female	( )
Male	( )

2. What is your age

18 — 28	( )
29 — 29	( )
40 — 50	( )
50— 60	( )
Above 60	( )

3. What is your level of Education

Education level	( )
No Schooling	( )
Primary	( )
Secondary	( )
College	( )
University	( )

4. Do you understand what is meant by mental Illness?

YES	( )
NO	( )

If YES, name some of the symptoms of mental illness that you know.

a.)

b.)

c.)

d.)

5. According to you, what causes mental illness?

6. From your point of view, is mental illness treatable?

YES	( )
NO	( )

7. In your own opinion how would you rate the level of access to health services that children with mental illness have?

No access	( )
Low access	( )
Moderate	( )
High access	( )

Part B: Socioeconomic factors influencing access to health care

8. What is your occupation

Formal employment	( )
Self employed	( )
Not employed	( )
Other	( )

9. What is your family monthly income (in Kenya shillings)?

Bellow Ksh. 5000 per month	( )
5,001-15,0000	( )
15,001-30,000	( )
Above 30,000	( )

10. Here are 7 socio-economic factors which prevent parents from taking their children with mental illness to hospital. Mark on the rating scale as per your opinion

Score scale: Highly disagree (1), somewhat disagree (2), Not sure/Neutral (3), somewhat agree (4), highly agree (5)

When he/she does not have knowledge of the disease 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

If the parent does not have formal education 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

The parent does not have money to pay in hospital 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Has no time to go to hospital due to other responsibilities 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Does not know the child is affected by mental illness 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Do not know if the mental health services exist 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

It is expensive to treat mental illnesses 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Part C: Cultural factors influencing access to health care

11. Have you ever heard about mental illness?

YES	( )
NO	( )

If yes, where did you get information about mental illness?

Radio	( )
Television	( )
Chief Baraza	( )
Church/Mosque	( )
School	( )

Family and friends ( )

Health worker ( )

12. Here are 5 cultural factors which prevent parents from taking their children with mental illness to hospital. Mark on the rating scale whether you agree or disagree with each.

Score scale: Highly disagree (1), somewhat disagree (2), Not sure/Neutral (3), somewhat agree (4), highly agree (5)

When the Parent is embarrassed to have a child with mental illness 1[ ]2[ ]3[ ]4[ ]5[ ]

When he/she does not have knowledge of the disease 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Religion/culture does not allow 1[ ] 2[ ] 3[ ] 4 [ ] 5[ ]

Believe that mental illness cannot be treated 1[ ] 2 [ ] 3[ ] 4 [ ] 5[ ]

When a parent believes that its witchcraft and looks for other methods of healing the disease other than hospitals 1[ ] 2 [ ] 3[ ] 4 [ ] 5[ ]

Part D: Geographical factors influencing access to health service

13. Which of the choices below describes your residence setting?

Rural ( )

Urban area ( )

14. Here are 3 geographical factors which prevent parents from taking their children with mental illness to hospital. Mark on the rating scale whether you agree or disagree with each.

Score scale: Highly disagree (1), somewhat disagree (2), Not sure/Neutral (3), somewhat agree (4), highly agree (5)

The hospital is far from home 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

When it takes long time to reach the hospitals hospital 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

When the parent stays in remote area with bad terrain 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Part E: Parents perception on the health condition

15. Which of the following conditions are associated with mental illness among children? Directly tick on those you agree with.

Depression ( )

Extremely violent behaviours ( )

Suicidal thoughts/attempt suicide ( )

Addiction to drugs ( )

Difficulties in making and keeping friends ( )

Post-traumatic stress disorder ( )

Anxiety disorders ( )

Mood disorder ( )

16. Has your child ever suffered from any of the above condition?

YES ( )

NO ( )

If yes, did you seek medical support?

YES ( )

NO ( )

Explain……

17. Here are 6 factors which prevent parents from taking their children with mental illness to hospital. Mark on the rating scale whether you agree or disagree with each.

Score scale: Highly disagree (1), somewhat disagree (2), Not sure/Neutral (3), somewhat agree (4), highly agree (5)

When the Parent doesn't think the child is suffering from mental illness

1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Lack of child's desire to receive help/child refuses to go to hospital

1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Believe that mental illness can be handled without treatment

1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

If the parents feels it is not severe 1[ ] 2 [ ] 3 [ ] 4 [ ] 5[ ]

Believe that children with mental illness are not handled with respect at the hospital 1[ ] 2 [ ] 3 [ ] 4 [ ] 5[ ]

Bad experience during previous visit with the health services

1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Part F: Solutions to the problem

18. From your experience list the main factors that can make children with mental illness in Endebes sub-county not to access medical services?

……

……

……

……

19. What are some of the solutions you propose to ensure that all children with mental illness access health care services? Also mention the institution/person to implement your solution.

PROPOSED SOLUTION	TO BE IMPLEMENTED BY WHO?
1.	
2.	
3.	
4.	

20. What is your position on the following statements?

Score scale: Highly disagree (1), somewhat disagree (2), Not sure/Neutral (3), somewhat agree (4), highly agree (5)

The government should establish tough laws to compel parents to take children with mental illness to hospital 1[ ] 2 [ ] 3 [ ] 4 [ ] 5[ ]

Provide free medical care including consultation and registration fees for children with mental illness 1[ ] 2 [ ] 3 [ ] 4 [ ] 5[ ]

Educate parents on importance of health care services 1[ ] 2 [ ] 3[ ] 4 [ ] 5[ ]

Conduct mental health screening to identify cases 1[ ] 2[ ] 3 [ ] 4 [ ] 5[ ]

Employ Psychiatric doctors to be based at Endebes District hospital

1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

Nothing can be done to correct these situation 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

21. Do you have any other information you wish to inform the researcher.

If yes, kindly feel free to write here……

Thanks you for your time.