UNDERSTANDING COMMUNITY PERSPECTIVES ON MENTAL HEALTH IN LIBERIA

A Feasibility Study for the Better Health Outcomes for Liberians Project in Montserrado, Margibi and Nimba Counties

2024

"Mental Health is Everybody's Issue"

- Health Worker at Renee Hospital -

ACTION AGAINST HUNGER

AFD
AGENCE FRANÇAISE DE DÉVELOPPEMENT

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RIGHTS AND PERMISSIONS

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ABBREVIATIONS

ACF	Action Against Hunger (*Action contre la Faim*)
AFD	Agence Française de Développement
BEHOL	Better Health Outcomes for Liberians
CM	Certified Midwife
CHA	Community Health Assistant
CHV	Community Health Volunteers
CHSS	Community Health Service Supervisor
GOL	Government of Liberia
HDI	Human Development Index
HFDC	Health Facility District Coordinator
JISS	Joint Integrative Support Supervision
LAPS	Liberia Association of Psychosocial Services
LiCORMH	Liberia Center for Outcomes Research in Mental Health
mhGAP	Mental Health Gap Action Programme
MNS	Mental, Neurological, and Substance Use Conditions[a]
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
OIC	Officer-in-Charge
PHQ-9	Patient Health Questionnaire-9
TBA	Traditional Birth Attendants
TTM	Trained Traditional Midwives
THP	Thinking Healthy Program
WASH	Water Sanitation and Hygiene
WHO	World Health Organization

TABLES AND GRAPHS

a The word *condition* is used in place of illness or disorder to connote a value-neutral term (i.e., state of health) and includes sub-clinical and clinical conditions of mental health, neurological and substance use.

EXECUTIVE SUMMARY

Better Health Outcomes for Liberians (BEHOL) is a three-year health systems strengthening project funded by Agence Française de Développement (AFD) and implemented by Action Against Hunger (ACF) and Expertise France in partnership with the Government of Liberia's Ministry of Health. The aims of the project are as follows:

- To strengthen Liberia's health system through leadership development within the Ministry of Health at the national and sub-national levels;
- To improve the quality of health service delivery in 25 targeted health facilities;
- To increase individual health literacy and health seeking behaviors; and,
- To improve community participation and ownership of health services.

To accomplish these objectives, **ACF commissioned, with the financial support of AFD, a qualitative mental health and psychosocial support (MHPSS) study in Liberia at the community** level to better understand the community members' perspectives on mental health and psychosocial support, health seeking behaviours for treatment of mental health conditions, and the current availability of mental health services at the community level. The objectives of the study were to:

- Describe signs and symptoms of mental health disorders and psychological distress in Liberia;
- Explore cultural representations and community perceptions of mental health disorders and psychological distress in targeted counties;
- Identify and understand mental health care seeking behaviours, including use of formal, informal, and traditional care;
- Identify and describe individual and/or collective coping mechanisms to address mental health disorders and psychological distress; and,
- Map community resources and analyze existing community mobilization around mental health rights (i.e., peer support groups).

Twelve out of the 25 health facilities in the BEHOL project were selected for this study and there were **33 focus group discussions and 22 key informant interviews** held in Margibi, Nimba and Montserrado counties. A total of **344 people participated in the study**. The communities who participated in the study were majority rural communities with agriculture-based activities as the predominate source of income. Among the community members there was a relatively equal distribution of male (47.4%) and female (52.6%) participants with more community participants from Margibi compared to the other two counties. This was due in part to convenience sampling and time constraints for conducting interviews. In Nimba, some community members were occupied with agricultural related activities and unavailable to participate in the FGDs. In total, there were 213 community members and 131 health workers who participated in the study (See *Table 1*). Among the health workers there were more workers from Nimba (48.9%) in the study compared to Montserrado (35.1%) and Margibi (16%). The health facility staff and community members were receptive to participating in the study and expressed a willingness to partner with ACF and the MOH to implement community-based mental health activities.

KEY FINDINGS

Key findings from the study included the following:

1. Signs and Symptoms

Community members often **focused on more severe signs and symptoms of mental health conditions** (e.g., walking and talking to oneself, being unkept and dirty, talking plenty) but also described **examples of somatic symptoms** (e.g., heart beating fast, pressure, heart palpitations, head and neck hurting, etc.), **emotional distress** (e.g., heart hurting, heart spoil, and sitting sad for sorrow), and **psychological distress** (e.g., too much stress on the mind, thinking too much). **Signs of substance use** were primarily external related behaviors, such as, theft, fighting, living on the streets, etc. and **epilepsy signs** included seizures, foaming at the mouth, and falling.

2. Cultural Representation of Mental Health and Community Perceptions

The cultural representation and community perceptions of mental health among the communities interviewed focused on **two main themes**: **1)** causes, risk factors, and beliefs about mental health, and **2)** community responses to mental health conditions.

Overall, **poverty and spiritual beliefs** were the predominant perceived causes of mental health conditions. Daily life stressors, loss of loved ones, gender-based violence, substance use, war, pandemics (Ebola, COVID-19) were identified as reasons for development of mental health conditions. **Despite fear and stigma** towards severe mental health, neurological and substance use (MNS) conditions, some community members described providing care and support through informal counseling, food and clothing, and emotional support to people with mental health problems.

3. Mental Health Care Seeking Behaviors

Across the three counties (Margibi, Nimba, and Montserrado), **mental health care seeking behaviors varied**, with participants utilizing traditional healers, religious leaders, health facilities, or doing nothing. The choice of care was often influenced by the type of condition, severity, and beliefs about the source of the problem (spiritual or not), accessibility to a nearby health facility and availability of medication. **Religious and traditional approaches** were commonly viewed as beneficial. Participants shared examples of seeking prayer from pastors or imams and used traditional healers, even if it sometimes delayed seeking care at the clinic. In Margibi, participants often reported going to **health facilities** first. In Nimba, the approach was mixed, with some people seeking traditional or religious care first and then treatment at the clinic. Community members who lived near the clinic were more likely to go to the health facility for care. In Montserrado, participants reported use of **both health facilities and traditional healers** for treatment of mental health.

Primary health facilities faced **significant resource needs** as they experienced lack of available medication, buildings and water and sanitation systems in need of repair, low pay, and limited training in mental health. **Specialized care** for severe MNS conditions was **available only in larger health facilities**, and the distance to travel and costs associated with treatment made it difficult for many participants to seek care. Health workers had **a strong desire for further training** in mental health care and support for implementation of mental health activities.

4. Mental Health Coping Strategies

Communities in Nimba and Montserrado reported predominantly **collective coping strategies** and in Margibi, FGDs identified **both individual and collective approaches**. Collective strategies in the counties included religious and spiritual activities, service activities (e.g., contributing to those in need), celebrating life events (e.g., dancing when a baby is born), youth and adult recreational activities (e.g., football, singing competitions), and self-help groups (e.g., farming co-ops).

5. Community Resources

Community resources identified by community members focused on general well-being and were not specific to mental health services. These included: **1)** local institutions (e.g., churches, mosques, health facilities, schools; **2)** projects sponsored by international organizations (e.g., Plan International, Save the Children, Carter Center, LiCORMH, FHI360), **3)** self-help groups (e.g., savings groups, agricultural groups), **4)** youth clubs (e.g., health clubs, a chess club) **5)** agricultural resources (e.g., public land for farming), and **6)** business centers and income generating activities (e.g., a curry income generating project in Gbaya-te). Besides health facilities and seeking support from traditional and religious community leaders, there were no other places where communities could seek help for mental health conditions.

GENERAL RECOMMENDATIONS

General recommendations for **strengthening the mental health care system** in Liberia include:

- Select health workers who can dedicate a portion of their time to delivering mental health services at the primary facility level.
- Build capacity of healthcare workers through mental health trainings (e.g., mhGAP, psychotherapies, safety and protection, etc.) and regular supervision and on-the-job mentoring.
- Equipe county mental health coordinators and district-level MOH staff with the resources needed to mentor and supervise health workers in mental health (e.g., training manuals, IEC materials, notebooks, scratch cards, transportation, etc.).
- Train community health workers (i.e., CHAs, CHV, TTMs) in psychosocial support activities (e.g., psychoeducation, active listening) and Community Health Service Supervisors (CHSS) trained as supervisors.
- Develop and clearly document mental health treatment protocols and referral resources at the health facilities.
- Create health education and mental health awareness materials that can be used at the health facility and in community-based groups.
- Culturally adapt mental health materials in local dialects and for lower literacy.
- Designate physical space at health facilities for mental health counseling.
- Invest in general facility improvements (e.g., repairing damaged physical structures, ensuring access to clean water and latrines).

This study confirmed ACF's proposed community mental health activities for BEHOL with **further suggestions based on the mental health feasibility assessment**:

- Improve the technical capacity of healthcare providers through trainings on mhGAP and and psychotherapies for treatment of depression, anxiety, trauma and substance use.

- Develop and disseminate clear standard operating procedures and job aids for mental health interventions at the primary facility level.
- Support the county and district level MOH teams in the delivery of regular (bi-weekly or monthly) supervision for primary health facility workers and community health workers and identify local supervisors who can be trained to supervise mental health activities at the community level on a weekly basis.
- Strengthen data collection and reporting through refresher workshops on quality data collection, data audits, and use of DHIS2 as outlined in the BEHOL proposal. In addition, develop protocols for record keeping ensuring all MNS conditions, including mild and moderate cases, are documented.
- Develop mental health education modules, IEC materials, storytelling and dramas for community dialogues to promote mental health awareness and reduce stigma.
- Develop culturally adapted group-based interventions (i.e., self-help, peer support, and youth) for psychological distress and mild to moderate symptoms of depression and anxiety with referral pathways for higher level of care as needed.
- Integrate evidence-based substance use interventions for youth and their family members within the groups.
- Adapt and pilot the Thinking Healthy Program (THP) in Margibi and Nimba and re-establish THP in Montserrado. Some suggested adaptations for the program based on the findings of the THP in Montserrado include: screening for depression and anxiety during prenatal and postpartum visits, adapting the THP to be flexible where women can receive the modules that best fit their needs and circumstances, engage male partners and family members in supporting women to participate, incorporate psychoeducation sessions, and promote income-generating activities.

BACKGROUND

1. CONTEXT

Liberia is located on the western African coast, sharing borders with Sierra Leone to the West, Côte d'Ivoire to the East, and Guinea to the North. It is a land **rich in natural resources** (e.g., iron ore, forests, etc.), yet ranks among the **least developed countries** (177 out of 193) on the Human Development Index[1]. A recent World Bank Poverty Assessment estimated that **over half of the population of 5.5 million Liberians are below the national poverty line** with the majority living in rural communities with scarce resources for quality healthcare, access to potable water and sanitation, and investment in education and job opportunities.[2] **Almost half of the Liberian population experience food insecurities**[2] and close to 40% of women and over 50% of children under five have anemia; 30% of children under five meet criteria for stunting.[3]

In Liberia, there are **more than sixteen ethnic groups** with Kpelle (20%), Bassa (13.6%), Grebo (9.9%), Gio (7.9%) and Mano (7.2%) being the top five languages spoken.[4] While English is the official language, there are **thirty-one registered indigenous languages**, including Liberian English, which is widely spoken.[5] **The predominant religions** are Christian (85.6%) and Muslim (12.2%) with the remaining minority adhering to no religion, indigenous religious beliefs, Baha'i Faith, Buddhism, Hinduism, Judaism and Sikhism.[6]

Cross-sectional mental health studies in 2008[7,8] and 2010[9] found **high prevalence of symptoms of post-traumatic stress** (12.6%[9] to 48.3%[8]), **intimate partner violence** (37.7% life time exposure for women[9]), and **major depression disorder** (10.6%[9] to 40%[7]) among Liberian adults.[7–9] Since then, there has not been a large-scale mental health prevalence study in Liberia and the Ministry of Health's routine data collection is the primary source of understanding the current context of mental health problems in Liberia, which leads to an **under estimation of the true prevalence of mental health conditions**. The Government of Liberia[10] has estimated the prevalence of mental health in Liberia based on global population estimates of 3% of the population will experience a severe mental health condition (e.g., psychosis, bipolar, chronic depression, schizophrenia) and 10% of the population will experience mild to moderate symptoms.

Humanitarian and development response efforts during the civil war (1990-2003) and later for the Ebola epidemic (2014-15) and COVID-19 pandemic have sought to strengthen a fragile health system with limited infrastructure, a shortage of skilled health professionals and limited financial resources. Over the past two decades efforts by international non-government organizations (INGOs) in partnership with the government have begun

to close this gap and rebuild the health care system, including mental health services.[11] The Ministry of Health's Mental Health Unit (MoH MHU) in partnership with international and local non-government organizations have developed **national mental health policies and strategies** to raise awareness on mental health and improve care and services for people living with mental health conditions.[12] These efforts have led to training mental health clinicians, launching local mental health organizations (i.e., CFUH and LiCORMH), training primary health workers in mhGAP, forming a psychiatry training program, establishing MoH wellness units, and the passage of the 2017 Mental Health Law.[13] As a result of these developments, there are now **800 health workers trained in mhGAP, 366 mental health clinicians, and 10 trained psychiatrists.**[12,14]

Since 1990, Action Against Hunger (ACF) has been in Liberia and is **one of the leading humanitarian and development organizations in the country** focused on addressing nutrition insecurity through health, nutrition, mental health and psychosocial support (MHPSS), protection, food security, livelihood, water sanitation and hygiene (WASH), and advocacy. ACF's target population has focused on **children under the age of five years, pregnant and lactating women, and adolescents**.

