**List of Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCMHS</td>
<td>Comprehensive Community-Based Mental Health Services</td>
</tr>
<tr>
<td>CoRPs</td>
<td>Community Resource Person</td>
</tr>
<tr>
<td>GCHVs</td>
<td>General Community Health Volunteers</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitudes, and Practice</td>
</tr>
<tr>
<td>LAMIC</td>
<td>Low and Middle Income Countries</td>
</tr>
<tr>
<td>MakSPH</td>
<td>Makerere University School of Public Health, Uganda</td>
</tr>
<tr>
<td>mhBeF</td>
<td>Mental Health Beyond Facilities</td>
</tr>
<tr>
<td>MHC</td>
<td>Mental Health Clinicians</td>
</tr>
<tr>
<td>mhGAP</td>
<td>Mental Health Global Action Program</td>
</tr>
<tr>
<td>mhGAPIG</td>
<td>mhGAP Intervention Guide</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistants</td>
</tr>
<tr>
<td>PSG</td>
<td>Patient Support Groups</td>
</tr>
<tr>
<td>PTSD</td>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>PWSMD/E</td>
<td>Persons with Severe Mental Disorders and Epilepsy</td>
</tr>
<tr>
<td>SCHT</td>
<td>Sinoe County Health Team</td>
</tr>
<tr>
<td>SMD</td>
<td>Severe Mental and Neurologic Disorders</td>
</tr>
<tr>
<td>TAU</td>
<td>Treatment as Usual</td>
</tr>
<tr>
<td>TCC-LMHP</td>
<td>The Carter Center – Liberia Mental Health Program</td>
</tr>
<tr>
<td>TPO-Nepal</td>
<td>Transcultural Psychosocial Organisation -Nepal</td>
</tr>
<tr>
<td>TPO-Uganda</td>
<td>Transcultural Psychosocial Organisation-Uganda</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
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Executive Summary

This report presents the findings of formative research for the “Mental health Beyond Facilities” project (mhBef) conducted by the Carter Center. Study activities took place in Greenville district, Sinoe County in March 2012. The purpose of the study was to inform the design and implementation of the evaluation of the Comprehensive Community-based Mental Health Services (CCMHS) package in 3 post conflict countries, Liberia, Uganda and Nepal. This qualitative study used two methods of data collection: key informant interviews (KII) and focus group discussions (FGD). Sixty participants provided information through key informant interviews (KII=22) and focus group discussions (FGDs=6). They included persons with mental health disorders and epilepsy (PWSMDE) and their family members or carers, healthcare workers, and community members and policy makers.

The formative research assessed the current mental health situation in the communities in Greenville district. It explored participants’ perception about the prevalence and causes of mental illnesses and epilepsy. It assessed the current health workforce, pathways to care, roles of the family members of PWSMDE, and potential roles for a new cadre of workers that would be community resource persons. The formative research also examined community attitudes towards PWSMDE and their families. It further explored access to and availability of psychotropic drugs in Sinoe County. The data collected was analyzed using NVivo 10 software. The analysis revealed the following:

Beliefs about mental illness and epilepsy that impact access to care:

- The majority of respondents in the study believed that epilepsy was the leading mental illness in the community, followed by depression, drugs abuse, schizophrenia, post-partum psychosis, and anxiety.
- Participants reported that the major causes of mental illness are frustration and “African Science”.

Health workers knowledge about mental health, and challenges confronting service delivery:
• Most participants opined that healthcare workers had little knowledge of mental health.
• Participants thought that with adequate training and tools with which to work, healthcare workers would be willing to deliver mental health services.
• All respondents outlined lack of transportation, low incentives for healthcare workers and lack of mental health drugs as the major challenges confronting service delivery.

The Referral Pathway:

• All respondents stated that mental health cases seen in the communities are referred to primary health care facilities, traditional healers, and religious leaders.
• Most respondents cited that major referrals are made to the county hospital (F. J. Grante) or to Monrovia the capital city of Liberia.
• Transportation and relocation costs were considered major challenges to referrals in the formal health system.

The Role of Family Members:

• Respondents believed that families could play an essential role by ensuring that PWSMDE received treatment and care.

The CORPS as a cadre of mental health workers:

• Participants saw potential roles for the CoRPs that included:
  - identify and refer PWSMDE for health care;
  - provide mental health literacy; and,
  - regularly follow-up on PWSMDE.

Attitudes toward Persons with Severe Mental Health Disorders and Epilepsy:

• Participants expressed and or reported on negative attitudes towards PWSMDE.
• Local stigmatizing idioms and insults were frequently identified.
• Participants confirmed mistreatment, social isolation and avoidance of PWSMDE by community members.
• Participants endorsed the concept of Patient Support Groups (PSG).
• Respondents attributed to such a group the potential for better livelihood support and enhanced socio-economic status of not only the PWSMDE but also their families and communities.
• Participants believed that PSGs could strengthen the fight against stigma.

Major challenges outlined throughout the study included:

• Lack of transportation;
• Low or no incentives for healthcare workers;
• Lack of mental health drugs; and
• Low staff capacity.
CHAPTER ONE

1.1 Introduction

As part of the inception phase of the mhBeF project the Liberia team conducted formative research in Greenville District in Sinoe County. The formative research looked at the communities and settings in which the program is situated. It is expected to support better understanding of the interests, attributes and needs of different populations and persons in these communities. In the mhBeF program, the formative research focused on domains believed to be central to successfully implementing a package of comprehensive community mental health services. The formative research examined the current mental health situation in the communities. It explored participants’ perception about the causes of mental illnesses, and what illnesses were more prevalent in these communities. It also looked at the current health workforce and the pathways to care for persons with severe mental health disorders and epilepsy (PWSMDE). The formative research also focused on the roles of the families of PWSMDE, and what would be the roles of a new cadre of workers such as community resource persons. It also looked at community attitudes towards PWSMDE and their families and further explored the needs and availability of psychotropic drugs in Sinoe County.

The project aims to define and develop a model that combines three key interventions that together will make up the Comprehensive Community-based Mental Health Services (CCMHS) package. Once implemented, the services and support package will maximize mental health and psychosocial wellbeing as well as improve social and economic functioning of people with severe mental health disorders and epilepsy (PWSMDE) in three post-conflict countries: Uganda, Liberia, and Nepal. The three key interventions that comprise CCMHS are (a) identification, referral, and clinical management of PWSMDE; (b) promote peer-to-peer support and provide livelihood interventions among persons with severe mental disorders; and (c) reduce the stigma associated with severe mental disorders and epilepsy. The mhBeF project is a partnership between the Carter Center Mental Health Programme in Liberia, TPO-Uganda Uganda, and TPO-Nepal. The study will
ensure that lessons learnt in the development and provision of this package of care can be broadened to cover other parts of these three countries, as well as replicated in other low and middle income countries.

