

A qualitative analysis of health care provider perceptions of depression and suicidality in

Mozambique

Manuela J. Raunig-Berhó

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Committee:

Deepa Rao

James Pfeiffer

Brad Wagenaar

Program Authorized to Offer Degree:

School of Public Health, Department of Global Health

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Manuela J. Raunig-Berhó

University of Washington

Abstract

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Manuela J. Raunig-Berhó

Chair of the Supervisory Committee:

Associate Professor, Deepa Rao

Department of Global Health

Aim: The purpose of this study is to identify and describe health care provider explanatory models, beliefs, attitudes, and practices regarding depression and suicidality in Sofala Province, Mozambique.

Background: There is currently limited knowledge about the prevalence of mental health conditions in Mozambique, particularly regarding more common mental disorders such as depression. Mozambique was recently listed as having the 7th highest suicide rate in the world. A lack of data and available treatment for common mental disorders contributes to cycles of poor mental health and poor physical health, while impeding efforts to improve access and availability of culturally appropriate mental health care in Mozambique. There is minimal qualitative research regarding stigma related to mental health in Sub-Saharan Africa.

Methods: We targeted health care providers to serve as key informants based on their respective mental health care knowledge. An in-depth interview (IDI) guide was used in conducting 25 semi-structured interviews of clinical providers knowledgeable on mental health in the community, and providers working in units with both high patient contact and high potential for depression and/or suicidal ideation.

Findings: Analysis revealed that most providers perceive a high prevalence of depression and suicide, with both of these issues cited as a mental health concern that should be treated. Providers indicated that patients had a limited knowledge of mental health services, and expressed a desire for increased training themselves. Isolation, familial and relationship conflict, and HIV diagnosis were common causes for depression and poor mental health, and many providers suggested a need for incorporating community and families in treatment.

Conclusion: There is a need to address stigma reduction by means of community education around mental health care, and health care provider knowledge of and comfort addressing depression and suicidality. Linkages should be strengthened between HIV care and mental health care.

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INTRODUCTION

The Global Burden of Diseases, Injuries, and Risk Factors Study 2010 stated that “depression, anxiety, and drug use are the primary drivers of disability worldwide”.¹ It has been shown that mental, neurological, and substance-use conditions account for 22.7% of years lived with disability,² and evidence from several post-conflict developing countries increasingly shows a high burden of these mental health conditions.³⁻⁵ Mozambique is estimated to have 0.04 psychiatrists per 100,000 individuals, with only 0.29% of the population having access to basic mental health services.⁶ While our knowledge about the burden of mental distress in post-conflict developing countries has been increasing, there is currently just a single population-based study on the prevalence of mental health conditions in Mozambique. This existing study was centered in the capital city, Maputo, and focused on psychosis and epilepsy,⁷ therefore providing some insight but offering limited data regarding more common mental disorders, such as depression, in the broader context of Mozambique.

There are no reliable epidemiologic data on key details such as prevalence, risk and protective factors, or on traditional care practices related to depression, anxiety, and suicide, which represent the highest morbidity and mortality among mental health conditions in similar post-conflict countries. In similar settings, traditional healers are consulted for treatment of mental disorders by community members and are able to recognize some mental disorders, but are limited in recognizing common ones.⁸ This lack of data around health care provider knowledge and practices related to mental health impedes efforts to advocate for, design, and integrate mental health care in primary care settings in Mozambique. Additionally, the lack of available treatment for common mental disorders contributes to cycles of poor mental and physical health, as well as to poverty, social exclusion, and stigma.

Mozambique was recently listed as having the 7th highest suicide rate in the world. At a rate of 27.4 per 100,000 population cited in the 2014 WHO world suicide report, the country's rate far exceeds the average of 11.4 suicides per 100,000 individuals.⁹ Mozambique does not have published national or provincial level suicide statistics, although this information is collected through the violent deaths registry as part of legal medicine services available at its three quaternary-level health facilities. As of 2011, Mozambique's mental health budget was merely 0.16% of the country's overall health budget,¹⁰ indicating minimal allocation of resources towards mental health care. To our knowledge, there are no published studies on how health care providers perceive depression, suicide, and suicidal ideation in the Mozambican context.