ACF integrates MHPSS activities as a component of health/nutrition, food security and livelihoods and WASH programming in addition to working closely with the MoH's Mental Health Unit. ACF regularly facilitates psychoeducation sessions for school health clubs, peer support and mother support groups, and provides technical support to MoH MH coordinators, including conducting quarterly Joint Integrative Support Supervision (JISS) visits. In 2023, ACF supported mhGAP training for 16 health workers and worked closely with the MOH and MHPSS stakeholders to draft the latest Liberia National Mental Health Strategy (2023-2027). Through these efforts, ACF also identified a need to strengthen monitoring and reporting of MNS cases at the community level and train MOH staff in DHIS2 reporting.

During COVID-19, in partnership with the Ministry of Health and other national stakeholders, ACF implemented the Emergency Response to the COVID-19 in Liberia, Beat the COVID-19 in Liberia (BECOL) from July 2020 to April 2022 covering 56 health facilities in three counties. This project focused on reducing the spread of COVID-19, distribution of public health awareness information on the prevention of the coronavirus, improving the surveillance system for COVID-19, training health workers on psychological first aid, gender-based violence (GBV), and psychosocial support interventions, and held psychoeducation sessions for community members.

Building upon the promising outcomes of the BECOL programming, **ACF and Expertise France**, with funding from the Agence Française de Développement (AFD), are **designing a three-year program** called "*Better Health Outcomes for Liberians (BEHOL)*," which aims to improve the health status of Liberians living in Montserrado, Margibi, and Nimba counties through higher quality of reproductive, maternal, neonatal, and mental health care. The BEHOL program aims **1)** to strengthen Liberia's health system through leadership development within the Ministry of Health at the national and sub-national levels, **2)** to improve the quality of health service delivery in 25 targeted health facilities, **3)** to increase individual health literacy and health seeking behaviors, and **4)** to improve community participation and ownership of health services.

2. OBJECTIVES

To achieve **these objectives**, ACF commissioned, with the financial support of AFD, a qualitative MHPSS study at the community level to better understand community members' cultural representation of mental health problems, internal and external resources used for coping with stress and mental health conditions, barriers and facilitators to engagement in mental health services, and formal and informal MHPSS services available in the three targeted counties. The mental health feasibility study is to help appropriately tailor the MHPSS activities to the targeted communities and identify the best approaches to integrate MHPSS within the health system and community-based services. This study complements the health facilities assessment (including the MH services component) and the baseline survey, providing further understanding on the perspectives of community members.

The specific objectives of the qualitative study are as follows:

1. To describe signs and symptoms of mental health disorders and psychological distress in Liberia;
2. To explore cultural representations and community perceptions of mental health disorders and psychological distress in targeted counties;
3. To identify and understand mental health care seeking behaviours, including use of formal, informal, and traditional care;
4. To identify and describe individual and/or collective coping mechanisms to address mental health disorders and psychological distress; and
5. To map community resources and analyse existing community mobilization around mental health rights (i.e., peer support groups, fight against stigma and discrimination).

METHODOLOGY

The research team consisted of a **lead consultant from the U.S., two research assistants affiliated with Liberia Association of Psychosocial Services (LAPS), and six enumerators**, two from each county. All enumerators lived and worked or went to school in the respective counties and provided interpretation for the interviews.

The research assistants received an initial training on the study covering the BEHOL Project, an overview of the qualitative study, how to use the interview guide, best practices in group facilitation (e.g., creating group rules, asking open-ended questions, follow-up questions, etc.), note taking procedures, ethical considerations, and how to complete the study consent form with the participant and take attendance. The two research assistants trained the six enumerators in the three counties following the above training topics.

1. DATA COLLECTION

The primary method for the data collection was qualitative through focus group discussions (FDG) and key informant interviews (KII). The research team received permission from the MOH county-level teams to conduct the qualitative interviews in the targeted areas. Members of the study team contacted and/or visited the communities and health facilities ahead of time to recruit and organize the FGDs and KIIs. In some locations, the team was unable to do this and recruited interviewees the same day as the interviews. All participants were informed of the study and gave voluntary written and/or verbal consent. Refreshments were provided to participants during or after the FGDs.

Site visits were conducted in twelve of the twenty-five Ministry of Health (MOH) facilities in Margibi, Montserrado, and Nimba counties chosen for the BEHOL project. **An interview guide** for the health facilities FDGs and KIIs was developed collaboratively with ACF's MHPSS regional team (See *Annex*). Interviews were conducted with health facility staff, community health workers, and community members from the surrounding health facility catchment areas. Throughout the data collection process, follow-up discussions and check-ins on the study protocols were done by the lead consultant.

A desk review was also conducted examining peer-reviewed research studies, ACF's Beat the COVID-19 In Liberia (BECOL) program documents, the BEHOL Gender Analysis and Protection Report, Ministry of Health (MOH) Mental Health policy documents, and grey literature from international organizations (i.e., World Bank,

WHO, Carter Center, etc.). Review of the BEHOL baseline survey from March 2024 was used to triangulate the qualitative study findings.

2. SAMPLING

The health facilities for the study were selected from the list of twenty-five health facilities targeted for the BEHOL project (See *Annex*). Using a stratified sampling approach by county and type of facility (i.e., primary or secondary), each facility for the study was **randomly selected using Google random generator**.[15] To minimize research fatigue by the health facilities, where possible, the health facilities where the Gender and Protection Analysis Study was implemented were excluded.

Convenience sampling was used for recruitment of community participants with intent to maximize representation of the different types of people who will be end users of the mental health services in BEHOL. This included women of reproductive age, pregnant and lactating women, men, youth (boys and girls), women headed households, people living with disabilities (e.g., epilepsy and mental health conditions), family members and caregivers of people living with mental health conditions, and community leaders (e.g., pastors, imams, teachers, village leaders). Recruitment of community members that represented diversity of age, education level, socio-economic background, religion, and ethnicity were prioritized when possible.

Health workers from different levels of the health system were selected to be interviewed that included the MOH County Mental Health Coordinator, the head of E.S. Grant, county-level health staff at C.H. Renee Hospital, professional health workers from primary and secondary facilities, and community health workers (e.g., community health assistants, traditional trained midwives).

Qualitative interviews were conducted from March 14th to April 3rd, 2024, at health facilities, in the community and virtually (with two national stakeholders). **Fourteen health facilities** were visited: ten primary, two secondary, one tertiary, and one national-level psychiatric hospital (See *Annex, Table A*). A total of **33 focus group discussions** with 336 participants and 22 key informant interviews (9 Female, 13 Male) (See *Table 1* and *Annex, Tables A and B*) were conducted.

Table 1 - *The number of participants by qualitative interview type, gender, and county*

		Nimba	Margibi	Montserrado	Total
Focus Group Discussions	Female	50	58	54	162
	Male	47	53	38	138
	Missing data	14	8	14	36
	Total	**111**	**119**	**106**	**336**
Key Informant Interviews	Female	3	2	4	9
	Male	5	4	4	13
	Total	**8**	**6**	**8**	**22**

Across the three counties, over **213 community members and 131 health facility staff** and/or community health workers were interviewed. In Margibi, eight FGDs were conducted with men, women, and youth and three key informant interviews with community leaders — one pastor, one imam, and one traditional healer. In Montserrado, there were eleven FGDs (5 women/youth and 6 men/youth), and one key informant interview with an imam.

In Nimba, there were five FGDs — three with community leaders and members (mixed gender), one women's group, and one youth group (mixed gender).

There were nine focus group discussions and twelve key informant interviews with health workers in Montserrado, Margibi, and Nimba counties (See *Annex, Tables A and B*). In addition, the study team interviewed the MOH mental health county-level coordinators for Nimba, Montserrado, and Margibi counties, the head psychiatrist at E.H. Grant Hospital, and representatives from Cultivation for User's Hope and Liberia Association of Psychosocial Services. In Margibi, at the facility level interviews were held with the officer-in-charge (OIC), traditional trained midwives (TTM), and a health district facility coordinator (HFDC) in Gbaye-te who oversaw the community health assistants and volunteers. For Nimba, officers-in-charge (OIC) of the health facilities, traditional trained midwives, certified midwives, community health support supervisors (CHSS), community health assistants/volunteers, and other health facility staff (i.e., vaccinator, register, nurse) were interviewed. In Todee district in Montserrado, the OIC at Goba Town facility and Pleemu were not present, and interviews were held with other staff members (i.e., midwife, vaccinator, health facility, dispenser, register). Lastly, in St. Paul River district, interviews were conducted with OICs and health facility staff.

3. ANALYSIS

A thematic analysis using an inductive and deductive approach guided by the study objectives was used for the data analyses. All interviews were **recorded and then transcribed** using Sonix AI software.[16] Transcripts were reviewed and edited for accuracy and then coded by members of the research team. Microsoft Excel[17] and Dedoose[18] were used to **identify and organize themes and sub-themes**. Notes from the interviews were used for verification of key messages and observations from the site visits.

4. LIMITATIONS

The study had some limitations. With a convenience sampling approach, many of the focus group discussion **participants were closer in proximity to the health facilities** and the perspectives of people who lived further away were fewer. Even with visiting the targeted communities ahead of time in Nimba, **logistics for organizing focus group discussions** with community members were difficult due to women and youth preparing their fields for the rainy season, far distances to travel on unpaved roads between communities, and poor phone connectivity. During the discussions, some community participants **focused more on poverty-related concerns** (e.g., lack of enough potable water, dilapidated health facilities, lack of transportation to health facilities, lack of jobs and the need for vocational training opportunities), and less on mental health problems. There were some limitations with **local dialects and communication** between Liberian English and English, but this was mainly overcome by having research assistants and enumerators who spoke both English and the local languages. Due to **time constraints** for the analysis, there was some limitations in **quality of the transcriptions** and subsequent editing needed due to the local dialects spoken, while also simultaneously coding and analyzing the results. With this came **limitations to the depth of the analysis** and organization of themes and subthemes. Revisions using an inductive-deductive approach and having different members of the study team helping with the coding and identification of themes mitigated some of this.

RESULTS

The following findings from the FGDs and KIIs are grouped by the study objectives and summarize the key points and themes from across the interviews in Margibi, Nimba and Montserrado counties.

1. SIGNS AND SYMPTOMS

> *"When I hear about mental health problems, I think that someone has a problem with their thinking. Some people express their emotions by yelling or crying or sitting sad."*
>
> -A Pastor in Kakata -

During the FGDs and KIIs signs and symptoms of mental health, neurological, and substance use (MNS) conditions were identified and described by community members and health workers. **Epilepsy and severe signs of mental health were more frequently mentioned than common mental health conditions** as they were more pronounced and deviated from common, everyday behaviors seen in the community. Often members of the group knew someone with a MNS condition and described what they had observed. *Table 2* shows a list of some of the signs and symptoms of MNS shared in the FGDs and KIIs.

Responses to observed conditions can be grouped into **four main categories** of 1) mild to moderate conditions, 2) severe conditions, 3) substance use, and 4) epilepsy.

1. Mild to moderate mental health conditions were expressed through somatic symptoms, emotional and psychological distress. Examples of these include:

    - Emotional distress: heart hurting, heart spoil, and sitting sad for sorrow, a bad heart and getting mad for anger. In Valley-te, wa pong and kokopo were used to describe someone aggressive or fighting and in Gbaya-te eating (too much) spice described being aggressive.[b]
    - Psychological distress: too much stress on the mind, thinking too much, and worry.

b FGD Valley-te Women; FGD Gbaye-te Women

- Somatic symptoms: heart beating fast, pressure, heart palpitations, head and neck hurting, stomach issues, trouble sleeping, feeling weak, changes in their eyes, and stress on the heart.[c]

Open mole is an indigenous condition believed to be "*a soft spot in the center of the skull*", with overlapping presentations of anxiety, depression and psychosis.[19,20] Most of the descriptions of open mole in the FGDs were moderate conditions that respondents said could lead to more severe cases if left untreated. People described open mole as a headache, thoughts going from place to place (mind running), body fatigue, neck pain, loss of appetite, and worry.

2. Community members across the three counties often spoke of **severe conditions when speaking about mental health problems** and these were expressed mainly through external behaviors, which included: hearing voices, walking and talking to oneself, getting crazy, being unkept and dirty, talking plenty, going off running place to place or running in the bushes, taking off clothes, eating one's feces, and being haunted by the war.

3. **Signs of substance use conditions** also focused on **external behaviors associated with misuse**, which included theft, fighting, living on the streets, and skipping classes. Emotional, psychological or physical symptoms of substance use were not discussed by the communities.

4. **Epilepsy, sometime referred to as jerking sickness by the respondents, was brought up when discussing mental health conditions.** Community members spoke about it being a common condition in their community and the need for medication to treat it. Having seizures, foaming at the mouth, and falling were the main symptoms shared by participants. Community respondents talked about the risk of getting injured when having a seizure and how people accidently fell into a coal fire.