1.2 Project Purpose and Background

The purpose of Mental Health beyond Facilities (mhBeF) is to develop and implement a sustainable Comprehensive Community-based Mental Health Service (CCMHS) package. With this program we want to evaluate whether treatment effectiveness is enhanced when we combine the mhGAP guidelines (World Health Organization, 2010) training on severe mental disorders (psychosis [mhGAP Module 2] and bipolar disorder [Module 3]) and epilepsy/seizures [Module 4] with three aspects of community-level interventions. These include: i) low-level health workers and Community Resource Persons (CoRPs) trained in community education and support; ii) Patient Support Groups (PSGs) made up of patients and their caregivers, who are trained to provide peer-to-peer support as well as being provided with knowledge, skills and resources to establish savings and credit schemes; and, (iii) anti-stigma activities including targeting felt stigma among PWSMDE. mhBeF will use a quasi-experimental research design (i.e. non-equivalence group design) to evaluate the impact of this community-based model of care at the individual level of disability and functioning as well as at household level of productivity. This project builds on other programs working to integrate mental health into primary health care: Program for Improving Mental Health Care (PRIME) in Uganda and Nepal, and The Carter Center Liberia Mental Health Initiative. The mhBeF project considers four innovative approaches: a) to supplement clinical initiatives with multi-sectorial community programming; b) to add an mHealth component which will facilitate clinical decision making as well as monitoring; c) to implement and evaluate effectiveness of the CCMHS in three post conflict countries, providing evidence to scale up in other low and middle income countries; and d) to include a socio-economic support system for PWSMDE and their household.
1.3 Liberia Country Context

Access to mental health services in Liberia is severely limited yet in high demand (Kruk et. al, 2011; Medeiros, 2007). Liberia emerged from 14 years of civil war in 2003. The 14 years of civil conflict, killed an estimated 250,000 people and left many more physically and emotionally traumatized. It also led to massive population displacement with severe insecurity and disruption of social services, including health care. The health system was destroyed in the war. Of the 293 public health facilities operating before the war, 242 (83%) were deemed non-functional at the end of the war due to destruction and looting. Many doctors, nurses and other health workers fled the country, leaving 30 physicians to serve a population of over 3 million (NTGL Joint Needs Assessment Report, 2004).

A 2008 review of the health system by the Ministry of Health and Social Welfare (MOHSW) estimates that nearly 40% of the population has access to general health care (Johnson, K. et.al, 2008). Mental health problems related to war trauma and exacerbated by dislocation are also a pressing concern. A 2008 survey found that 40% of the population had self-reported symptoms indicative of major depression and 44% with clinical symptoms of post-traumatic stress disorder (Johnson, K. et.al, 2008). Other studies found that less than one-third of health care facilities provided mental health care and only 18% of health care facilities in the 2011 government accreditation survey reported that they had clinicians trained to provide mental health services (RBHS, 2010; Ministry of Health and Social Welfare., 2011).

A qualitative assessment by The Carter Center (TCC) in four Liberian communities found that one-third of respondents did not believe that individuals with mental illnesses can engage in income-earning activities. In addition, between 75-100% endorsed the notion that people with mental illnesses impacted negatively on their families and communities in the area of economic development.
1.3.1 Project Site

Sinoe County is county host to the project site jointly selected by the Ministry of Health & Social Welfare and the project team. Sinoe is one of Liberia’s 15 counties and has 17 administrative districts. It is located in the Southeastern region of Liberia with Greenville City as its capital. Sinoe has approximately 111,267 inhabitants ("2008 National Population and Housing Census: Results"). The major languages spoken in Sinoe are: Liberian English, Kru, Sarpo, Krahn and Bassa. The county’s health infrastructures consist of 33 health facilities including one hospital F. J. Grante Hospital and 32 clinics. Of the 32 clinics, the County Health Team supports 22 clinics while partner health organizations support 10 clinics.

Thirty nine percent (39%) of the population lives within 15km (3-4 hour walk) to access to a health facility. This results in Sinoe being extremely limited in access to facility-based deliveries, a key indicator for the Ministry of Health & Social Welfare (MOHSW). While all health facilities have at least one health professional in the county, Sinoe experiences significant health human resource capacity gaps. It has the third highest maternal mortality rate in the country (Ministry of Planning & Economic Affairs., 2010). According to the 2011 Accreditation Report, Sinoe ranked last in the national assessment of health care facilities and was the poorest performing county in health care production (Ministry of Health and Social Welfare., 2011). These indicators led to identification of Sinoe County as best positioned to benefit from improved community-based mental health services.

1.3.2 Healthcare work force in Sinoe

Chart one show the population of healthcare workforce currently involved in service delivery within Sinoe County:
Six of the ten health districts in Sinoe will be involved in the project with a combined total population of 49,321 people, and the districts included are:

1. Greenville District
2. Tarsue District
3. Butaw District
4. Dugbe District
5. Jeadea District
6. Kpanyan Districts
CHAPTER TWO

2.0 Methodology
2.1 Data collection methods and tools

The formative research used qualitative approaches to collect data. These included focus group discussions (FGDs), and key informant interviews (KIs). The tools for data collection included structured and semi-structured FGD and KI guides. The qualitative tools were developed based on the study objectives (See Appendices). Four research assistants were trained to collect and transcribe data.

Two types of interviews were conducted: 1) key informant interviews, and 2) individual interviews with key stakeholders and experts. Focus group discussions were conducted that addressed issues of service utilization, as well as perceptions and other factors that contributes to the degree to which individuals access or provide mental health services and programs. Key informant interviews were conducted with key stakeholders or specialists, in order to gather information on available mental health service data. Key informant interviews also sought to explore the following themes and issues: health care workforce, new cadre of workers, the role of family members and stigma (See table below). The types of respondents represented expertise in the following areas: health organization, health facility and community. Participants were presented with interview questions and vignettes to which to respond.

Table 1: Main themes and sub themes of the formative research

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-themes</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare workforce</td>
<td>- Knowledge and skills gaps</td>
<td>KII</td>
</tr>
<tr>
<td></td>
<td>- Training needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Current curriculum and accreditation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Training organization, when trained and training duration</td>
<td></td>
</tr>
<tr>
<td>Supply chain of psychotropic medicines</td>
<td>- Currently available mental health drugs, mode of supply and frequency</td>
<td>KII</td>
</tr>
<tr>
<td></td>
<td>- Cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Essential drug list</td>
<td></td>
</tr>
</tbody>
</table>
| Patient Support groups | - Size, content and structure (procedure and composition)  
- Feasibility  
- Existing treatment costs | FGD |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma</td>
<td>- Stakeholder's knowledge, attitudes and practices</td>
<td>KII</td>
</tr>
</tbody>
</table>
| Role of the family of PWSMDE | - Burden  
- Needs | FGD |
| Role of CoRPs          | - Feasibility, acceptability and willingness of CoRPs to be involved | KII |
| Pathways to care       | - Current pathways to care for person with severe mental disorder and epilepsy  
- Availability and use of formal MH services | FGD  
KII |

Interviews were recorded using a digital recording device, and the recordings were transcribed. Transcriptions were edited for accuracy. Written interview summaries were compiled and reviewed. A “grounded theory” approach was used to identify codes and themes.

2.2 Sample size and Sampling procedure

The sample size of the formative research is 60 (22 KIIs and 6 FGDs consisting of 5-8 participants each). Three KIIs were conducted with service users, one with family members and seven with community members including a general community health volunteer and community leaders and policy makers. At the facility level, eight KIIs were conducted with individuals from health facilities including an administrator, a pharmacist, primary health care workers and mental health clinician. Three KIIs were also conducted with health organizations. Examples of health organizations in the county are Merlin and Mercy Corps. These are non-governmental organizations (NGOs) managing health services in the county. The description and type of persons and organizations chosen for KIIs and focus group discussions (FGDs) are presented in Table 2 and Table 3. Sixty nine percent respondents in the study were males while the average age of all respondents was 38
years. Forty percent of participants were from the Kru ethnic group, fourteen percent from Sarpo ethnic group, while forty eight percent were from other five ethnic groups.