Table 2 - *Signs and symptoms of distress*

Counties		
Margibi	**Montserrado**	**Nimba**
Heart beating fast	Open mole	Isolate
Head hurting	Cursing	Forget about daily activities
Open mole	[Abnormal] appearance and behavior	Fatigue
Too much thinking	Fighting	Poor appetite
Talking to yourself	Arguments	Alcohol and substance use
Changes in their eyes	Smoking	Thinking too much
Eating their own feces	Taking in drugs	Little madness
Stress on their heart	Drinking alcohol	Heart problems
Falling	Disrespect of authority	Heart spoil
Hot temper	Excessive talking	Headache
Bad heart (getting mad)	Too much stress on the mind	Too much thinking
Sorrowful	Load is heavy	Can't sleep
Not sleeping	Pressure goes up	Sharp pain
Heart hurting	Worry	Worry
Heart spoil	Red in the face	Forgetfulness
Feeling weak	Lack of sleep	Not paying attention

c FGD Pleemu Health Workers

Fighting
Foaming of the mouth
Jumpy
Being haunted by the war
Taking off clothes
Running in the bushes
Getting mad
Heart palpitations
Hearing voices
Walking and talking to themselves
Using kush or smoking
Getting crazy
Aggressive behavior
Sitting sad
Unkept and dirty
Talking plenty
Worry
Pressure
Going off running place to place
Stomach issues
Eating enough (too much) spice

Acting mad or confused
Grief
Angry
Movement that looks funny
Shouting
Talking plenty
Insulting people
Stealing
Untidy
Too much worry
Depression
Someone getting crazy
Crying
Not talking
Vexed

Pressure
Misbehave
No appetite
Walking on the road
Confused
Talking incoherently
Dress half naked
Steal and have no regard for others
Use of kush, THC, and alcohol
Brain problem
Severe headache
Cry
Feel bad
Regret
Withhold things

In general, community members reported more severe signs and symptoms of mental health conditions when asked about mental health and less on mild to moderate symptoms perhaps because severe conditions are more pronounced and observable (i.e., seeing a person walking and talking to themselves, acting aggressively, and wearing dirty clothes). **Symptoms of depression** (e.g., sitting sad, sorrowful, no appetite), **anxiety** (e.g., worry, stress on the heart) and **psychosis** (e.g., hearing voices, walking and talking to themselves) were present in the signs and symptoms shared in the interviews, but symptoms of post-traumatic stress (e.g., strong physical or emotional reaction when reminded of a traumatic event, flashbacks, unwanted dreams, etc.) from the DSM-V were not often mentioned unless more directly asked about these symptoms. Even then, **only a few people mentioned the impact of the war or current symptoms of post-traumatic stress**. This may be likely due to psychological and emotional distress related to traumatic experiences being described differently in Liberia (i.e., open mole, talking and walking, acting aggressively), the method of data collection being open-ended focus group discussions, and not a mental health assessment or prevalence study, the wording of the questions posed to interviewees, respondents not associating distress from traumatic experiences with their mental health, avoidance of talking about traumatic memories that happened many years ago, and/or some of the respondents being younger and they had not lived during the civil wars.

In comparing the responses from this study to the Liberian Distress Screener (LDS)[21] in Maryland county, only two of the signs and symptoms in the interviews were identical to the local idioms of distress on the LDS, *thinking too much* and *headaches/head hurting*. Other items on the LDS, such as, *problems with the heart* and *heart not good*, corresponded to similar concepts about the heart from the interviews such as, *bad heart*, *heart hurting*, and *heart spoil*. *Heartbeat fast* on the LSD was similar to *pressure*, *heart palpitations*, *heart beating fast* mentioned in the Margibi and Nimba interviews, and *worrying too much* on the LSD to *worry* in the interviews.

Three out of the eight items on the locally adapted PHQ questionnaire[21] corresponded to the findings from the FGDs. These included: *trouble sleeping*, *feeling weak/tired*, and *trouble eating*. However, the other items on the Liberian PHQ were not directly mentioned in the interviews. These items were *ashamed*, *downhearted/overlooked*, *completed work halfway because of thinking plenty, and moving/talking too slowly/fast*, which were not specifically described. While these items did not emerge from the interviews, they are likely **still relatable to communities in the BEHOL targeted areas** and can help detect depressive symptoms. However, incorporating examples of local expressions for sorrow (*e.g.*, *heart spoil*, *sitting sad*, *crying*) and daily functioning (*e.g.*, *forget about daily activities*) may be helpful for better understanding a person's mental health condition in the targeted geographical areas of the BEHOL project. A more rigorous validation study targeting the BEHOL geographical areas is needed to determine the items most appropriate to use.

Depending on the ethnic group and languages spoken, variations of idioms of distress were described in the interviews. It will be beneficial for mental health workers to **understand these regional and local variations of common mental health symptoms** to improve detection of these conditions and linkages to psychosocial support and mental health treatment. Since communities in the interviews focused more on severe mental health signs and symptoms, **raising awareness on mild to moderate mental health conditions** and promoting strategies to manage stress and improve mental health can be an important gap for the BEHOL project to fill to help prevent severe mental health conditions and assist communities in flourishing in a context of limited resources.

> *"All of these problems are caused by harmful drugs, hardship, etc. It makes people crazy. Yes, some of these sicknesses are caused by ginnah or evil spirit — that is why I can treat them when they come from the hospital, and no solution. Some from bad luck by stealing from other people and the person make medicine or juju."*
>
> - Traditional Healer in Kakata -

2. CULTURAL REPRESENTATION AND COMMUNITY PERCEPTIONS

The findings on the cultural representation and community perceptions of mental health centered on **two major themes** of **1)** causes, risk factors, and beliefs about mental health and **2)** community responses to mental health.

2.1 CAUSES, RISK FACTORS AND BELIEFS

Daily life stressors, poverty, loss of loved ones,[d] gender-based violence, substances use, biological/medical conditions (e.g., complications at childbirth[e]), war, pandemics/epidemics (i.e., Ebola and COVID-19), and spiritual sources were reported as **causes and/or risk factors for mental health conditions** among the communities interviewed. **Open mole**, a belief that a hole formed in the head, was believed to be from several sources, such as spiritual sources, wrong doing, prolonged exposure to natural elements (i.e., being in the sun or rain too long), and trauma-induced affliction.[19–22] If open mole or too much thinking were left untreated, then it was viewed by community members that this could lead to more severe conditions.[f]

d FGD Blamacee women
e KII Kakata Pastor
f KII TTM Gbaye-te. FGD Blamacee women

2.1.1 Poverty

In a context where many communities had **scarce resources** and were **focused on meeting their basic needs**, stress related to money, providing for their households, and seeking better opportunities was identified by interviewees as reasons for mental health problems.

> *"The reason why some of our brothers are challenged, traumatized is because there is no single trade school in the Tenegar Community, no job facility, the only thing to do is to burn coal for survival."*
>
> - Tenegar Men's FGD -

> *"It's making us feel less important because you can't tell me you spend almost 12 to 13 years in school, you graduate and then you are unable to even attend college or maybe even acquire vocational skills or stuff, and it makes you feel less important. Is this helping us mentally?"*
>
> - Blamacee female youth FGD -

2.1.2 Legacy of the War

Many community members said that the **Liberian civil war** was long behind, and it no longer impacted them. However, **a few still felt the impact of war**. A woman in Nimba said that she still relives the traumatic experiences of the war and has flashbacks.[g] Another woman, also in Nimba, talked about the profound losses from the war and the sorrow that she experienced.[h] Women in Margibi shared of the distress from the difficulties they still face in daily life from losing their partners during the war.[i]

> *"We are left alone [after the war]. Single, struggle for our children. Pressure, diabetes, what have you, all these things because we worry."*
>
> - Medina women FGD -

2.1.3 Spiritual Causes of Mental Health and Epilepsy

Beliefs in evil spirits or witchcraft were attributed to **epilepsy and mental health problems** by community interviewees. Epilepsy is known as spell in Liberia and thought to be **a curse**.[j] Other terms such as, being bewitched, cursed, having a djinn inside of someone, a spirit in a dream,[k] and ginnah sickness were used to describe the spiritual nature of mental health conditions.[l] It is believed by some that when a person falls down from a seizure and passes out, then epilepsy can spread to others or if a person touches a person's saliva who has epilepsy, then they can develop it too.[m] A health worker in Saclepea explained how **people with epilepsy were seen as being contagious** and community members would not want to eat with them.[n]

g FGD Beadatuo Community Members (Women and Men)
h FGD Zodru Community Members (Women and Men)
i FGD Medina Women
j Carter Center's anti-stigma bump sticker campaign for epilepsy
k FGD Tenegar Health Workers
l FGD Tenegar Health Workers
m KII Tenegar community health worker and vaccinator
n KII Saclepea Health Worker

2.1.4 Youth Substance Misuse

Youth substance misuse was seen as **a major community and national problem** that needed more attention and resources to combat the crisis. Substance misuse was associated with mental health problems (e.g., sense of hopelessness from a lack of opportunity) and externalizing problematic behaviors (e.g., aggressive behavior, stealing, etc.). In Blamacee,[o] three boys had died due to overdose, and mothers there expressed their distress over the crisis and watching their children's lives be harmed by substance misuse and drug related activities in the community (e.g., theft, fights).

Lack of formal education, vocational training, and job opportunities were often cited as reasons for the high prevalence of substance use.

> *"[There are] no job opportunities and because of that some people here are on drugs."*
>
> - FGD Tenegar Men -

> *"There's no good education so because of that, early marriages are taking place.... no support for agriculture, no safe drinking water, and youth taking in drugs."*
>
> - FDG Gbondoi Women -

Community respondents also identified **peer pressure, idleness, and poor parental supervision** as risk factors for youth using substances.[p,q,r] Other studies in Liberia have identified similar reasons, such as, peer influence, legacy of the war, coercion, poverty, coping with difficult emotions, wide spread availability of alcohol and drugs, fear of failure, being male, sexual behaviour, and violence.[23,24,25]

The newly elected President Joseph Boakai declared substance misuse a national public health emergency in January 2024, and attributed the crisis to a lack of quality education for youth.[26] Studies have estimated as high as 51-81% of high school youth in Monrovia used alcohol and 9-22% reported marijuana use.[27,28] The passage of the **Controlled Drugs and Substances Act of 2023** was an effort by the government to curtail drug activity with more severe penalties (e.g., illegal drug activity punishable to up to 10 to 20 years in prison).[29]

2.1.5 Gender-based Violence

Gender-based violence was not the focus of the qualitative interviews but during KIIs with health workers in Saclepea and Luogatuo (Nimba county), cases of intimate partner violence and sexual assault were discussed. In Saclepea, one community health worker described the **widespread problems in the community** with men physically assaulting women and men paying for sex with children. Women in Tenegar spoke about **conflicts between partners** and how women will fight with their men for basic needs, such as food. A midwife working on GBV cases at the health facility shared about the stigma, mental and emotional distresses of women who have been raped. A health worker in Luogatuo spoke about a woman at the clinic whose husband denied her pregnancy and the heightened psychological and emotional distress she exhibited. She reported that these cases are not frequent but happen a few times in a year.

o FGDs Blamacee Teenage Mothers, Men and Women
p FGD Blamacee Teenage Mothers
q FGD Tenegar Men
r FDG Gbondoi Women

"...most people in the community they [have] violence. Yes, a lot of violence. [There] are men going against their women. Men hitting women..."

- KII Saclepea CHSS -

"They gang rape in some cases."

- Zodru health worker -

"Husband denying the pregnancy because of another woman.... then the men will come there and beat on her. It just happened recently..."

- Luogatuo midwife -

"[people] are in the community and say, I have money I'll just [have] somebody's child."

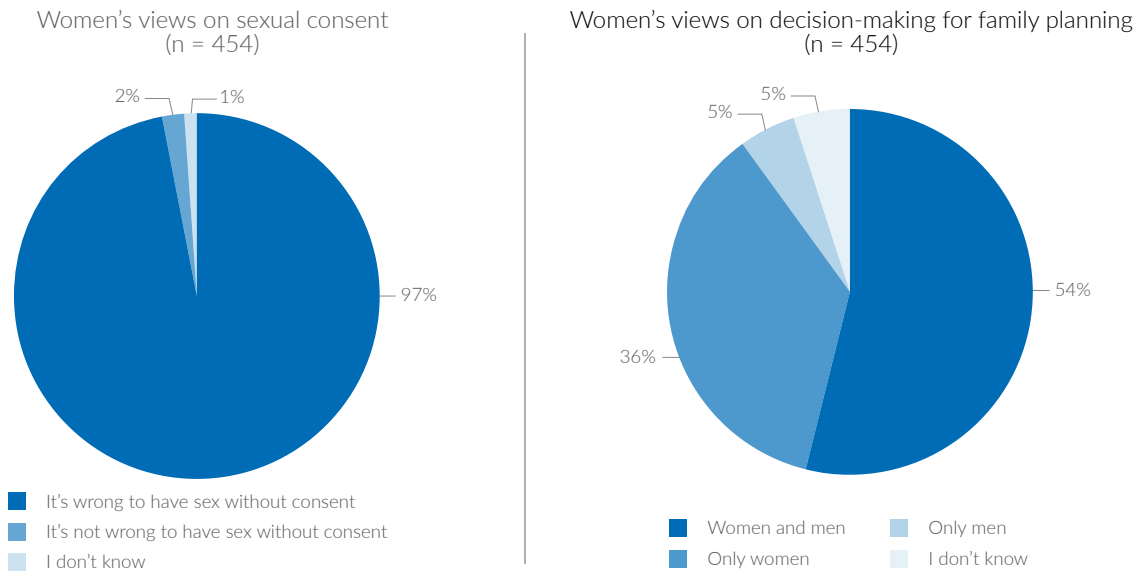
- KII Saclepea CHSS -

"Some women here fight or argue with their men for food."

- FGD Tenegar Women -

The findings of the BEHOL Gender Analysis and Protection Report supported what the respondents shared: **incidence of GBV are widespread across the three counties with women holding limited power and choice in a patriarchal society**.[30] The BEHOL baseline survey data showed that women want their voices to be heard. The majority of women (97%) reported that it's wrong to have sex without consent. And, when it comes to decision-making on family planning, 54% of women responded that women and men should both be involved in the decision-making, 36% only women should make the decision, 5% only men should make the decision, and 5% unsure.

Figure 1 - *Women's views on sexual consent and family planning*



In summary, **poverty and evil spirits were the dominant causes of mental health conditions** from the interviews. Evil spirits were often shared as a reason for mental health problems and had a greater influence in

their decision making for treatment of mental health. **Widespread gender-based violence**[31] **and substance misuse**[10,25] were pervasive during the war and can be linked to present day problems of gender-based violence and substance misuse.[32,33] However, they were less frequently discussed among the community participants as a cause of mental health conditions. While there was an acknowledgement of the impact of the civil war on people's lives, there was not a strong identification by the communities of it still impacting their well-being and mental health.

2.2 COMMUNITY PARTICIPANTS' PERSPECTIVES ON MENTAL HEALTH PROBLEMS

From the FGDs and KIIs, respondents described various responses to someone with a mental health condition, epilepsy or substance use problem. These responses can be grouped into three main categories: **1)** stigma, fear, rejection, and abandonment, **2)** community reactions to substance use and aggressive behavior, and **3)** care, support, and counseling.

2.2.1 Stigma, Fear, Rejection, and Abandonment

Community members and health workers described **stigma towards people with severe mental health conditions and epilepsy**. Participants shared how they would keep a distance from someone who had a severe mental health condition, especially when they acted aggressively. Often people were fearful that the person would harm them in some way. Family members were known to even abandon someone if they could not help the person get appropriate treatment.

> *"People here treat these people [with mental health problems] well because the community people are afraid of them."*
> - FGD Tenegar Women -

> *"Some people here are afraid of patients with mental health. There's no care for them. They are even abandoned by family members."*
> - Gbondi Health Workers -

> *"People are fearful of people who talk out loud to themselves."*
> - FGD Gbaye-te Women -

> *"People will say, 'do not help that person because he is sick.'"*
> - FGD Gbay-te Men -

Epilepsy was seen as contagious, and people would not want to be near someone who had a seizure. Health workers in Saclepea and a traditional healer in Kakata both described how community members would not want to eat with them.[s]

> *"Sometimes some of the people are not allowed to drink from the same cups or eat from the same pan with their family — for me I feel bad about the sick people…. For the men sometimes they go from one place to another because their family can't care for them again."*
> - KII Kakata Traditional Healer -

s KII Saclepea Health Worker

"They [say] don't go there to drink water. They get crazy person. They get epilepsy person. Don't play with them, don't play with them. Don't go there. They are trying to avoid them. The community dwellers don't like people with the condition to come around, they advise their children to stay away from such family, not to even drink water from them saying that the family have illness. People with mental health problems and epilepsy families are always stigmatize."

- FGD Beadatou TTM -

2.2.3 Community Reactions to Substance Use and Aggressive Behavior

Some community members interviewed talked about taking **people who acted aggressively to the police**. For example, in Zodru they spoke about people being arrested for Kush, and in Medina, men talked about taking a "*misbehaving*" person to the police. In Gbondoi, the community created laws to fine people who acted aggressively:

"Some of the things that is helping us in the community is we have laws and when anyone insults another person, you will pay a fine/money. When you fight, you will pay a fine. In the town when you curse/insult, you will have certain amount to pay, when you fight, you have certain amount to pay."

- FGD Gbondoi -

Youth who misused substances were referred to by interviewees as *zogo* (or *zoko*) and *zoga* (for females) and were considered useless people or criminals by community members.[t] Interviewees in FGDs shared that youth who misused substances would live on the streets, steal, and act aggressively leading community members to attempt to intervene and to try to counsel them to change their behavior.

2.2.4 Support, Care, and Counsel

Responses were **a mix of both fear and support**. While many interviewees described community members being fearful and keeping their distance from someone with mental health problems, other people described how they had cared for someone with a mental health problem and supported their family members. Informal counsel, providing food and clothing, and showing emotional support were ways that health workers and community members helped someone with a mental health problem.

"A mentally ill female will give birth in the street and they the midwives will take the child and provide care. She has a crazy woman in her village who usually give birth in the street. She (midwife) will take the child and buy clothes and all other things for the child. When they get home on the street so they, maybe they can take care of the child... Sometimes what we do is to talk with them, counsel them, give them food, give them water to take bath, especially if a woman is naked in the street, we can give her lappa to tie."

- TTM Beadatuo -

"They are united...They can [pull] together and see how best to go close to the family and see how best they can go to traditional healer. So they believe."

– TTMs Zodru -

t FGD Tenegar Men; FGD Blamacee women

"We normally counsel the relative of the person who is ill. Because the person is always discouraged. … Let's say it's a person who is ill is very close to the person. So, we decide to counsel the person who is normal, not the person who is victim… That's one of the counseling we provide."

– Blamacee FGD Men -

The responses from the interviews confirmed what prior studies[19-20, 22-23] **on stigma in Liberia had found** and showed how people with mental health conditions and epilepsy in Liberia face stigma and social isolation due to fears, misinformation about their conditions, and beliefs that the person and their family are cursed. Studies on stigma in Liberia have shown that people with a mental health condition or epilepsy experienced diminished quality of life through abuse and neglect, derogatory name calling and labelling, exclusion from school and workplace activities, and face barriers to treatment.[19] People with severe mental health conditions in Liberia are known to face stigma from family and community members, as well as health care staff.[11,34] **Despite the pervasive stigma**, there were examples of community members and health workers who showed care and support towards people with mental health conditions and epilepsy. **These examples can be used to raise awareness** to reduce stigma and show how communities can provide support and help towards people with mental health conditions.

"Trust God, don't worry, go to the hospital."

- TTM Gbaye-te -

3. MENTAL HEALTH CARE SEEKING BEHAVIORS

Throughout the three counties, participants in the study utilized traditional healers, health facilities, religious leaders or did nothing. Participants from Margibi often reported going to the clinic or hospital first for mental health treatment.[u] In Nimba, this was more mixed with some people going first to traditional healers and religious leaders and later the clinic, and others going to the clinic initially then pursuing traditional and spiritual options afterwards or alongside the medication (e.g., going to the clinic for medication but then going to a pastor for prayer). In Montserrado, community members reported seeking care at both the clinic and traditional healers.[v,w]

In the FGDs and KIIs, **mental health care seeking behaviors varied** based on the type of condition, severity, and belief about the source of the problem, whether it was from a spiritual source or not, and whether there was a nearby health facility offering treatment for mental health. If it was believed to be from an evil spirit, then community members would go first to the traditional healer and then potentially the health clinic, if the symptoms did not improve. For treatment of open mole, respondents in all three counties went first to a traditional healer for herbal treatment. If people believed that medicine could cure their condition, then they went to a health clinic if they had the time and/or money to travel there. Some shared that traditional health seeking approaches were pursued when the clinic could not help them.[x]

u FGD Valley-te Women, KII Kakata Traditional Healer; FGD Medina Men
v FGD Blamacee Men
w FGD Blamacee teenage girls
x FGD Medina Men, FGD Valley-te Women, KII Kakata Traditional Healer

3.1 TRADITIONAL AND SPIRITUAL CARE

Participants in the FGDs and KIIs viewed **religious and traditional approaches to mental health care as normative practices**.[y] Going for prayer to a pastor or imam was seen as helpful; traditional healers were beneficial but could sometimes make a condition worse and delay seeking care from a health clinic. Community members shared that for some people traditional approaches were the only option as there were no health facilities where they could receive treatment. Many people reported seeking treatment from traditional and spiritual approaches and health facilities.

> *"People here treat people with such cases [mental health conditions] by being supportive, by taking care of them. Family members take these people to traditional healers…There are no health services here for them. Sometimes people take these people to traditional healers or the church."*
>
> - FGD Gbondoi Men -

> *"The pastors are here sometimes because it is not everybody that can immediately come to the clinic. Yeah, sometimes they go there first and pray. Seek for prayers, seek for counseling, seek other people. Trust the pastor more than the others. Trust the spiritual, the religious leader. Yeah, okay. But if it is there and they are not seeing that way through, then either the pastor or the deacon, the elders, the religious leader will say, well, let us first of all, go to the hospital."*
>
> - KII Beadatuo OIC -

> *"The religious people they are here even they can carry the person to church for constant prayer. Still, even if they know and they can call, they can say follow up in a hospital."*
>
> – FGD Zodru TTM -

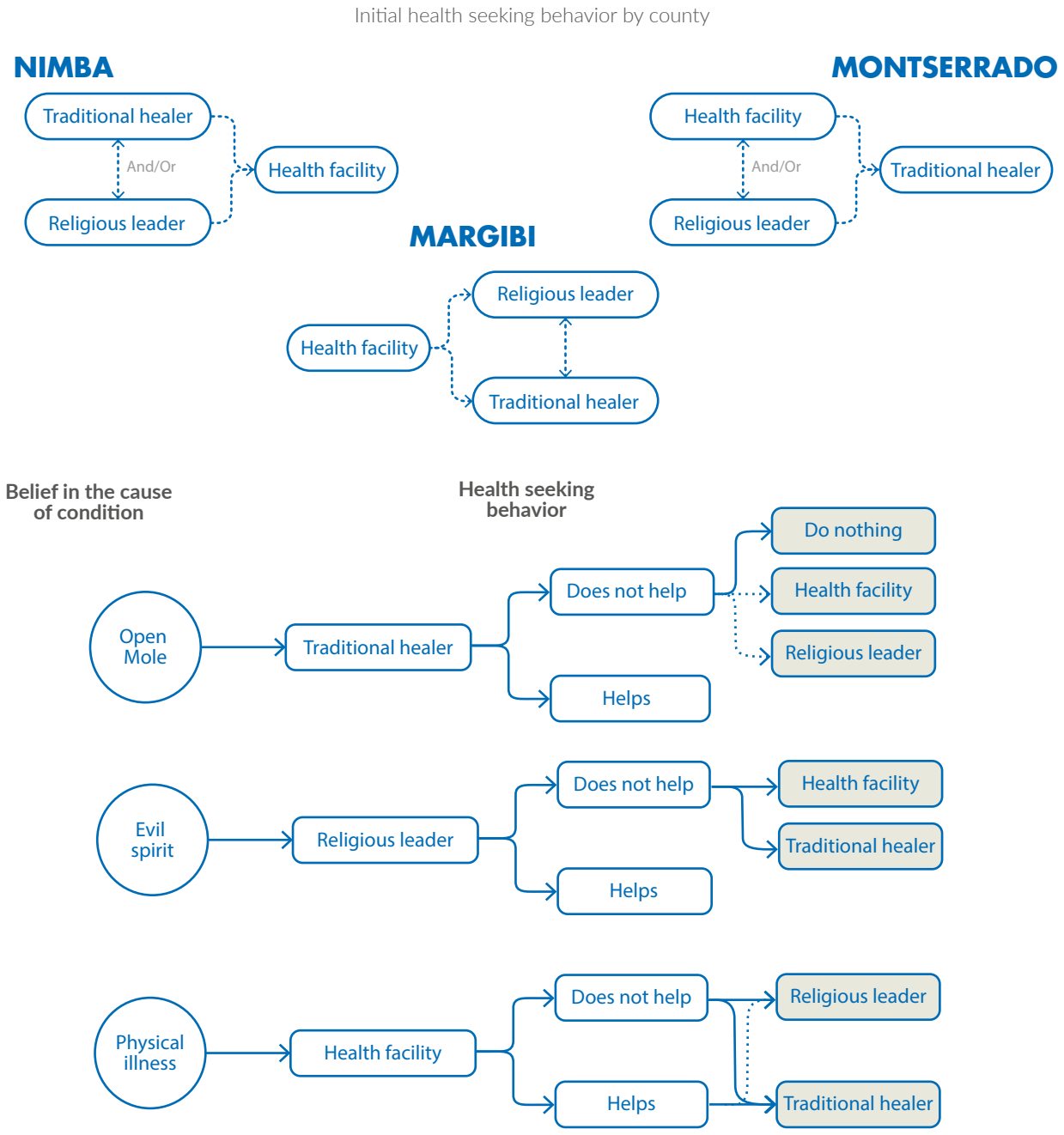
> *"The community, most of them can bring the patient to the clinic when it starts. They will be using Neecee (Islamic treatment) on them, carrying their juju man from place to place."*
>
> - KII Tenegar Health Worker -

> *"When they go to traditional healers, they make the sickness worse so going to the hospital is better."*
>
> - FGD Valley-te Men -

A traditional healer in Margibi, shared that he always recommends that people first go to the hospital before they come and see him.[z] Some healthcare workers and community members viewed country medicine as unhelpful or even a harmful means of treatment.[aa] However, young mothers in Blamacee described the herbalist's traditional methods of chalk and clay-like substances as being more helpful than the medication at the facilities.[ab]

y FGD Tenegar Women; FGD Valley-te Women, KII Kakata Traditional Healer; FGD Medina Men; FGD Gbondoi Health Workers
z KII Kakata Traditional Healer, FGD Valley-te Women
aa FGD Valley-te Men; FGD Tenegar Health Workers
ab FGD Blamacee young mothers

Figure 2 - *Respondents health seeking behaviors and views on where to seek care*



3.2 BARRIERS AND PERCEPTIONS OF HEALTH FACILITY SERVICES

Health facilities had limited resources for their work and some staff were not on the payroll or received meager salaries[ac] and reported seeking supplemental income generating activities.[ad] Participants from the FGDs in the community had **both positive and negative reviews of facilities**. Some found the health workers supportive and helpful, yet others mentioned that it was difficult to pay for health services fees (e.g., the cost of delivery) or medication (e.g., often needing to travel to a pharmacy in a nearby town) and that there was no medication

ac FGD Renee Hospital, KII Zodru Health Workers, FGD Valley-te Health Worker, FGD Pleemu Health Workers
ad FGD Pleemu Health Workers

available at the facilities. **Clinic hours were limited to weekdays** (often 8am to 4pm) and community members found this difficult for seeking help during an emergency that occurred in the evening or weekends. Many health workers in Nimba county as well as health workers in the district of Tenegar spoke abou the far distances needed to travel for patients, making it difficult for patients to come for regular counseling sessions.