Table 2: Profile of KII Participants

<table>
<thead>
<tr>
<th>KII</th>
<th>Occupation</th>
<th>Gender</th>
<th>Age</th>
<th>Education</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KII Health Facility (8)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Facility</td>
<td>Pharmacist</td>
<td>Male</td>
<td>44</td>
<td>College</td>
<td>Kpelle</td>
</tr>
<tr>
<td>Health Facility</td>
<td>Nurse Supervisor</td>
<td>Female</td>
<td>30</td>
<td>College</td>
<td>Krahn</td>
</tr>
<tr>
<td>Health Facility</td>
<td>Nurse Supervisor</td>
<td>Female</td>
<td>49</td>
<td>High School</td>
<td>Grebo</td>
</tr>
<tr>
<td>Health Facility</td>
<td>Logistics Officer</td>
<td>Male</td>
<td>55</td>
<td>High School</td>
<td>Kru</td>
</tr>
<tr>
<td>Health Facility</td>
<td>OIC*/HCW/Nurse</td>
<td>Female</td>
<td>31</td>
<td>College</td>
<td>Lorma</td>
</tr>
<tr>
<td>Health Facility</td>
<td>Health Adm.</td>
<td>Male</td>
<td>30</td>
<td>College</td>
<td>Kru</td>
</tr>
<tr>
<td>Health Facility</td>
<td>Mental Health Clinician</td>
<td>Female</td>
<td>34</td>
<td>College</td>
<td>N/A</td>
</tr>
<tr>
<td>Health Facility</td>
<td>HCW/Nurse</td>
<td>Male</td>
<td>31</td>
<td>College</td>
<td>Lorma</td>
</tr>
<tr>
<td><strong>KII - Health Organization (3)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Health Organization</td>
<td>Dispenser/Nurse</td>
<td>Male</td>
<td>63</td>
<td>High School</td>
<td>Kru</td>
</tr>
<tr>
<td>Health Organization</td>
<td>Nurse/District Health Officer</td>
<td>Male</td>
<td>30</td>
<td>College</td>
<td>Bassa</td>
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<tr>
<td>Health Organization</td>
<td>Service Head/ Psychosocial Counselor</td>
<td>Male</td>
<td>51</td>
<td>College</td>
<td>N/A</td>
</tr>
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<td><strong>KII - Service Users (3)</strong></td>
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<td></td>
</tr>
<tr>
<td>Service User</td>
<td>Service User</td>
<td>Male</td>
<td>22</td>
<td>High School</td>
<td>Kru</td>
</tr>
<tr>
<td>Service User</td>
<td>Service User</td>
<td>Female</td>
<td>43</td>
<td>Elementary</td>
<td>Kru</td>
</tr>
<tr>
<td>Service User</td>
<td>Service User</td>
<td>Female</td>
<td>33</td>
<td>Elementary</td>
<td>Sarpo</td>
</tr>
<tr>
<td>Family member</td>
<td>Family Member</td>
<td>Female</td>
<td>41</td>
<td>Elementary</td>
<td>Kru</td>
</tr>
<tr>
<td><strong>KII - Community (7)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>Religious leader</td>
<td>Male</td>
<td>N/A</td>
<td>College</td>
<td>N/A</td>
</tr>
<tr>
<td>Community</td>
<td>Religious leader</td>
<td>Male</td>
<td>45</td>
<td>College</td>
<td>Kru</td>
</tr>
<tr>
<td>Community</td>
<td>Traditional Leader</td>
<td>Male</td>
<td>45</td>
<td>High School</td>
<td>Sarpo</td>
</tr>
<tr>
<td>Community</td>
<td>Policy Maker</td>
<td>Male</td>
<td>N/A</td>
<td>College</td>
<td>Kru</td>
</tr>
<tr>
<td>Community</td>
<td>Leader/Disability Union</td>
<td>Male</td>
<td>47</td>
<td>High School</td>
<td>Kru</td>
</tr>
<tr>
<td>Community</td>
<td>Community Health Volunteer</td>
<td>Male</td>
<td>37</td>
<td>High School</td>
<td>Sarpo</td>
</tr>
<tr>
<td>Community</td>
<td>Police Officer</td>
<td>Male</td>
<td>37</td>
<td>College</td>
<td>Kpelle</td>
</tr>
</tbody>
</table>

*OIC (officer in charge)
Table 3: Profile of Focus Group Discussions Participants

<table>
<thead>
<tr>
<th>Focus Group Discussions</th>
<th>Number of Participants</th>
<th>Sex</th>
<th>Avg. Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD-01 - Community (Banna town)</td>
<td>11 Participants</td>
<td>Male &amp; Female</td>
<td>48 years</td>
</tr>
<tr>
<td>FGD-02 - Service Users/FM*</td>
<td>7 Participants</td>
<td>Male &amp; Female</td>
<td>41 years</td>
</tr>
<tr>
<td>FGD-03 – Community</td>
<td>8 Participants</td>
<td>Male &amp; Female</td>
<td>36 years</td>
</tr>
<tr>
<td>FGD-04 – Health Facility</td>
<td>7 Participants</td>
<td>Male &amp; Female</td>
<td>35 years</td>
</tr>
<tr>
<td>FGD-05 – Community</td>
<td>7 Participants</td>
<td>Male &amp; Female</td>
<td>48 years</td>
</tr>
<tr>
<td>FGD-06 – Service Users/FM*</td>
<td>9 Participants</td>
<td>Male &amp; Female</td>
<td>33 years</td>
</tr>
</tbody>
</table>

*FM (family members)

2.3 Data Analysis

The recorded interviews were transcribed by four research assistants. An independent transcriber was hired to review and clean the data. The data was coded and analyzed using NVivo 10 software.

2.4 Ethical Considerations

The study was approved by the University of Liberia – Pacific Institute for Research and Evaluation Institutional Review Board (UL-PIRE IRB) on February 28, 2013. Participants in the focus group discussions and key informant interviews were informed about their rights to participate, to refuse to participate or to quit at any point of the interaction without any penalty. They were told about the purpose, procedure, and duration of the study, and confidentiality, potential risks and benefits of the study. Researchers obtained informed consent from each individual participating in the study.
3.0 Research Findings

3.1 Current Mental Health Situation

3.1.1 Perceptions about causes of mental illness

This section describes data in the matrix about the health care workforce and about the mental health situation in the communities. The data was obtained from key informant interviews and some focus group discussions. The key informants included religious leaders, nurse supervisors, service users, a pharmacist, a policy maker, a traditional leader, a health administrator, a police officer, mental health clinician, and others. The focus group discussions were conducted among members of the community, service users, and health facility participants.

Twelve of the participants of the KIs and a few of the FGD participants identified or endorsed the major causes of mental illness as frustration and African Science. These top responses were followed by demonic spirits, and witchcraft, accidents, drinking alcohol and smoking drugs. Malaria, spoiled medicine law, spiritual factors, and prolonged labor during delivery were other causes mentioned by participants. A majority of participants in focus group discussions that were exclusively made up service users felt that malaria was the cause for epilepsy.

“That’s what I am saying some say African Science can cause the epilepsy; it can cause the brain even the mental problem we are talking about, this is Africa. African science anything is possible now so the thing can cause lots of thing, they say malaria can cause that same thing called epilepsy too.” *(FGD 06 – Service Users/Family members)*

“Sometimes when you do something bad to someone they able to go to someone then you get mental problem.” *(KII 22 – Service Users)*

“Some people say malaria can do it; they say malaria can cause that same thing epilepsy.” *(FGD 02 – Service Users)*
3.1.2 Kinds of Mental illness observed in the communities

Researchers asked participants about their perceptions of mental illness in the community as well as their understanding of the causes mental illness. Epilepsy was the most recurring theme as a cause of mental illness in the community. Depression closely followed epilepsy as a cause of mental illness that respondents identified. Depression could be classified into 3 categories (1) problems on the mind, (2) heart spoiled, and (3) frustration as terms most frequently mentioned or endorsed. Epilepsy and depression were followed by other causes such as drug abuse, schizophrenia, post-partum psychosis, and anxiety.