"[We like] the health center, [there is] 'no bad record', and like the way that health workers take care of us."
- FGD Tenegar Men -

"The health staff does not talk to us nicely and demand that we buy a copy book which costs $100 LD."
- FGD Valley-te Men -

"Midwives take the pregnant woman to the hospital for delivery. The clinician in the wellness center can always treat the patient but [there is] no medicine now, according to the patient that can go there."
- KII Kakata Traditional Healer -

"There are no [mental health] services here for them."
- FGDs Tenegar Men and Tenegar Women -

"Sickness is going low because of the clinic treatment."
- Valley-te Men's group -

Professional staff at primary health facilities were nurses and midwives with limited training in mental health care. Some had received basic training in school on mental health conditions and had participated in the mhGAP training, and/or in delivering the Thinking Healthy Program (THP), a group-based intervention for perinatal depression. Others had mentoring and on-the-job training from the mental health county coordinators but little to no formal training.

Health providers at some of the facilities used mhGAP to diagnose patients and then would prescribe medication for them to purchase at a pharmacy in a close by town. For some patients the cost of travel and medication made it difficult to adhere to their treatment. Community health workers received some on-the-job training in identifying psychological distress and common mental health conditions and would refer people to the clinic for further evaluation and follow-up.[ae]

"For the clinic, we really need [medication]. Because some of the patients when we do referrals, they will go one or two times [then] there is no money for them to continue going for their treatment. They will just sit...Because like epilepsy is a continuous process, a continuous treatment. So, the person goes this week, this month, next month when you ask them why you didn't go for your tablets they say, 'I don't have or get transportation'."
- Tenegar Health Worker -

"It's like somehow difficult to get patients coming back all the time for counseling. So only thing because I'm in a community, I'm going to do follow up at times and check on the patient."
- KII Zodru CHSS -

ae KII Zodru Health Worker

Maternal Mental Health Support

Nurses and midwives counseled women about their problems with their husbands and post-partum depression but **did not have the opportunity to see the patient regularly for counseling**. TTMs provided some informal supportive counseling as needed for perinatal women during their follow-up visits, but this was not a formal mental health program (i.e., Thinking Healthy Program) or structured protocol.

The WHO recommended Thinking Healthy Program was implemented in 60 facilities in Montserrado[af] and was well received by the health workers who participated in the study:

> *"And the mothers were very happy for helping them, talking to them, visiting them, encouraging them. Some of them started making their own food, producing their own gardens, making food and all of that, but the [Thinking Healthy] Program died down/closed."*
>
> - KII Tenegar OIC -

Desire for Mental Health Training and Programming

Overall healthcare workers interviewed were **eager to receive mental health training and willing to participate in BEHOL mental health project activities** as described by the OIC in Saclepea:

> *"I would like to prioritize the health workers as well as the, the CHAs and the CHVs because we the health workers, we are at the facilities level and then the CHAs and CHVs, they are in the communities. The CHVs are trained, the health workers are trained. And the CHV and the CHAs are trained how to detect somebody with psychological problem and then they just refer the person right away. It will help us. Then we are there at the facility level to also receive them and treat them appropriately."*
>
> - KII Saclepea OIC (secondary facility) -

Referrals to Secondary Health Facilities for Mental Health Treatment

When severe mental health conditions could not be treated at the primary health facilities, people traveled to larger health facilities, for example, E.S. Grant hospital in Monrovia, C.H. Renee Wellness Unit in Margibi county, and health facilities in Tappita, Ganta, and Saclepea in Nimba county for treatment. E.S. Grant is the national psychiatric hospital and offers both inpatient and outpatient treatment for mental health and has a team of psychiatrists, clinical psychologists and social workers on staff. The head psychiatrist reported that 80-90% of their patients had psychotic symptoms and approximately 8-10% substance use problems. Often their family members bring them to E.S. Grant as a last resort for treatment.

af Thinking Healthy Program Liberia Final Report

C.H. Renee Wellness Unit

In Margibi county, there are 27 mental health clinicians trained through the Carter Center's mental health program for nurses and who received training in mhGAP. Five of the mental health clinicians are at the C.H. Renee Wellness Center, the only wellness unit for all of Margibi, which provides assessments, diagnoses, follow-up for medication management, and short-term counseling for patients. The intake consists of a comprehensive bio-psychosocial assessment and screening tools (e.g., GAD-7, PHQ-9, TSQ, CAGE, Edinburg, WHODAS) for diagnosis and treatment planning. Clinicians track patient progress using follow-up treatment forms that adhere to the SOAP (Subjective, Objective, Assessment, Plan) note taking format for on-going monitoring and treatment.

3.3 DIVERSE COMMUNITY STRATEGIES FOR TREATING SEVERE MENTAL HEALTH CONDITIONS

Interviewees described several **different examples of community approaches for addressing mental health and substance use problems**. Many community members shared about ways that they care for someone with a mental health condition and support their family members. In Blamacee, a group of neighbors created a safety watch group to take turns helping their neighbor whose stepson showed signs and symptoms of psychosis. They reported that they took away any dangerous objects from the home and provided emotional support to the family. One woman in Valley-te shared about encouraging people to be consistent with treatment. Men in Medina talked about how community members and family will care for people living with mental illness. Some community participants described physically restraining a person by tying them with sticks and then giving them herbs for treatment.

"[We] counsel them, [use] traditional leaves, and put their feet in sticks while they are receiving treatment in order for them not to leave."

– FGD Valley-te Men's group -

"[Community members] get herbs to treat him or use sticks to tie him or cuff his feet."

- FGD Valley-te Women -

"People treat people with mental health conditions with love, care, and affection."

- FGD Gbondoi Women -

"For children, they will not chain them but will 'keep them somewhere safe.'"

- FGD Gbaye-te Women -

With scarcity of options for quality treatment of mental health conditions, community members were often presented with **limited, to no options for receiving effective treatment of mental health conditions**. As a result, **traditional and religious** were often the first place many people turned to for help or forming collective strategies with their neighbors and family members (e.g., safety watch, tying someone to a stick).

4. COPING MECHANISMS

"We group ourselves to maybe do a kind of work, we are always willing to. So, we are together, we are there for one another."

- FGD Pleemu Women -

The focus group discussions in Nimba and Montserrado counties described more **collective ways of coping**, whereas the focus group discussions in Margibi included both **individual and collective strategies**.

4.1 MARGIBI

Interviewees in Kakata district described **internal and external coping strategies** to address distress, open mole, and mental health conditions. Individual strategies for managing stress and mental health problems outside of going to the health facility included self-care, spiritual practices, earning money, working, and seeking social support. **Collective coping mechanisms** focused on involvement in spiritual communities, collective farming and income generating activities, and activities for children, for example, going to school, playing football, youth club, listening to music.

4.1.1 Examples of Individual Strategies for Addressing Any Mental Health Condition

Sleeping, rest, drinking cold water, being alone, focusing on what they can control, reading the Bible, fasting, being informed about what is happening around them, working, and farming, and seeking counsel from the town chief, pastor and/or imam, and going to the clinic. **Negative coping strategies** included drinking alcohol and using Kush.

4.1.2 Examples of Collective Strategies

Going to the church to pray, dance, clap and sing; visiting the mosque; contributing financially to someone in need; encouraging children to go to school; listening to music with children; collective farming; and having a sense of unity within their community.

Open mole and epilepsy were two of the more frequently talked about conditions and the coping strategies in the FGDs. Coping responses for open mole focused more on self-care and traditional medicine while epilepsy focused more on treatment at the clinic and providing emotional support.

4.1.3 Coping Strategies for Open Mole

Self-care, such as hydration (e.g., drinking coconut water, oral rehydration solution (ORS), and water), rest, using a wet towel, putting herbs on the head and wrapping a tie around the head. It also involved seeking help from a pastor for pray and having him pour water over their head or seeking help from a traditional healer.

4.1.4 Coping Strategies for Epilepsy

Respondents often shared about ways to support people with epilepsy, which included offering emotional support (e.g., asking what happened to the person), taking the person to the clinic for treatment, helping the person get needed medication, and reminding the person to be cautious around fires.

4.2 NIMBA

When asked about the ways that people in their community responded to stress and mental health conditions, community members and health workers in Nimba tended to describe **collective coping strategies more than individual approaches**. Categories of collective coping strategies for daily life stressors included helping those in need, supporting others during life events (e.g., a birth), participating in recreational activities, attending religious activities, seeking spiritual healing, and engaging in self-help groups (i.e., savings and farming co-ops).

4.2.1 Spiritual and Religious Activities

In Saclepea, one health worker described church conferences and singing competitions between church members as forms of general support in the community. For residents of Luogatuo, receiving holy water from a pastor was one way that people sought healing from a mental health condition.

> *"The pastor, I don't know his name, but he's in one of the villages here that almost everybody goes to and he gives them this Holy water."*
>
> - KII OIC Luogatuo -

4.2.2 Recreational Activities

Recreational activities were present in the communities and varied based on age and gender. This included children playing in the river, playing lapa (a children's game with sandals), men and youth playing soccer, and women playing kickball. Playing music, dance competitions and community rallies were activities that took place in Saclepea.

> *"When the children come from school, after eating they can go to play…. They will go to play jumping rope, lappa (local game with sandals). The boys will go to the field to play football."*
>
> - KII Beadatuo Health Staff -

4.2.3 Social Support as Prevention

Unity and togetherness were words used to describe what community members appreciated most about their community during the introductions and opening statements for the interviews (i.e., when asked to give their name and what they liked about their community). Different social support activities were described by interviewees later in the interview when asked about ways that the community members support each other, highlighting preventive measures for mental health and promotion of well-being. Community-led activities

included dancing at the clinic when a woman gave birth and carrying her home with her baby; clearing fields together, a youth-led coco agricultural project in Zodru, savings groups, and taking up a collection when someone fell sick.

> *"We got a lot of activities. The women celebrate like just when somebody gave birth or even if somebody pass off and then they go to the bereaved family.... [If] somebody graduate from high school or somebody was sick and then taken to hospital, after getting better and [they] recover and come back, they have a celebration for that person."*
>
> - KII Beadatuo OIC -

> *"...she left her county of origin and came to Zodru and got marry, since then she has seen the unity among the people, she like the way they care for each other."*
>
> - FGD Zodru TTM -

> *"They have their working group where they go to each other farm to work one at a time, put money together and buy gift for one another, they even fetch firewood for each other. They are in a susu (you give me, and I give you) where they give lappa to each other."*
>
> - KII Beadatuo OIC -

4.3 MONTSERRADO

Generally, respondents focused on **broad community activities** when asked about coping strategies for mental health. This may have been due to the wording of the questions and/or their cultural values of a collective approach to solving problems and coping with stress and mental health and substance use. Similar to Nimba and Margibi, respondents in Montserrado shared about **different forms of social support and recreational activities**.

4.3.1. Social Support

Interviewees in St Paul River and Todee districts shared about the different ways community members were united and supported each other. This included women's support groups, farming co-ops, financial clubs, and a conflict management group, and informal counseling by community leaders. In Blamacee, participants shared about giving emotional support and providing food and money to someone with a mental health condition.

> *"...there were a few women that came together and made a rule that any woman that will stay in the town and abuse a person will be called to that group and ask them, why are you abusing them? What's the problem? And they will advise the person, talk to the person so that the group helps the women to be calm... if there is something making you angry, you have to meet that group and share with them. You don't just come out and just burst your anger out [in public in the village]."*
>
> – Pleemu Women FGD -

4.3.2 Recreational Activities

In St Paul River, community members shared about cultural and recreational activities that people in their community did that included playing football, dancing, music, singing, and Islamic cultural activities.

Social support, religious practices, cultural activities, and self-help groups (e.g., collective farming, savings groups, etc.) were the main coping strategies that came from the FGDs. While participants in Margibi shared self-care strategies for open mole, epilepsy and mental health conditions, most respondents shared group versus individual approaches.

> *"...she loves the unity, [and] the women have a financial saving club in the village... she loves the way they care for each other."*
>
> - FGD Beadatuo Community Members -

5. COMMUNITY RESOURCES

Community resources identified by community members in the FGDs consisted of **1)** local institutions, **2)** projects sponsored by international organizations, **3)** self-help groups, **4)** youth clubs, **5)** agricultural resources, and **6)** business centers and income generating activities. Examples of these included the following:

5.1. LOCAL INSTITUTIONS

- Churches, mosques, health facilities, and primary schools (a few secondary schools)

5.2 PAST AND PRESENT SUPPORT FROM INTERNATIONAL ORGANIZATIONS

- Plan International (current): Plan International provided financial support to community health assistants in Nimba county
- Save the Children (past): Save the Children had supported maternal health activities in Valley-te and Gbaye-te in Margibi and worked in Tenegar, Montserrado.
- LiCORMH and Carter Center (past): The Thinking Healthy Program was implemented in Pleemu and Tenegar in Montserrado county (total 60 health facilities participated in THP)
- Jhpiego (past): Past support in maternal health and health strengthening in Gbaya-te, Margibi.
- FHI 360 (current): HIV programming in Loguatuo
- USAID (FARA and Health System Strengthening Accelerator projects)
- World Bank Group (Performance-based financing project)
- Médecins Sans Frontières (MSF) supports a select number of health facilities in psychotropic medications and clinic-based mental health services in Montserrado county
- BRAC for community-based savings programming

5.3 SELF-HELP GROUPS

Communities throughout the three counties had **locally organized support groups that included savings groups and farming co-ops**, etc. Cultivation for User's Hope (CFUH) has peer support groups for people living with mental health conditions and active groups in Margibi, Nimba and Montserrado. However, these groups were not mentioned during the interviews with community members and health care staff. Likewise, AIFO, an Italian NGO, is present in Nimba and supports people living with disabilities, but was also not identified in the FGDs.

- Zodru savings group: A health worker described an informal savings and loan group that he helped start in the community to save and acquire a lump sum of money.
- Zodru women's self-groups: This centered around agriculture activities where women organized themselves to help each other with their fields and put money aside from agriculture income generating activities to assist financially if someone was in a need of a lump sum of money. These women groups would come together to give soap to a woman who gave birth or help a woman with household chores, for example, carry firewood.
- Pleemu agriculture group: Community members organized themselves in a group to clear away an area of local land that was free to residents to cultivate and then would share the harvest of the crop (i.e., cassava or rice) and/or proceeds of its sale.
- Gbondoi agriculture group: Community members organized themselves to help with agricultural activities and put money together to buy supplies.
- Valley-te women's self-group: Women organized themselves in groups for agricultural income generating activities.
- Saclepea financial clubs: Susu clubs normally took place at the end of the month in Saclepea where people would come together to eat and then contribute financially to help members of the group invest in an income generating activity, for example, buying chairs to rent out for events.

5.4 YOUTH GROUPS

This included youth health clubs, an informal chess and sports club, and youth-led agricultural project.

- Breakthrough ACTION, a USAID funded social and behavioral change project, partnered with the Ministry of Health and Ministry of Education to promote adolescent and school health clubs in Nimba, Montserrado and Margibi (among other counties) to train teachers and peer mentors in health topics, such as, family planning, teenage pregnancy, self-esteem, goal setting, etc.[35,36] One of the health workers in Saclepea reported about the presence of these health clubs in his community and the work of male and female peer mentors.
- In Margibi, an OIC shared about the youth activities that he started, which included a chess and soccer club for youth.
- In Zodru, youth had organized themselves to work on a coco project, assist community members in farm work, and contributed to different community development activities, such as, volunteering to help build a community palava hut.

5.5 AGRICULTURAL RESOURCES

The communities in rural areas had readily **available land for farming and fruit trees** (e.g., coconut, pineapples, etc.).

5.6 BUSINESS ACTIVITIES

Men in several communities gathered coal for income, in Gbaya-te (Margibi) women worked in a curry income generating project, and many community members earned income through farming activities, fishing, and small business activities (e.g., selling dried fish, etc.).

The communities visited for the study had access to health facilities, schools, churches, income generating activities, self-help groups, and in the rural communities' access to farmland. Participants in rural communities, especially, spoke about how self-help groups and income generating ideas united the community members and they supported each other in daily life. One woman in Pleemu shared about how much she values her community and the help that they provide one another that she would not want to move anywhere else. **Peri-urban communities such as Medina appeared to struggle more with daily life stressors as they had less opportunities for agricultural activities and were more dependent on other forms of income.**

CONCLUSION

In conclusion, the findings from this qualitative study showed that community members identify severe mental health conditions and epilepsy more often when they talk about mental health conditions compared to mild and moderate symptoms. Somatic symptoms and emotional and psychological distress were described for more common reactions to daily stress that were believed could develop into more severe conditions. Findings from the study were **consistent with other qualitative studies** in mental health in Liberia that focused on cultural perspectives, such as the concept of open mole and describing emotional problems as conditions of the heart (e.g., heart is spoil). Many idioms of distress were similar to prior studies on mental health conditions, though there were some expressions among the respondents that were new that can inform minor adaptations to the Liberian assessments (PHQ-9 and Liberian Distress Scale) for further validation and testing for the regions in the BEHOL project. Especially due to the diversity of ethnic and linguistic communities (e.g., Kpelle in Margibi, Gio, Kru, and Mano in Nimba, etc.) within the target areas, there will be a need for translation and cultural adaptation of materials.

Teenage pregnancy and youth substance use were identified as priority issues in the BEHOL proposal, and the findings from the community FGDs confirmed that these problems are prevalent within the communities. Findings from the Thinking Healthy Program in Liberia also **confirmed the demand for mental health services among adolescent mothers** as over 60% of their participants were young women ages 10 to 24 years old. Substance use among youth and related aggressive behaviour (e.g., stealing, fighting, etc.) were frequently raised by community members across the three counties as a major public health concern. There was a need for more support from government and non-government organizations to help with this crisis.

There is widespread stigma associated with mental health conditions, epilepsy, and substance use, and a need for community sensitization efforts to help counter myths and misinformation about conditions and promote evidence-based information on treatment and support for people living with MNS conditions.

Communities have a **variety of local strategies** for how they respond to someone with a mental health condition, some more beneficial in the long term than others (e.g., providing food and clothing to someone with severe mental health more helpful than tying someone to a stick to physically restrain a person).

Several of the communities in the study were **proud of their unity** and shared many examples of the ways that they supported one another in general through agricultural self-help groups, savings groups, etc. and helped people

with mental health problems through providing for their basic needs and offering support to family members who had someone with a mental health condition.

Spiritual, religious, and traditional practices are an integral part of health seeking behaviors among respondents in combination with seeking treatment at facilities. Integrating and respecting these approaches and the leaders within these communities can help to promote buy-in for community-based mental health activities. The religious leaders and traditional healer who participated in the study spoke positively about seeking mental health care from the facilities and encouraged community members to go there for treatment. This may not be the case for all traditional healers and religious and community leaders within the targeted communities for BEHOL, but identifying leaders who do support seeking mental health care at facilities can be a good place to start for promotion of mental health activities and encouraging community members to go to facilities for mental health treatment. **Involving community leaders throughout the MHPSS implementation process** will be important for local ownership, identifying community members who can be trained as lay providers or focal persons for psychosocial support, and creating lasting programs within the targeted communities.

The lack of quality mental health services at the community level makes it difficult for people with mental health conditions to receive the care that they need. Only some health facility staff have basic training in mental health through the mhGAP, and while this provides a framework and guidance for assessment, diagnosis, medication management, and treatment planning, most providers at the primary facility level have not received this training and further do not have training and experience implementing psychological interventions. There is a scarcity of government supplied, free medication that people have access to for long-term treatment. While patients can receive prescriptions for psychotropic medications and one off, basic supportive counselling, there are gaps (e.g., lack of medication at the facility level, absence of evidence-based psychotherapies, limited number of mental health providers, etc.) in comprehensive mental health services at the primary care level.

In general, there was a greater concentration of mental health resources closer to the capital area compared to Nimba. In Margibi and Montserrado counties there were more mental health programming and training of health workers in mhGAP reported in the interviews compared to the interviews in Nimba. Carter Center had a presence in Margibi in the past with their work with the Wellness Unit and on-going training their mental health staff, LAPS had worked in the past in Margibi and currently implements mental health projects in Montserrado county. LiCORMH and Carter Center had implemented the Thinking Healthy Program funded by Grand Challenges in Montserrado County. Presently, in Montserrado, Médecins Sans Frontières (MSF) supports health facilities. ACF also provides mental health activities in Montserrado and planned mental health activities in Nimba or Margibi under the BEHOL project.

Given the scarce resources invested in mental health services at the community level in the three counties, there is a need to strengthen all levels of the IASC MHPSS pyramid (i.e., social consideration in basic services and security, family and community supports, focused care, and specialized care) through coordinated efforts with the Ministry of Health, local community leadership, and national and international MHPSS stakeholders in order to have a system where people with mild to moderate as well as severe mental health, neurological and substance use conditions can receive the care and support needed to thrive within their communities.

RECOMMENDATIONS

The following are recommendations **1)** for general strengthening of Liberia's mental health system of care at the primary and secondary health facility level by the Ministry of Health in partnership with local and international MHPSS stakeholders based on the findings of the study and best practices in mental health system strengthening and **2)** specific program recommendations for ACF's mental health and psychosocial activities at the community level.

1. GENERAL RECOMMENDATIONS FOR STRENGTHENING THE MENTAL HEALTH CARE SYSTEM

1.1 HEALTHCARE WORKER CAPACITY BUILDING

a. Train 2-3 health care workers (i.e., officers-in-charge, nurses, mental health clinicians, midwives) at each primary health care facility in mhGAP to be able to identify, assess, and treat MNS conditions. Many of the health care facility staff who participated in the study were not fully trained in mhGAP and there is a need to have all professional health workers knowledgeable and proficient in the mhGAP protocol to help with accurate assessments and treatment of mental health conditions. Since one-off trainings are not sufficient to master skills needed to implement mhGAP, it is recommended to organize annual refresher trainings for current health workers trained in mhGAP and regular (i.e., weekly or bi-weekly) supervision by a mhGAP trainer/consultant who can provide oversight and supervision on clinical cases and the implementation of mhGAP protocol.

b. Provide trainings in mental health and substance use interventions based on the list of WHO recommended psychological treatments:[37]

- Behavioral activation and problem-solving therapy for depression;
- Motivational enhancement therapy and brief interventions for hazardous and harmful substance use;
- Interpersonal skills training for adolescents with disruptive behaviors;
- Cognitive behavioral therapy for anxiety, depression, and post-traumatic stress;
- Stress management skills including relaxation and mindfulness for emotional and psychological distress.[ag]

ag ACF created an Emotion and Stress Management Intervention (ESMI) during COVID-19 that incorporates the circle of control, identification of coping strategies and problem solving, and relaxation.

c. Conduct regular training opportunities for all community health workers (i.e., CHSS, TTMs, CHWs, CHAs, etc.) to be able to identify common symptoms of MNS conditions and provide psychosocial support activities (e.g., psychoeducation, health education, active listening, referrals to treatment) to community members. As mentioned in ACF's proposal, CHSS can be trained to provide supervision and oversight to the community health workers.

d. As part of a general prevention and protection strategy,[38] train health workers in safety and protection by providing annual trainings for all health workers in suicide and homicide safety planning, gender-based violence, and child protection issues.

e. Select dedicated health workers (either health facility staff or community health workers) at the primary facility level who have the time, capacity, and motivation to be trained in evidence-based psychological interventions for treatment of mild, moderate and severe mental health and substance use conditions for individuals seeking care at the health facilities. Staff at the primary health facility level did not have formal training in evidence-based psychological treatments and often spoke of the lack of medication to treat MNS conditions but talked little about non-psychotropic medication options for effective treatment of mental health conditions. Ensure all mental health/psychosocial providers are trained in basic counseling elements, such as empathy, collaboration, active listening, normalizing conditions, and involvement of family treatment planning.[39] Incorporate family-based strategies[40] that focus on psychoeducation, how to manage a crisis and safety planning, treatment and referral options, and daily care for a person with a mental health condition. Health workers desire further training in mental health but need the resources (i.e., allocated time, funding, available space, training) to be able to do this.

1.2 ADAPTATION OF MHGAP PROTOCOL FOR MILD TO MODERATE SYMPTOMS

Since the mhGAP focuses on more moderate to severe mental health conditions, it would be helpful to develop a protocol for providers to incorporate treatment options and referrals for patients who present with mild to moderate symptoms but could still benefit from psychosocial support or a psychological intervention. One option is to integrate locally adapted assessments, such as the Liberian Distress Screener (LDS)[21] or Patient Health Questionnaire-9 (PHQ-9L). Since open mole is common throughout the communities in the study and can present with depressive, anxiety and post-traumatic symptoms,[20] it could be helpful to incorporate follow-up questions related to open mole and include regional examples of idioms of distress (e.g., sitting sad, heart spoil), if not already in the adapted LDS. For example, when asking about physical symptoms, that may be unexplained, providers can include questions about open mole (i.e., Do they experience any symptoms related to open mole, if so, what are they? Have they been treated for open mole by a traditional healer? What was the outcome? Was there any negative side effects?).

For example, if the person does not meet the threshold for depression but endorses some symptoms of depression and/or anxiety, it is recommended to still provide psychoeducation, information on stress management and promotion of healthy daily activities, and schedule a follow-up visit by a community health worker in 2-3 weeks to see if their condition improves. If during the follow-up meeting, their condition persists, then refer them to treatment, either group-based psychosocial support (for mild severity) or individual counseling in an evidence-based treatment (e.g., CBT, IPT, BA and/or problem solving).