I have not really gone to check but the one that is really visible here is epilepsy, many people have been saying it and the people have been saying that these are bad mental disorder, the schizophrenia like the crazy people we see around. (KII 01 – Pharmacist)

“Yea for epilepsy, I think about 75% of the cases I received in let’s say October and up to now are epilepsy.” (KII 17 – Mental Health Clinician)

“You know I can say depression is one of the mental disorder that we can see, refusal to speak to anybody, the major one is the one that we can see the person walking up and down in the street they are gone mad.” (KII 09 – HCW/Midwife)

“I came across lot of people with mental disorder to be precise DIP which is Drugs Induced Psychosis. It’s a serious problem. We got lot of aggressive patients here that really need to be in the hospital where we will cater to them but there’s no way, there’s no wellness unit, nothing established.” (KII 17 – Mental Health Clinician)

“People with epilepsy come more, maybe depression but we see other cases like this anxiety, where they feel that their head is opening.” (KII 17 – Mental Health Clinician)
3.2 Health Care Workforce

3.2.1 Knowledge of health care workers about mental health

This section describes data in the matrix on knowledge of the mental health care workforce. The participants were asked about health workers being trained to perform tasks that are currently being performed by mental health specialists. In particular, researchers asked about health care workers’ knowledge about mental health. Most participants thought that the health care workforce had little knowledge of mental health. One respondent however thought that the knowledge of health care workers was adequate. All respondents thought that all health care workers have done at least a course on mental health while in school.

“We may not be mental health clinicians but at least we got some basic ideas from school. We did theory for 12 hours a month for three months, so we know that when someone is having a disorder.” (KII 02 – HF/Nurse Supervisor)

“When I was in college it was just a topic while I was doing my junior courses, it was just a surface not even deep. Actually they talked about the personality disorder mostly human behavior, that every human being is not 100% but when it go beyond certain range then you get to know that it becomes a disorder.” (KII 17 – HF/Mental Health worker)

“I did psychiatry as a course. Well, I have not had any formal training in mental health, it helped me in that, at least I can be able to identify some mental health cases and be able to refer patients to the responsible people that were trained to carry on.” (KII 18 – HF/Nurse)

“I did psychiatric nursing in school, where we learned a lot about some psychiatric disorder, where we talked about schizophrenia, historunic, panic anxiety, we discussed a lot about hallucination, and we talk about auditory visual hallucination.” (KII 11 – HO/Nurse)
3.2.2 Current training curriculum and accreditation

Researchers asked participants to discuss training curricula for health care workers regarding mental health. They responded to questions on training and whether the training was accredited. Specifically they were asked about their knowledge of mental health curricula, accreditation, and licensure for health care workers. Most respondents indicated that the accreditation of institutions and licensure of health care workers is needed. They stated that accreditation of health institutions are jointly done by the Ministries of Education and Health & Social Welfare. Some respondents felt it was acceptable for mental health care workers to be trained in the community or at the community level.

“For the nursing institution, to have these training accredited you must sit the state board examination; make a pass in psychiatry nursing before you can be a licensed nurse in Liberia.” (KII 21 – HF/Health Adm.)

“All medical schools in Liberia have been accredited by the Ministry of Health and Ministry of Education to run and I believe that they have included this psychiatry training in their curriculum, because they know the whole part of the health work.” (KII 01 – HF/Pharmacist)

3.2.3 Training needs and suggestions for training content.

Study researchers asked respondents from health care setting about the types of training that they think health care workers would need before they could deliver mental health. Most participants responded that counseling was most important, followed in descending order by case identification and diagnosis, treatment, good communication skills, training on ethics, and fundamentals of mental health.

“For the nursing institution, to have these training accredited you must sit the state board examination; make a pass in psychiatry nursing before you can be a licensed nurse in Liberia.” (KII 21 – HF/Health Adm.)

“All medical schools in Liberia have been accredited by the Ministry of Health and Ministry of Education to run and I believe that they have included this psychiatry training in their curriculum, because they know the whole part of the health work.” (KII 01 – HF/Pharmacist)

“First of all I will really want to be trained in the fundamental. You know, everything you have to go through the fundamental stage, how to identify mental health, somebody with mental health. If I can identify a problem in people with mental health then I will be looking at how to treat them. Everything you do is associated with counseling; yes the first thing is, in order if I should identify, I should be able to counsel, I should be able to treat, and I should be able to care for them.” (KII 18 HF/Nurse)
3.2.4 Willingness of HCW to provide mental health service

This section describes the willingness of health care workers to provide mental health care. Researchers inquired as to what respondents thought about health care workers being trained to perform tasks that are currently being performed by mental health specialists. Specifically they were asked if the shifting of tasks would be acceptable to health care workers and if the health care workers would be willing to take on this extra task. All respondents reported that health care workers would be willing to provide mental health care. They reminded researchers that mental health was a part of the basic health services package\footnote{(Developed in 2007, the BPHS was the first set of standardized criteria for health care provision in post-conflict Liberia)}; therefore they felt that health care workers would be equally willing to provide mental health service as they have shown for providing other services such as HIV and tuberculosis. Respondents agreed that once health care workers are given the proper training and tools to provide mental health service, they will be willing to take on additional task related to mental health. One respondent, however, thought they were probably willing to take on extra tasks.

\begin{quote}
“They are willing, this is why we sent them on the training; since those we sent to the training were well trained, they are capable to do their jobs and they are doing it well.” \textit{(KII 13 – HF/Logistician)}
\end{quote}

\begin{quote}
“For the PHC workers they will have to be fully equip counseling, diagnose, treatment I mean just everything because out there you are alone, you can’t just depend on something little and say oh yes I can make it. They will need to have every idea, everything that they supposed to know.” \textit{(KII 02 – HF/Nurse Supervisor)}
\end{quote}

\begin{quote}
“They need sufficient training, they have to be well knowledgeable before you take care of clients, before you take care of people with mental problems, you have to be well knowledgeable, and you have to get good communication skills.” \textit{(KII 18 – HF/Nurse)}
\end{quote}
3.2.5 Challenges faced by health care workers

Key informants responded to questions about challenges related to training and service provision. Most respondents thought that low incentives and poor or no motivational package were the biggest challenges. They reported that the current salary structure for health workers was low and therefore better incentives were needed to motivate them. Lack of drugs, particularly the lack of psychotropic drugs, was listed as the next most pressing challenge they faced. Respondents argued that the current supply chain needs to be strengthened. Most respondents reported that getting the drugs or other essential commodities from Monrovia to the county was a big challenge due to deplorable road conditions. Some respondents also mentioned increased work load as one of the challenges. They said that adding on additional tasks would increase the load of work health workers are required to perform. Others thought that lack of staff and high attrition rate among health care workers presented a big problem in rural communities. One respondent stated that people are more likely to relate to people of their own culture than from another culture thus making cross-cultural relationships more challenging. He further recommended that when recruiting or assigning health workers one should consider place of origin and culture as strong factors for placement.

“The best motivation that will be okay for them is probably their salary those are one of the things clinicians usually complain about.” (KII 02 – HF/Nurse Supervisor)
3.2.6 Recommendations for training

Participants responded to invitations for recommendations on the training of health care workers (HCWs). Most respondents felt that providing incentives for HCWs was very important. They also indicated that providing extra incentives was paramount to maintaining health care workers in rural communities. Others interjected that because of the large geographic areas that HCWs covered and the long travel distances involved that providing transportation was necessary. Some also felt that providing regular supportive supervision was important.

“They would need transportation. They would need incentives; incentives would cover a wide range of things.” (KII 20 – HO/Service Head)

“To make those people useful we should regularly do supervision, mental health focal person who is almost like a coordinator for mental health in the county can supervise them.” (KII 21 – HF/Health Adm.)
3.3 Pathways to care

3.3.1 Current pathways to care for PWSMD & E

This section of the study describes the current pathways to care for persons with severe mental health disorders and epilepsy from the perspective of the study's respondents. It describes the availability and use of formal mental health services and the referral system in the county. Respondents discussed the current referral system. All respondents stated that individuals seen in the communities were referred to a range of care providers including: the primary health care facilities, traditional healers, and religious leaders. Most respondents, however, mentioned that the major referral site was the county hospital (F. J. Grante Hospital). Participants also stated that individuals with serious mental health cases were referred to Monrovia and the Jackson F. Doe Memorial Hospital in Tappita, Nimba County. In these instances, they confirmed, there were enormous challenges considering transportation and relocation cost.

“We need DSA (daily subsistence allowance) and transportation, some of us our distances are not easy, you have to use motor bike to go there, so we will need transportation and we need modules from trainings and DSA.” (KII 14 – HF/Nurse)

“Most of the epileptic patients will usually walk into the screening room and say oh dad I am here for my medication. I also saw a case where the person was referred to Monrovia, to Duport road, to where you have the Grant mental health hospital.” (KII 11 – HO/Nurse)

“Whenever (a) crucial situation comes they will refer because they don’t have (it) the tools for it. Probably they have to refer to Monrovia.” (KII 01 - HF/Pharmacist)
3.3.2 Formal Mental Health Services

Researchers asked respondents about available service in health facilities. Respondents from health facilities reported that mental health services such as general counseling and treatment for epilepsy, mild depression, and drug-induced psychosis were being provided at F. J. Grante Hospital. At this facility, they stated that three trained mental health clinicians were providing mental health care including short stays on an in-patient basis. A mental health clinician reported that they are also engaged in mobile mental health service and prison service in Greenville district. However, they reported that the mental health in-patient short stay has a capacity of two beds. Respondents reported that psychotropic drugs were not available at primary health care facilities, and these facilities experienced mental health capacity gaps. Some respondents reported that general counseling and treatment for epilepsy were provided at some PHC facilities.

“If we are treating a patient and notice that we see some signs of mental disorder, we call these mental health clinicians, they can come and they (are) always talking to the person. Sometimes I can see them, they can carry the person in a special place and they take time off to talk to that person.” (KII 14 – HF/HCW - Nurse)

“Presently we do counseling, as you may see, we talk to the people, and sometimes we go through full commands of the mental health programs.” (KII 14 – HF/HCW Nurse)

“We only get Diazepam, which is given for our facility; we don’t have actual medicine for mental health. We only do counseling, like when we find (out) that the patient is combative, we serve Diazepam.” (KII 14 – HF/Nurse)

3.3.3 Other Mental health services

Most participants confirmed that PWSMDE seek care from traditional healers and religious leaders. Participants reported that apart from seeking formal mental health care; PWSMDE were more likely to seek care from religious leaders compared to traditional healers.
3.3.4 Factors influencing choice of care

Two KII participants and some FGDs respondents commented that the choice of care depended on what family members thought was the cause of illness. If they believed that the cause of mental illness was witchcraft, they were more likely to seek care from the traditional healers. Similarly, if they thought the cause of mental illness was spiritual, they would go to the religious leader for care. However, most respondents reported that the health facilities were the preferable choice for seeking mental health care. They stated that cost of services were far cheaper at health facilities than religious or traditional care. Some respondents also thought that services at the health facility required too much time, because of this they would rather go to a religious leaders or traditional healers. Some service users also stated that they buy drugs from the local pharmacy.

“It depends on the cause, what the family member thinks is the cause. If some family member starts to have mental illness, and I think that the reason for this is because of witchcraft I will want to take that person to country doctor. Or (if there is) some spiritual cause I will say let me carry the person to the church so they can pray for the person, so what is bothering the person, that demon or so can leave the person. So it depends on what I think is the cause of the problem.” (FGD 04 – Health Facility)

“They go to country doctor. Sometimes when they go the hospital nothing moves from there, (then) they go to the church nothing move from there, then they say but then let me go to the country doctor.” (KII 22 – Service User)

3.3.5 Gaps in pathways

Respondents regarded the lack of transportation as a major barrier to care. They stated that during referral, getting PWSMDE from their communities to Greenville or out of the county for major referrals was challenging. Others thought that lack of capacity was a major barrier to care. Respondents also indicated the lack of mental health drugs in primary health care facilities as a challenge.
“Sometimes the transportation to get them from your facilities, you will try to refer them and they will refuse, they tell you (say) that they don’t have transportation.” (KII 14 – HF/Nurse)

“Like (if) someone has a mental health problem in Gbana town, the last district in Sinoe, to refer them to Greenville here, you know it can be expensive, this is a problem.” (KII 15 – Community)

“We have low staffing problem. We don’t have sufficient nurses or midwives to sit down (you know) because dealing with mental illness or mental health problem, it has to take long time, and you can’t really do it in a hurry.” (KII 09 – HF/Midwife)

### 3.3.6 Cost of Services

Considering the three types of services mentioned by participants, researchers asked participants to reflect on cost of seeking these services. Most participants from FGDs and some KIIIs felt that services at the health facilities were free or less costly compared to care provided by traditional healers and religious leaders. Similarly they thought that the cost of seeking traditional care was much higher than religious care and care provided at health facilities.

“For the hospital it is free. You only just have to come, it is the matter of coming, it leaves (its left) with your effort for coming. But these traditional people, they charge you LD $1000, some LD $3000, sometimes LD $4000.” (FGD – 05 - Community)

“The traditional healers are very (very) expensive, because, the first thing if you go to any traditional herbalist, the first they tell you is to put them in the bush and they are going to tell you the fixed price, sometime they tell you say ok you bring two thousand dollars or five thousand dollars to get in the bush.” (FGD – 03 - Community)
3.4 Patient Support Groups

3.4.1 Acceptability of PSGs

Participants welcomed the idea of the Patient Support Groups (PSG) and generated a range of responses regarding structure and functioning of such groups. Participants indicated that having such a group could ensure better livelihood support and enhance the poor socio-economic status of not only the PWSMDE but also their families and the community. They envisaged a genuine social support system that would ensure treatment adherence for families.

“*The patient support group will always be in the vanguard of going to parents that have mental patients in their family to at least talk to them to find reason so as to take that person to the nearest facility (FGD 03 - Community)*”.

Participants suggested strong involvement and participation of the community in the identification and selection of the community resource persons and referral of members and patients to form part of the groups. They said that community leaders could play a meaningful role in the decision-making process and formation of the group. They also believed that community members would be more likely to join, support and work to own the group. Participants also reported that a major possible challenge to the Patient Support Group may be the unwillingness of some family members to allow their loved ones with mental disorders to form part of the group.

3.4.2 Goals of PSGs

Participants highlighted four key objectives and roles of the PSG:

1. Promoting care and treatment among patients: Participants believed that the promotion of care and treatment among PWMHDE and family members is essential to the establishment of the PSG. They indicated this role would be necessary at the community level while psycho-education would be meaningful to the household level.

“The key objective of this group should be to promote care and treatment of mental illness and disseminate every formation, positive information." *(KII 02 – HF/Nursing Supervisor)*
2. Providing effective psycho-education and training: Participants said that the PSG could create a safety-net for PWMHDE where family members and carers would be open to “encourage patients to take their treatments and make them feel welcome” to the community as a way of tackling the stigma and discrimination.

“The patient support group should be able to encourage them, talk to them, from there they themselves too they will be getting faith; they will be serious in taking their medicine.” (FGD 03 - Community)

3. Social support through positive experience sharing: Participants discussed that the PSG could provide social support among members where they would be able to share positive experiences and consolation to help each other. This strategy they believed could enhance patients’ adherence to treatment, as they could regularly be encouraged to do so. They also mentioned that this promoted visitation of parents, families and carers to encourage taking their loved ones to the nearest health facility for treatment.