1.3. HEALTH EDUCATION AND MENTAL HEALTH AWARENESS MATERIALS AND ACTIVITIES

a. Health Education Talks: Develop a curriculum of stand-alone mental health sessions that can be integrated within the health facilities routine schedule of health talks for patients and staff. This can include how to manage stress, sleep hygiene, stigma, signs and symptoms of perinatal depression, emotional regulation, education on substances, how families and caregivers can support someone with a mental health condition, etc. Health facility staff already have health talks on a weekly basis and integrating mental health topics could be an effective strategy for raising awareness on mental health topics and reducing stigma related to MNS conditions. This can be done by one of the professionally trained staff, for example, OIC, midwife, CHSS, or a nurse.

b. Anti-stigma initiatives in the community: Consider developing dramas, songs, jiggles, and stories about MNS conditions and how people sought treatment from health facilities and are in recovery that can be promoted by community leaders and/or community health workers (e.g., TTMs, CHVs, CHAs, etc.). Expand upon the efforts of the Carter Center and Cultivation for Users' Hope in their anti-stigma and anti-discrimination messaging for the BEHOL targeted communities. Due to varying levels of formal education of community health workers (i.e., TTMs and CHAs), adapt health education and mental health awareness curriculum to include picture aids and simple, easy to understand words translated in Liberian English and in the local dialects that can be understood by people with limited literacy.

1.4 HEALTH FACILITY RESOURCES

a. Clearly document clinical protocols, resources, and referral pathways with job aids (i.e., flow charts) for psychosocial and mental health services at the health facilities to show the referral pathways at the community, district, and county levels. Since mental health services are integrated within other health services, the starting point for screening and identification of a mental health condition will be part of routine care at the health facilities, but the protocol and follow-up steps should be specific to mental health and in writing with picture aids for all professional staff at the primary care level to understand.

b. Create an up-to-date list of referral resources at the community and district levels for protection services, legal support, education and livelihood programs, self-help groups, and other social service programs run by government and non-government organizations. This list should be reviewed and updated annually.

c. Ensure each health facility has a dedicated room or area that is private where they can provide person-to-person counseling sessions. Many of the health facilities were crowded and did not have a designated space for counseling and this was identified by providers as an important part of offering mental health services.

d. Strengthen data collection and reporting through annual refresher trainings on the signs and symptoms of mental health conditions and requirements for monthly reporting and tracking in DHIS2. While monitoring and evaluation were not the focus of the study, the research team did review the paper records of MNS cases. Many of the records reviewed were for epilepsy with few cases recorded for other MNS conditions. This may be due to only recording severe cases of MNS and not keeping track of mild to moderate cases. MOH in partnership with ACF should review the protocol for case reporting and provide refresher trainings and clear guidelines for health care workers (health facility staff and community health workers) to identify cases and track them through their data reporting system.

2. ACF BEHOL COMMUNITY-BASED MENTAL HEALTH ACTIVITIES

Based on the findings of the study and the outlined strategies and activities for the BEHOL project, the following recommendations are made (See *Annex D* for recommendations based on counties).

2.1 IMPROVE THE TECHNICAL CAPACITY OF HEALTHCARE PROVIDERS

The BEHOL project aims to support ToT trainings for mhGAP for the Mental Health Unit master trainers who will then train county level CHT and DHT focal points to provide trainings at the community level. The findings from the study support the need for health workers to be trained in mhGAP, especially in Nimba county where there were fewer health workers at the facility level who had received mhGAP. As mentioned above, all health facilities in the study would benefit from having 2-3 health staff trained in mhGAP with regular supervision sessions. Given the distance to travel in Nimba and poor phone connectivity, it will be important to provide adequate resources for regular supervision for the health workers there.

In addition to mhGAP, master trainers in BEHOL would benefit from being trained in 2-3 WHO recommended psychological interventions. Based on the findings of the study, interventions focused on substance use, depression, anxiety, and general psychological distress should be prioritized at the primary health facility level. This could include behavioral activation and problem-solving therapy for depression, cognitive behavior therapy for anxiety, and motivational enhancement therapy and brief interventions for hazardous and harmful substance use. It would also be beneficial to have specialized training in treatment of trauma (i.e., exposure therapy). In addition, with the initial promising outcomes of ESMI as a psychosocial support intervention during COVID-19, this could be further tested among community health workers as part of their psychosocial support activities.

2.2 REVIEW AND DISSEMINATE GUIDELINES AND PROTOCOLS

With the mental health training and supervision, it will be important to have **clearly written standard operating procedures** and for ACF to assist with any needed job aids and IEC materials for implementation of the interventions at the community level.

2.3 SUPPORT OF REGULAR SUPERVISION, INCLUDING THE COUNTY AND DISTRICT HEALTH TEAMS QUARTERLY JOINT INTEGRATED SUPPORTIVE SUPERVISION (JISS)

Based on the interviews with health workers, there is a need for regular supervision (e.g., weekly or bi-weekly) **and on-the-job training at the health facility level.** Having the BEHOL project support these endeavors will help to strengthen the capacity of health care providers to provide quality mental health services. CHSS and TTMs have a structured supervision schedule that ACF can support with further mentoring and support based on the implementation of community-based mental health activities (e.g., group-based psychosocial support groups, etc.).

2.4 STRENGTHEN DATA COLLECTION AND REPORTING

As part of the BEHOL project, ACF plans to work with the MOH to **provide refresher workshops** on collecting quality data, creating data audits, use of DHIS2, and data analysis supported health facilities. It would be helpful for ACF to review the protocol for record keeping and reporting of MNS conditions and support the MOH in refresher trainings on identification of signs and symptoms and best practices in documentation and reporting.

2.5 SUPPORT COMMUNITY AWARENESS ACTIVITIES

An activity within BEHOL is to support community health workers to raise awareness about mental health, substance use and epilepsy. The study findings support the need for this awareness and de-stigmatizing messages about MNS within the community. Developing a series of MNS modules that can be integrated into community health education dialogues and other health forums, such as the health talks at the facility, can help streamline this. Incorporating dramas, narratives, songs or other creative means of expression can also help connect the anti-stigma messaging and promote mental health seeking behaviors.

2.6 IMPLEMENT GROUP-BASED INITIATIVES

a. Self-help and group-based interventions focused on MNS were recommended by community members in addition to having opportunities to receive individual mental health care (outlined above). Adapting and piloting a WHO recommended intervention, such as, PM+[41] or another evidence-based group-based interventions that target psychological distress and mild to moderate symptoms of depression and anxiety can provide an opportunity for people to learn skills to manage stress and mild mental health symptoms, while also serving as a referral pathway for people with more moderate to severe symptoms that need specialized treatment. Exploration of partnering with already established self-help groups (i.e., agriculture groups, savings groups, youth groups, etc.) can be a way to build upon existing community resources and provide a sustainable means of MNS support at the community level. Working with leaders from these groups to adapt and pilot the mental health intervention curriculum can help to ensure that the MNS interventions are appropriate and acceptable to the community. Further, having the groups co-facilitated by a dedicated health worker (i.e., nurse, TTM, CHSS) and respected community member (i.e., leader of men's or women's groups, etc.) can help create a sense of community ownership and support the goal of BEHOL to improve community participation and ownership of health services.

b. Develop peer support groups for people with mental health conditions, substance misuse, and epilepsy and their caregivers to have a space to share their experiences and receive recommendations on best practices. Incorporating persons with lived experience and their family members within peer support groups is recommended as there were several family members who expressed a need and desire for further support and help with their family member who were suffering from a MNS condition.

- Explore having separate groups for family members and/or caregivers and people with lived experience as well as mixed groups with both.
- Consider having the groups facilitated by a community health worker and someone with lived experience.
- Include psychoeducation and narratives and examples of how families and communities can support people with mental health, epilepsy, and substance use conditions.
- Where feasible, partner with Cultivation for User's Hope to leverage their network and expertise in providing peer-based support.

c. As outlined in the BEHOL project activities, the findings from the study support the formation of youth health groups at the community level. It is recommended that the groups focus on prevention and promotion of mental health and psychosocial well-being as well as harm reduction for substance use through psychoeducation and skill-based training (i.e., saying no to peer pressure, pursuing activities and opportunities that promote healthy living, problem solving, learning how to find a job or start an income generating activity, etc.). Additional recommendations for the youth groups include:

- Identifying group facilitators who are closer in age to the youth to work with health providers;
- Forming partnerships with local organizations who can provide vocational training to youth;
- Providing linkages to higher level treatment and services when needed, especially for youth with hazardous substance use.

2.7 ADAPTING AND IMPLEMENTING THE THINKING HEALTHY PROGRAM

It is strongly recommended in partnership with the Government of Liberia (GOL) and ACF.[ah] This was **one of the recommendations that came from the GOL and mental health stakeholder meetings in 2023**, and the need is supported by this study. With the prior implementation of THP in Liberia, there are existing resources (e.g., master trainers, trained providers, and culturally adapted materials) that can be used to further adapt and expand the program.

Based on the findings of the THP in Liberia and review of other maternal mental health programs (e.g., Mother Time in Ethiopia[42,43]), it is recommended to consider adaptations for implementation of the THP for BEHOL:

a. Screen for depression and anxiety at both prenatal and postpartum visits to capture women who may experience postpartum depression that was not present during the ANC visits.

b. Adapt the THP to be a flexible intervention where women can receive the sessions that fit their needs. For example, if a woman is screened and endorses symptoms of anxiety and depression during her ANC visits, then she can start at module 1, but if a woman screens during a postpartum follow-up visit, then she can be offered sessions that are tailored to modules 2-5.

c. Due to the findings of the THP in Liberia that fewer women participated in the later modules (3-5) after delivery of the child, explore adapting and shortening these modules to include fewer sessions or consider adapting the curriculum of the Mothers Time program in Ethiopia that targets postpartum women.

d. Engage male partners, parents, family members and community leaders in supporting women to participant and engage in the sessions as recommended by the THP in Liberia.

e. Include psychoeducation sessions on maternal mental health that were used in the Liberia THP (i.e., common signs and symptoms of mental health problems during pregnancy, coping and stress management skills, and parenting skills).

f. Incorporate incoming generating activities as found helpful in the prior implementation of the THP to address the stress from lack of income and difficulty providing for their families.

g. Explore delivering the THP sessions in the community by community health workers (e.g., TTMs, CHAs, etc.) to reduce barriers related to cost of transportation and time spent traveling for women to come to the health facilities.

ah Since the Thinking Healthy Program was one of the only EBT mental health interventions implemented in the targeted communities, we could provide more specific recommendations for further implementation.

ANNEXES

ANNEX A: HEALTH FACILITIES IN THE MENTAL HEALTH STUDY

#	COUNTY	HEALTH DISTRICT	NAME OF HEALTH FACILITY	CATCHMENT POPULATION	TYPE OF FACILITY	PREVIOUS SUPPORT BY BECOL PROJECT	URBAN/ RURAL SETTING	PLANNED FGDS	ACTUAL FGDS
1	Nimba	Tappita	Zodru Clinic	5,902	Primary	Yes	Rural	2-3	3
2	Nimba	Gbehlay Geh	Loguatuo Clinic	8,793	Primary	Yes	Rural	2-3	2
3	Nimba	Zoe Geh	Beadatuo Clinic	9,604	Primary	No	Rural	2-3	2
4	Nimba	Saclepea	Saclepea Health Center	28,075	Secondary	Yes	Rural	2-3	2
5	Margibi	Kakata	Kakata Health Center		Primary	Yes	Urban	2-3	2
6	Margibi	Kakata	Gbaye-Ta Clinic	2,663	Primary	Yes	Rural	2-3	3
7	Margibi	Kakata	Vellay-Ta Clinic	3,173	Primary	Yes	Rural	2-3	4
8	Margibi	Kakata	C.H. Renee Hospital	32,131	Tertiary	Yes	Urban	2-3	1
8	Montserrado	St. Paul River	Blamacee Clinic	5,042	Primary	Yes	Rural	2-3	4
9	Montserrado	St. Paul River	Tenegar Community Clinic	8,795	Primary	No	Rural	2-3	3
10	Montserrado	Todee	Goba Clinic	6,820	Primary	No	Rural	2-3	1
11	Montserrado	Todee	Pleemu Clinic	6,161	Primary	No	Rural	2-3	3
12	Montserrado	St. Paul River	Gbondoi Health Center	4,212	Secondary	Yes	Rural	2-3	3
13	Montserrado	Monrovia	E.H. Grant Hospital	5.5 million	National psychiatric hospital	No	Urban	n/a	n/a (KII)

ANNEX B: COMMUNITY LEVEL PARTICIPANTS OF FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

	NIMBA	MARGIBI	MONTSERRADO	TOTAL
Community members	**50**	**103**	**60**	**213**
		Men		
Men (25+)	19	33	10	62
Male youth (17-25)	6	13	8	27
Unknown	0	3	9	12
Sub-total	25	49	27	101
		Women		
Women (50+)	7	10	0	17
Women (25-49)	6	30	5	41
Female youth (17-25)	12	9	13	34
Unknown	0	5	15	20
Sub-total	25	54	33	112
Health workers	**64**	**21**	**46**	**131**
		Professional health facility staff		
Officer-in-charge	4	4	3	11
Certified midwife	2	0	6	8
Mental Health Clinician	1	2	0	3
Sub-total	7	6	9	22
		Community Health workers		
TTMs	15	3	0	18
CHVs	2	1	0	3
CHAs	22	0	2	24
CHSS	5	0	0	5
HFDC	0	1	0	1
Sub-total	44	5	2	51
Other health workers/ facility staff	**14**	**10**	**39**	**63**
Total	**114**	**124**	**106**	**344**

ANNEX C: FOCUS GROUP DISCUSSION AND KEY INFORMANT INTERVIEW GUIDE

1. Focus Group Discussion Guide

INSTRUCTIONS

1. Greet all participants
2. Introduce your name and your role in the study.
3. Have each participant introduce themselves and share one thing that they like about themselves or their community.
4. Explain the study using the formal consent form and have each individual sign or give verbal consent. For adolescents younger than 18 years old, consent from a caregiver is required.
5. If anyone does not agree to participate, invite him/her to leave. For the remaining persons find a private location (if not already in one).
6. On the Focus Group Discussion form fill in information about date and site of interview, county, district, name of interviewers, their ages and gender, and total number of participants. Ask participants to sign in on the participant sheet.
7. Begin focus group discussion.