“The patient support group will always be in the vanguard of going to parents that have mental patient in their family to at least talk to them to find reason so as to take that person to the nearest facility.” (FGD 03 - Community)

“Some of the things that they could do is by sharing their experiences with others, like for example after you come out of that, you go you share your experiences.” (FGD 04 - Health Facility)

4. Ensuring independence and ownership: Participants said that the group’s independence and community ownership would be important. They reported that family members who are part of the group could help to address health-related issues of their loved ones without waiting on aid from NGOs or government. They believed that carers or family members, through the PSG would be encouraged to assume responsibility for their loved ones by purchasing medications or providing other necessary care and not depend entirely on the government to intervene. They could simultaneously engage in other feasible entrepreneurial enterprises that could boost up their economic status.
Importantly, participants also indicated that it is possible that some PWMDE could refuse to form part of the group but the PSG could still function to ensure that aid can reach such persons through regular visits in order to follow-up on their well-being, treatment adherence and to provide other support as may be needed.

“The patient support group should be able to encourage them, talk to them, from there they themselves will be getting faith; they will be serious in taking their medicine. (FGD 03 - Community).

### 3.4.3 Feasibility of PSG

Participants stressed that the four factors (geography, training, independence and autonomy and entrepreneurship) would be crucial to the PSG operating smoothly and being sustained in the community.

1. Situation/locality of the group: Participants felt that having the PSG, as a community-based group would be important. They believed that PWMHDE, family members, and carers would be more likely to trust the PSG when it is a local group and they are familiar with the members.

   “The patient or the patient relative will be able to trust these support groups because they are all in the community.” (KII 02 – HCW/Nurse Supervisor)

2. Training for group members: Participants also discussed that some level of training should be provided to PSG members to help them with mental health literacy on how to manage their conditions, coping strategies, anti-stigma activities, and what they need to know about treatments. They believed that such knowledge and skills could be used to support members of the group as well as extend education to the larger community as a way of tackling stigma and discrimination.
3. Autonomy and independence: Participants discussed ensuring autonomy and independence of the PSG in running its affairs. They said that the PSG should be allowed to establish its own leadership to run the day-to-day activities of the group and the leaders can subsequently develop the necessary policy, objectives and guidelines to manage the group.

“After we form the group, they should find their own leader.” (FGD 02 - Community)

“Yes once this group is organize; they will have their objective and hey will have a policy, what this group is organize for they must know their own objective.” (FGD 05 - Community)

4. Agriculture/farming and small businesses: Participants suggested agricultural projects to be part of the group’s activity. They found this feasible and convenient at the community level. Such projects could include small farms/gardens from which they can sell their produce to the community and local market in order to generate funds to sustain the group and family members.

They believed that the PSG could also help people to engage in small business like palm business (making palm oil). The PSG could be an opportunity for members to get small loans to make individual businesses to support the purchase of drugs, food supplies and other basic needs for themselves and family.

“They can organize a project, like a garden project that also they can get funding from.” (FGD 05 - Community)”
3.4.4 Composition and structure:

Participants felt that the first major issue concerning the composition of the PSG would be the involvement of patients, especially those who undergo therapy and are stable, including persons with epilepsy. They thought that such persons could serve as example to encourage other patients who are afraid to come out and join the group. However, they thought that PWMHDE who are so ill that they have trouble functioning and participating should be put on a waiting until they become stable and are able to participate.

The inclusion of women, especially mothers, was recommended in composing the group because according to participants, women tended to be more successful in such activities (community based loan groups) compare to men.

“Okay this group should include mothers because women most of the time are successful in a lots of thing as such. I think women will be the best people (KII 02 – HCW/Nurse Supervisor)”

The participants also recommended that community leaders (elders, chief, chairperson, and spiritual leaders) be part of the group. They confirmed that the community leaders are the ones from whom all community programs get approved and accepted from and that citizens look up to them for answers and questions. These community leaders would be the ones to convene a meeting and inform the citizens of the purposes of the PSG and this will encourage citizens to participate in the group.

“Include the elders, the chief, the community leaders, because whatever thing that starts in the community people always go to the leaders to seek advice. The community leaders will always encourage the citizens because they are the ones who will always see the people, but once their leadership is not involved in that particular thing, it will be hard for people to come” (FGD 04 – Health Facility)
Meanwhile, some participants raised concerns about the group’s size. They suggested that the total membership should be about 15 persons because larger groups may enhance the chance of group conflict.

“The group members must not be plenty (large), maybe 10 persons or sometimes 15 persons will be ok. We don’t want noise (fuss) within groups; because when there are many people there is heavy noise, hala, hala (lots of fuss).” (KII 22 – Service Users)

Others participants suggested that the membership of the group should be left open so that more people could be encouraged to join. These participants felt that as the news spread about the PSG more people with problems would want to join the group. Thus, if there is a strong limitation the size, this will discourage people from coming out and seeking help through the PSG. These participants also believed and suggested that the group’s leadership should be restricted to a fixed number of persons and not be left open.

“It should be open, not specific amount, so that more people will encourage a lot of people to come in and by more people coming in, the message will be spread, that will help.” (FGD 04 – Health Facility)

3.4.5 Frequency of PSG meetings:

In terms of frequency of the meeting, participants’ opinions varied between once a month and once every two months.

3.4.6 Cost of PSG:

Participants found the concept of the PSG to be less cost intensive compared to many other community-based groups. They noted that the PSG would be of no extra cost in terms of establishment and functioning based on the fact that it assumes a strong community based structure.
“Well groups like these are mostly community based so no special cost to them.” *(KII 02 – HCW/Nurse Supervisor)*

However, they suggested that some form of incentive would be useful to encourage the members to continue the group and ensure its sustainability. Some participants felt that incentives need not to be monetary and could be given during meetings. Among the goods, services, and commodities that participants cited as most likely to be included in the cost were transportation, training, and sporadic provision of gift items.

“The best you can do is just find some kind of encouragement for them from time to time, probably every time they come for some meeting you can give them something little it doesn’t have to be money.” *(KII 02 – HCW/Nurse Supervisor)*

### 3.5 Role of Community Resource Persons

Participants’ views on the roles of the community resource persons were also requested. They outlined several roles that they thought community resource persons should play. Some participants thought that the major roles are to identify and refer persons with severe mental disorder and epilepsy for health care. They also mentioned that CoRPs should be able to provide health education in the community, as well as, at the health facilities. Other respondents thought that CoRPs should also make routine follow-ups on PWSMDE and serve as a link between the health care workers and family members, carers and PWSMDE. They should ensure that medications are taken by PWSMDE and that the family be made aware of basic home-based care.

“Community health volunteers should be knowledgeable as it relates to intervening in the early stage whenever there’s a mental health condition suspected in the community, these people should have a role that will be linked to identification and referral to the primary health care facilities”. *(KII 20 – HO/Service Head)*

“As GCHVs we are taught to do health education in our areas, we are doing it all over. In the clinics and the communities, we do health education, because a lot of sick people are there, a child or who so ever we are there to put them on bed or do referral. We do referrals too, like for those critical cases, we sent for ambulance”. *(FGD 05 – Community)*
3.5.1 Feasibility of using CoRPs

There were mixed views from respondents concerning the participation of community volunteers. Some respondents believed it would be helpful to recruit individuals from the communities because they can better understand the situations in these communities. They thought that community members would be more likely to trust and cooperate with individuals selected from within the community than other health workers. They also mentioned that general community health volunteers (gCHVs) have been trained and used for other projects and this has yielded good outcomes. They believed that if those gCHVs are trained and given the support to perform their tasks, it will have a great impact.

“It will be of help to use people from the community because those problem come from the community really, they don’t come from anywhere but the community; so if you recruit from the community it will be of helpful.” (KII 20 – HO/Service Head)

“The gCHV, those volunteer community workers, I mean they need training also because they are the ones (who are) always in the community, they are the ones always based in the community and it will help them too to bring cases and recruit cases and then we will go ahead, I mean we can minimize the situation.” (KII 20 – HO/Service Head)

“Yes it will have an impact when the gCHVs are trained because what we have done in the past we tried to train them to various aspect about mental health so if they are taught about the mental health issue it is acknowledgeable for us, and I think it would help a lot.” (FGD 05 –Community)

On the other hand, during one focus group discussion the participants argued that some volunteers were not actively performing their duties. They noted that some gCHVs felt reluctant to render free service, as a result, the impact of their activities were felt less in the communities.

“I want to really say this, the establishment of the gCHV I think it was necessary but I believe for my community or all other communities we only see them passing around and I see no impact for being assigned for the reason of creating programs for them, I see no impact.” (FGD 05 –Community)
3.5.2 Challenges

Some participants felt that the idea of volunteerism may be a challenge. They noted that getting committed individuals to render free services in the community becomes difficult. They indicated that some people become reluctant if they do not stand to get any financial benefits.

“Some of the obstacles involving them is that people may not agree to render free services to our people.” (KII 12 – Community/gCHV)

Respondents also mentioned lack of transportation as one of the challenges. They mentioned that because the communities are far apart, and the roads can be deplorable, moving within these communities becomes difficult especially during the wet season.

“Most of the difficulties that I am seeing for those that will even be willing is the way to get to other communities. Because sometimes you are leaving from here to community X for an example, and there is no car road going there, you have to walk from this community to that place to have the people served.” (FGD 03 - Community)

3.5.3 Recommendations for enhancing CoRPs activities

Respondents introduced the idea of a motivation package. Some respondents thought that to maintain the enthusiasm of gCHVs, it will be necessary to include a motivation package. They suggested that a “motivation package” should include transportation allowance, phone cards for communication, and resource materials for providing health education. The participants also felt that with the proper education and training, the gCHVs will meaningfully contribute to healthcare delivery as they have shown for immunization, HIV/AIDS and other health programs.

“If the gCHVs are trained to know various aspects about mental health and they are also taught about the mental health issue it will be good for the communities.” (FGD 05 – Community)
3.6 Roles of the family of PWSMDE

This section describes data about the role of family of persons with severe mental disorders and epilepsy. The data was obtained from key informant interviews and focus group discussions in which a variety of individuals participated. Respondents were asked about their views on what roles the family of PWSMDE should play and what are the burdens and challenges they faced. Most respondents believed that the most essential contribution from family members towards PWSMDE is to provide financial support to enable the individual to seek treatment. A majority of respondents in the study believed that the first and most important action from the family is to galvanized support for PWSMDE to seek treatment whether at the health facilities, traditional care or religious care. They also reported that love was an essential attribute that enables the family to perform this task. They further mentioned that PWSMDE are more likely to receive care from family members or be taken for treatment if he or she is loved by the family.

“We need daily subsistence allowance, transportation and scratch (phone) cards, for some of us our distances are not easy, you have to use motor bike to go do our work, so we will need transportation and we need materials for trainings.” (KII 12 – Community /gCHV)

“Sometimes the family just has to put things together, like little money together and carry the person somewhere, the person will get that treatment there”. (KII 22 - Service User)

“As a family member the first thing you do perhaps you show [the] love for that person, once you have the love the next thing is you need to have money in order to solve the problem, because it is money that does everything”. (FGD 03 –Community)

“Sometimes it depends on loving the patient, because if I have love for my brother and he is a part of this thing, I will always stick by him in times of difficulties in the sense that I love him and you know I will be by him”. (FGD 03 –Community)
3.6.1 Challenges and burden faced by families

3.6.1.1 Financial burdens. Respondents in the study identified financial burdens as the major challenge faced by families of PWSMDE. Study participants mentioned that the responsibility of providing financial support and seeking care for persons with mental disorder and epilepsy is a serious challenge that the family members faced. They indicated that because PWSMDE may not be able to engage in productive and income generating activities, the burden has to be shifted to family members and this may sometimes limit the movement or create problems for their care givers.

“Another thing could be like the continuous support, like maybe grown up person that should have been doing everything on their own, now that (the) family will have to do everything for you, besides that some are getting to the stage that maybe other family members will not be able to move, and travel out”. (FGD 04 –Community)

3.6.1.2 Family members feeling embarrassed. Respondents also noted that family members feel embarrassed and ashamed by the actions of persons with severe mental illness and epilepsy. They suggested that in extreme conditions, persons with mental health disorders may be disruptive or misbehave in the community and even destroy other people’s proprieties. Such behaviors may cause the family to get into disputes with other community members. Some participants noted that PWSMDE are often insulted and stigmatized by others.

“When you are a relative to the person (PWMDE) when they are behaving abnormal and people looking at you, you can be shame (ashamed), when the person doing some funny thing in the community it can embarrass you. So you just have to find way so that the person can be normal”. (FGD 06 – Family member)

“It can’t be easy, the mentally ill people they can frustrate their people. There are a lot of things they can do, they can misbehave because they do things that the family members don’t expect them to do, and it puts worriedness on the family.” (FGD 04 –Community)
3.7 Stigma:

3.7.1 Attitudes toward PWSMDE

Negative attitudes towards persons living with severe mental disorders and epilepsy were identified through the formative research. The majority of the respondents referred to PWSMDE as “crazy” or “mad people.” A health facility worker described that even after receiving treatment, PWSMDE continue to be labeled as “crazy” and called other stigmatizing names. Some respondents believe that PWSMDE could never recover from their condition.

“The people, even when somebody has had that mental illness and the person gets better, they can say crazy man can never be normal again, then they can say the man was crazy before oh! It is hard for craziness to finish.” (KII 09 – Health Facility/Midwife)

Local stigmatizing idioms and insults were also identified such as “zepsi, cracky, and sarkar.” These terms were endorsed by four participants. Another potentially negative term was “not sound.” Not sound was endorsed by three participants. One health worker pointed out that these are stigmatizing terms heard in the communities and health facilities.

“Some of the words they use, they say” sarca, cracky, crazy,” you see, they stigmatize them.” (KII 09 – Health Facility/Midwife)

Participants confirmed that PWSMDE are mistreated in the communities. Two of the respondents reported witnessing PWSMDE being mocked and teased. Others mentioned that PWSMDE are blamed for their conditions.

“In the community even you sit with some of them, they stigmatize them, they tease them and give them mark, and they give them names, “that other one there that her own medicine do her like that”. (KII – 17 – HF/Mental Health Worker)
Regarding the stigma against persons with epilepsy, reported by respondents to be the major condition seen in the communities, one participant identified the cause as witchcraft. (See causes section of formative research):

They refer to them as witchcraft that is someone who got medicine somewhere either to harm somebody, so while you are going to harm somebody the medicine turn against you that how people take the condition of some of these people.” (KII – 04 – Community/Religious leader)

Four respondents reported that PWSMD and epilepsy are often chained by family members, religious leaders, and traditional healers. One respondent reported that PWSMDE are beaten.

“When you reach in some villages, their relatives because they have mental problem they are tied, or chained, so because they don’t know where to go and where they can get some help or assistance rendered for that person, they will just keep that person into the village on chain, tied up.” (KII 18 – Health care worker)

3.7.2 Social Isolation and avoidance

Social isolation and avoidance of PWSMDE were endorsed by most of the participants. For example, one respondent reported that persons with epilepsy should not get married. Another respondent confirmed that if community members identified someone as a drug addict, they would not want that individual around. A law enforcement officer stated that the rights of PWSMDE are being denied. He explained that PWSMDE are being denied jobs, an assertion that was later confirmed by three other respondents.
3.7.3 Health workers attitude towards PWSMDE

Respondents indicated that health care workers were among those who stigmatized PWSMDE. One participant reported that some health workers have been seen stigmatizing PWSMDE. A mental health worker reported experiencing negative responses from other health workers in the facility. The mental health clinician stated that they are referred to as “Crazy Doctors”.