INTRODUCTION

Hello, thank you for attending this focus group discussion. We appreciate your participation. Each of you should have already signed a consent form that described the purpose of these discussions.

My name is _____, I work as _____ for Action Against Hunger (ACF). And this _____ who will be taking notes and helping with the audio recording. This _____ who will be interpreting as needed. ACF has asked us to conduct a study to better understand the perspectives of people living in _____(community) about problems related to thoughts, feelings, and behaviors, how people describe these problems, available services and resources used to address these problems, and the type of activities that people normally do to care for themselves, their family, and community. We would like to learn more about this by talking with you.

Before we get started in asking you questions, we want to go over a few ground rules: **a)** Only one person speaks at a time; **b)** There are no right or wrong answers; **c)** You do not need to speak in any particular order; **d)** You do not have to agree with the views of other people in the group; **e)** Silence phones; **f)** Any additional rules? Any questions?

OPENING QUESTION

1. Can you tell us about the problems which impact_____ [target group] and their families in your community?

   You mentioned a number of problems [READ OUT ALL PROBLEMS NAMED ABOVE RELATED TO THINKING, FEELING, BEHAVIORAL, AND RELATIONSHIP PROBLEMS]. Of these problems, which is the most important? Why?

- Of these problems, which is the second most important? Why?
- Of these problems, which is the third most important problem? Why?

NOTE: The facilitator should select the problems that are ONLY relevant to mental health/psychosocial support such as: **1)** Problems related to relationships (domestic and community violence, child abuse); **2)** Problems related to feelings (i.e., fear, sadness, grief), thinking (i.e., worry) or behaviors (i.e., substance use).

CULTURAL REPRESENTATION AND COMMUNITY PERCEPTION

2. **Cultural Representation**: What local words or phrases are used to describe psychological distress in your community?

Prompts:

- How do we name those problems?
- How do we call people with problems related to feelings, thinking, or behaviors?
- What words are used to describe someone suffering with psychological distress?
- What is(are) the first word(s) that come to mind when you hear about psychological distress and/or mental health problems?
- How do people in the community express their emotions, when they suffer/ feel sad, angry? What about women, men? Boys and girls?

3. **Stigma**: How are people in your community treated who experience these problems [repeat top problems]?

Prompts:

- How do families treat someone who has mental health problems? How are their families treated?
- How do you feel about people who suffer from psychological distress?
- What do you think about them? Are there differences between men and women and boys and girls?
- What do you think is the cause of someone who has psychological problems? How does this happen? Explore the external factors (such as war, difficulties with life, poverty, etc.) as well as traditional beliefs (bad luck, bewitchment, evil spirits, debt to pay, etc.).
- To what extent do you think something like this could happen to you? To someone in your family?
- In your opinion, is there a way to prevent this?

SIGNS AND SYMPTOMS OF MENTAL HEALTH DISORDERS AND PSYCHOLOGICAL DISTRESS

4. How would an outsider recognize someone who is experiencing mental health problems or psychological distress?

Prompts:

- What does the person look like?
- How do they behave?
- Are there different types of this problem (i.e., expression of distress)? What are they? How can I tell the difference?"
- What does it look like for someone with mild or a few problems?
- What does it look like for someone with moderate mental health problems? With severe problems?
- Are there differences between men and women? And between boys and girls?

- What emotions would you say people living in your community feel the most when in emotional distress? (Note the emotions mentioned and the frequency of response)
  - → Fear
  - → Anger
  - → Surprise
  - → Shame
  - → Disgust
  - → Guilt
  - → Sadness
  - → Other [please, specify]

INDIVIDUAL AND/OR COLLECTIVE COPING MECHANISMS

5. What do people do in your community to address these problems? When someone is in psychological distress or has a mental health problem, what does he/she do to feel better?

Prompts:

- What does the family and/or community do to help someone with mental health problems or in psychological distress in your community?
- What are the helpful activities someone can do to feel better? What are some negative activities someone can do to feel better in your community?
- Are there beliefs or experiences that can help the community cope with these feelings?
- What kind of things do [name of target group] to deal with such problems? For example, things they do by themselves, things they can do with their families or things they do with their communities. Does doing that help with the problem?
  - → Do you know of someone in your community who has used traditional remedies for nerves, head, etc.?
  - → Do you know of someone in your community who has seen a traditional healer for nerves, head, etc.?
  - → Do you know of someone in your community ever seen a religious leader for nerves, head, etc.?
  - → Do you know of someone in your community ever seen TTM for nerves, head, etc.?
  - → Do you know of someone in your community who has seen a CHV for nerves, head, etc.?
- What are the general activities that [target group] in your community do frequently to care for themselves when someone is in distress to help them feel better?
- What are general activities that [target group] do frequently to care for their families when they are in distress?
- What are general activities that [target group] do frequently to contribute to their community or help others in distress in your community (e.g., support group, savings and loan group, church, mosque)?

MENTAL HEALTH CARE SEEKING BEHAVIOURS, INCLUDING USE OF FORMAL, INFORMAL, AND TRADITIONAL CARE

6. **Existing services**: Where do people go in your community for help with mental health problems?

Prompts:

- Who do people go to in the community for help? For example, professionals, non-professionals, traditional healers, doctors.
- What services or programs are available?
- Where do people go with severe problems? What do people go for help who have thoughts about ending their life?
- Where do people go with mild problems?
- Who do people talk to about this?
- Are there support or self-help groups in the community?
- Do cultural and social activities take place?
- Are there community activities?
- Are there formal or informal educational activities for children?
- Are there leisure activities for children?
- Are community activities organized in your area that provide emotional support and well-being? Describe the community activities that are carried out.

7. **Experience with services**: What is your experience seeking help for mental health problems or psychological distress?

Prompts:

- What is your experience like with community health volunteers? Traditional midwives? Religious leaders? Traditional healers?
- When dealing with mental health psychological distress?
- What is your experience like with health staff at health centers and wellness units?
- What is your experience like with self-help groups? Who do you work with for these? What is helpful? What is not helpful?

8. **Mental health awareness**: What are the messages, i.e., public health awareness campaigns about mental health in your community?

Prompts:

- How helpful are they?
- What have you heard from them?
- Have you learned from them?

9. **Recommendations**: What is missing? What can be implemented or developed further?

- In your opinion, what activities are best to support people in psychological distress in your community?
- Do you prefer activities that are stand alone or a part of other health services?
- Do you prefer group-based activities like MSGs and FSGs, peer support groups or individual based with CHV or TTMs, etc.?
- What are the barriers that could be encountered to access these services?

- What can be done to mitigate those barriers?
- Who needs to be involved for the activities to work? Who should conduct/facilitate those activities and where?

COMMUNITY MAPPING EXERCISE

Using paper, pencils, markers, and post-it notes, create a community map with resources including, health care, mental health services for severe mental health and mild/moderate symptoms, NGOs, religious places, traditional places of healing, community support groups, etc.

2. Key Informant Interviews

Key informant interviews are semi-structured interviews that can consist of separate interviews and range from 60-90 minutes for each interview based on the knowledge and information shared by the interviewee.

Key informants at the county level will focus on the top priorities raised by the focus groups and any outstanding questions from focus group discussions in that location as well as the questions below. People at the county level can include:

- Mental Health County Coordinator;
- Ministry of health staff working in mental health (One stop center staff);
- Ministry of Gender, Children and Social Protection (MoGCSP) staff working in mental health and psychosocial support;
- Health facility staff;
- Wellness Center staff;
- Leaders/focal points in the community including religious leaders, traditional healers, social workers, youth workers, midwives, etc.

The interviewer should ask open-ended questions and prob/ask follow-up questions as needed. The interview is semi-structured and not all questions will be asked to each participant. Please go over the consent form before beginning the interview. Once the interviewer has provided verbal or written consent to be interviewed and recorded, document that they have consented for the feasibility study and proceed.

Introduction to study:

Action Against Hunger has received funding from the French Development Agency (AFD) for a three-year program called "*Better Health Outcomes for Liberians (BEHOL)*" which aims to improve the health status of Liberians living in Montserrado, Margibi, and Nimba counties through higher quality of maternal, neonatal, and mental health care. The BEHOL program aims **1)** to strengthen Liberia's health system through leadership development within the Ministry of Health at the national and sub-national levels, **2)** to improve the quality of health service delivery in 25 targeted health facilities, **3)** to increase individual health literacy and health seeking behaviors, and **4)** to improve community participation and ownership of health services. As part of the planning of this study, ACF has hired a research team to conduct a feasibility study to inform the community-based mental health programming.

The aims of this study are to better understand the signs and symptoms of mental health disorders and psychological distress in Liberia; explore cultural representations and community perceptions of mental health;

identify and understand mental health care seeking behaviours; identify individual and collective coping mechanisms; and identify existing community resources and mental health programming.

We'd like to learn more about your work in mental health in Liberia to inform ACF's community-based mental health programming and services.

Questions:

1. What are your priorities for mental health prevention and treatment in your community (district, county)? What is done in terms of prevention? Treatment?
2. What mental health services currently exist in your area? What resources exist in the community, district level, and county level?
3. What organizations do you partner with?
4. Where do people go with severe mental health problems? What do people go for help who have thoughts or talk about harming themselves or others? What are the main barriers to access to services?
5. Where do people go with mild to moderate problems, e.g., when their heart is spoiled or are feeling distress? what are the main barriers to access to services?
6. Who have you worked with on these services?
7. Who are these services for?
    a. Adults?
    b. Children
    c. adolescents?
8. What kind of assessments are used for triage and referral making?
9. What are the gaps in your system of care?
10. How do community members know where to go to seek help for mental health problems?
11. Who are the best people in your community to provide community mental health services? Who would you recommend to partner with?
12. Are services individual-based or group-based?
13. Are there support or self-help groups in the community?
14. Do cultural and social activities take place?
15. Are there community activities?
16. Are there formal or informal educational activities for children?
17. Are there leisure activities for children?
18. Are community activities organized in your area that provide emotional support and well-being? Describe community activities carried out.
19. What do you recommend to improve mental health prevention and treatment in your community?
20. Who else should we talk to about mental health in your community?
21. Providers (only): Can you tell us about a typical workday? What are your primary responsibilities? Have you worked in mental health? If so, can you tell us about it.

ANNEX D: RECOMMENDATIONS FOR THE BEHOL PROJECT COMMUNITY-BASED MENTAL HEALTH ACTIVITIES

COUNTY	DISTRICT/TOWN	PRIORITY ISSUES FROM FGDS	RECOMMENDATIONS FOR ACF BEHOL PROJECT AT THE COMMUNITY CATCHMENT AREAS OF THE PRIMARY FACILITIES
Margibi	Medina	Open mole, psychological distress, anxiety, somatic symptoms	• Group-based psychosocial support • Peer and family support groups • Youth groups
	Valley-te	Caring for people with mental health conditions and epilepsy Youth focused health clubs Lack of medication	• Peer and family support groups • Youth groups
	Gbaye-te	Substance use Psychological distress, worry, hopelessness, and stress Epilepsy	• Peer and family support groups • Group-based psychosocial support • Youth groups
Montserrado	Todee District	Youth substance use and related externalizing behaviors Interpersonal conflicts	• Youth groups • Substance use and mental health awareness activities* • Group-based psychosocial support and conflict management skills • Revitalize the Thinking Healthy Program
	St Paul River	Teenage pregnancies, poverty, lack of opportunities for youth, deaths due to substance overdose Family members caring for people with severe mental health conditions and epilepsy Maternal mental health	• Youth groups • Substance use and mental health awareness activities* • Group-based psychosocial support • Thinking Healthy Program
Nimba	Beadatuo	Substance use, interpersonal conflict, psychological distress	• Peer and family support groups • Group-based psychosocial support • Youth groups
	Zodru	Depression Alcohol and substances Teenage pregnancy Psychological distress Post-partum depression/psychosis Conflicts with partners	• Group-based psychosocial support • Thinking Healthy Program with an interpersonal communication component • Youth groups
	Luogatuo	Women not having support from husbands during pregnancy Epilepsy and psychosis/severe mental health	• Peer and family support groups • Thinking Healthy Program with an interpersonal communication component • Youth groups

*Recommend piloting awareness activities in these areas first

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