“For the others like you are health worker but you don’t have the training they always pushing them a far, they don't want to even be acquainted with them, that negative impact, that negative feeling, it’s in their mind, because they don’t have formal training.” *(KII – 17 – HF/Mental Health Worker)*

“Because we deal with people with mental illness, so we are stigmatized. We know of it. We know that we (have) been stigmatized so I mean we cope with it and we just live with it and accept it because it’s from the lack of their knowledge.” *(KII – 17 – HF/Mental Health Worker)*

3.7.4 Stigma Reduction Strategies

Regarding recommendations to reduce stigma, six participants advocated for raising awareness in health facilities, churches, and through media such as radio stations for the community.

“Awareness should also be created so that when someone, in the community becomes mentally ill, family people or community members shouldn’t think that's it’s because of witchcraft.” *(FGD 04 – Health Facility)*
Five participants reported the need to train health workers and community members about stigma reductions activities. One participant recommended that community leaders, council of elders, women and youth groups be involved in stigma reduction education and activities. Others felt it was important to have family members trained to enable them adopt positive attitudes.

“The first thing will be training, because when you are not trained, it will be hard for you to change. They get different types of mental illness, so that’s why they need to be trained, and they will be able to go out and identify those that have the problem. Where proper management and care can be given to them than the person can be relieved from that particular condition.” (FGD 04 – Health Facility)

“The best thing they can do now is to get involved in the mental health education, community should be fully part to educate people, they should be taught, the youth leader, the women leader, the council and elders, they should be taught on (different) different kinds of mental disorders, then in return they will go and be preaching the message to people, when time comes maybe we will afford to start giving diagnosis on phone, but for now let’s focus on the community.” (FGD 04 – Health Facility)

“For that aspect we need to give continue [continuing] health education to the family members so they may be able to accept the treatment, because when they are aware about the treatment it would make it easier for the person with the problem.” (FGD 05-Community)

Two participants also reported that the use of drama would be helpful in stigma reduction.

“One of the major roles we should play to stop stigma is to spread the education to our people ok, sometimes some of them will even be played to see how they can dramatize it; because once you have epilepsy my brother you will be neglected yes in society, but once it is dramatize it will help.” (FGD 03 - Community)
3.8 Supply chain of psychotropic medicines

3.8.1 Current available psychotropic medicines
This section provides an overview of the pharmaceutical needs and availability of psychotropic drugs in Sinoe County. The data from this section reveals that psychotropic medicines were scarce in the county pharmacy. Health workers reported that Phenobarbitone was the drug often used for epilepsy. Some health workers said Diazepam, Amitriptyline and Carbamazephine were also used to treat persons with mental health conditions at health facilities.

“We only get Diazepam that is given to our facility; we don't have actual medicine for mental health. We only do counseling. When we find that the patient is combative we serve Diazepam.” (KII 14 – Health care worker)

“When I see the patient convulsing I give Phenobarbitone, like for epileptic patient, I try phenobarb. I don’t really have drug to treat mental health patients.” (KII 14 – Health care worker)

“I may not know the other name of the drug but I can hear them talking say they want give person Carbamazephine.” (KII – 09 HF/Midwife)

3.8.2 Cost of psychotropic drugs
Respondents reported that all primary health care facilities were providing drugs free of charge. They mentioned that in some facilities, specifically the county referral hospital (F. J. Grante Hospital) the Ministry of Health & Social Welfare and UNFPA were providing free services, while Merlin, an international non-governmental organization that partnered with the Sinoe County Health Team previously supported eight of the primary health care facilities in the county.

“The beneficiaries they don’t pay for drugs, every drug here has been provided for by the government of Liberia (and it) is free of charge.” (KII 01 – Pharmacist)
Respondents reported that even though drugs were provided free of charge at primary health care facilities, psychotropic drugs were not readily available in the county. One service head confirmed that the county often runs out of drugs and patients have to buy from local pharmacies. PWSMDE further reinforced that if drugs prescribed by primary health care workers are not available at the facilities, they would have to purchase those drugs from the pharmacy. One service user revealed that drugs are supposed to be given free of charge but some facilities do sell them.

“We get drugs free through the Ministry of Health; they provide it to the County Health Team.” (KII 14 – Health care worker/Nurse)

“No money for it, at our facility here everything here is free, nobody (is) paying money for anything, I haven’t heard that before.” (KII 09 – HF/Midwife)

“I think, UNFPA, MERLIN, they are supporting the hospital here; they give drugs free, UNFPA, MERLIN and MOH.” (KII 20 – Service Head)

“When we don’t get the drugs that were prescribed by the medical doctor then you will have to go to another pharmacy, clinic or hospital to buy it.” (KII 07 – Community Leader)

“Some of the hospitals, sometime the drugs they can sell it, sometimes they sell it to you, sometimes when you don’t get money you can’t buy the drugs.” (KII 22 – Service User)

“They are supposed to be free, but most often, the county runs out of drugs so the patients themselves have to buy it. Patients go to the drug stores to buy drugs that are not available in the hospital.” (KII 20 – Service Head)
Summary of Key Findings and Implications for the Research in Liberia

Beliefs about causes of mental illnesses often at odds with the biomedical approach

Findings from the formative research revealed that participants understanding of the causes of mental illness do not coincide with the bio-medical approach thereby raising the need for intensive and culturally-appropriate mental health education in communities and health facilities. Beliefs that witchcraft, demonic possessions and “just world” retribution as causes of mental illness and unhealthy treatment practices remain pervasive in certain areas. In addition, participants reported that health care workers had little knowledge about mental health. This suggests that efforts to address the knowledge gap must also target health care workers.

Health care workers willing to provide mental health services but entrenched barriers loom large

All respondents reported that health care workers would be willing to provide mental health service. They identified however, major challenges that included low or no incentives for health care workers, lack of psychotropic drugs, lack of staff and increased work load. These barriers pose potential risks for implementation where study resources do not cover these types of costs.

Knowledge of the referral pathway high

The findings also show that respondents in the study were familiar with referral pathways for PWSMDE.

Costs, a major factor in choice of care

Cost of service was a major factor in deciding whether individual accessed formal mental health service or traditional and religious services. Some respondents also believed that the choice of care depended on the effectiveness of the treatment, as well as, what family members perceived was the cause of illness. Comparing the cost of seeking mental health services across all sectors, participants believed that cost of care provided at health facilities was much cheaper than religious care and spiritual care.
CORPS development perceived as a positive step

Respondents endorsed the concept of having CoRPs, a new cadre of mental healthcare workers form part of service delivery. They stated that their potential roles would be identifying and referring PWSMDE for care, making regular follow-up and providing mental health literacy. Participants also welcomed the idea of establishing PSGs and indicated that it would enhance economic well-being and promote effective psychosocial functioning of PWSDME. They reported that the PSG could minimize the financial burden families of PWSMDE faced. They, however, stressed that community leaders could play important roles in the formation of PSGs. This emphasis on a prominent role in PSGs for community leaders may diminish or even challenge the opportunities for empowerment of service users, one of the major goals of the projects.

Stigma is pervasive

Respondents also reported practices that stigmatize against PWSMDE, their families and healthcare provider. This finding reinforces the a priori assumption that the study needed to focus on different types of stigma.

Logistical Supports and Health Care Worker Payment Represent Potential Risks to Study and Eventual Implementation

Throughout the study major challenges outlined were lack of transportation for healthcare workers and particularly PWSMDE during referral, low or no incentives for healthcare workers, low staff capacity for service delivery and lack of mental health drugs. These findings while not surprising, do pose risks to start-up and roll out of the study, as well as, potential replication.

High rates of individuals with epilepsy

Coinciding with various treatment data reported by Mental Health Clinicians from across the country and in the 2011 Accreditation Report, this study revealed a high number of epilepsy cases seen at the health centers and within the community. This finding confirms concerns that the high number of clients with epilepsy compared to those with serious mental disorders may lead to over-representation of that neuropsychiatric disorder in a
study that seeks to address the needs of those with epilepsy, as well as, those with other serious mental health disorders.
References