In similar settings, some commonly perceived causes of mental illness are supernatural, drug-related, and HIV-related.¹¹ Explanatory models can provide a useful framework within which to examine mental illness using a context-specific socio-cultural lens.¹² Alternative explanatory beliefs about mental illness held by the community can result in seeking treatment outside of the health system. In Haiti, religious explanatory models for mental health did not act as an impediment to seeking care, but impacted type of care sought. Individuals were more likely to seek care from folk practitioners, and generally perceived biomedical practitioners as ineffective for mental health treatment. However, community members and health care providers alike cited the lack of available mental health services and infrastructure as a significant barrier to care.¹³ Health care providers have expressed that they often feel that mental health training is relevant to their work but that they have limited knowledge regarding mental health problems and suicidality.¹⁴ In Mozambique, religious beliefs around causes of mental health disorders have been found to influence care-seeking practices, with belief of spiritual causes for PTSD and trauma-related symptoms associated with seeking help from traditional healers.¹⁵

Health care providers have been shown to hold negative attitudes towards people with mental health conditions in Western and African settings.^{16,17} While it has previously been suggested that stigma towards individuals with mental health conditions is less severe in African countries,¹⁸ Corrigan and Watson have argued that the lack of data in African countries may explain why mental health related stigma may appear to be less prevalent.¹⁹ In Nigeria, health care providers have been shown to possess stigmatizing attitudes towards mental health patients, and attribute symptoms to a range of factors including supernatural causes, misuse of drugs and alcohol, and traumatic events.¹¹

Furthermore, there is a dearth of qualitative studies providing insight regarding stigma related to mental health in Sub-Saharan Africa. In neighboring Zambia, one study determined that stigma among community members and health care providers in this setting is strongly tied to social and cultural beliefs around the cause of mental illness and its transmission, and revealed strong associations between HIV and mental health conditions.²⁰ In South Africa, community members' knowledge of mental illness was low, and stigma towards people with mental illness was high, displaying a possible connection between lack of information or familiarity and stigmatizing attitudes towards mental illness.²¹ Primary and mental health care providers in Zambia have also expressed stigmatizing attitudes towards patients with mental health conditions, with primary care providers expressing high levels of discomfort at working with patients with mental health conditions, which has negative implications for care integration.²²

The current paper presents data collected from qualitative interviews assessing health care provider explanatory models, beliefs, attitudes, and practices regarding depression and suicidality in Sofala, Mozambique. The objective behind this research is to move forward with creating locally-relevant diagnostic materials and to improve treatment access through

development of referral strategies and strengthening integration between current psychiatric care delivery and primary care. Additionally, we aim to examine current consideration of care for depression and suicidality by non-specialist psychiatric workers in Mozambique.

This paper aims to shed light on health care provider explanatory models of depression and suicidality in Sofala, which in turn influence attitudes towards depression and treatment practices. These practices can impact access to mental health services and stigma surrounding mental health treatment, which directly impacts patient experience and potentially healthcare utilization for mental health complaints. We focus on identifying and describing health care provider explanatory models and perceptions, including socio-cultural factors, religious beliefs, presence of social support or isolation, experiences of trauma and substance use, and biological factors as potential components influencing how health care providers explain and perceive depressive symptomatology.

METHODS

Study Setting

Sofala Province, Mozambique was the focus for this pilot project based on demonstrated health needs. We used the approach developed with Belkin et al.'s "implementation rules" to augment community mental health care in developing counties.²³ This entails assessing the context of mental health, examining how it is understood, described, and addressed by both providers and community members, in order to identify and map existing and future care pathways and treatment approaches. We explored health care providers' explanatory models, perceptions, and practices surrounding depression and suicidality in Sofala Province, Mozambique, in order to understand current mental healthcare pathways and gain insight into

current community practices. Sofala Province has approximately two million inhabitants, with only 16 psychiatric technicians, 2 psychiatrists, and 7 clinical psychologists providing mental health services for the population. There are 18 health facilities providing mental healthcare services, operating across 12 of the province's 13 districts.²⁴

Data Collection

We used purposive and theoretical sampling to obtain data for this study. We targeted health care providers to serve as key informants based on their positions in health posts and respective mental health care knowledge. Working in partnership with the Beira Operations Research Center (CIOB) and a local research assistant, we refined and translated an in-depth interview (IDI) guide for use in conducting 25 semi-structured interviews of clinical providers who are knowledgeable on mental health in the community, and providers working in units with both high patient contact and high potential for depression and/or suicidal ideation. Interviews included providers working in emergency services, maternal and child health, infectious and chronic diseases, and mental health services. We accessed non-mental health care providers by means of snowball sampling following key informant interviews with psychiatric technicians. Participation was voluntary, and written and verbal informed consent was obtained in Portuguese for each participant. An informational sheet regarding the study was provided to each participant in Portuguese and reviewed verbally in Portuguese. All interviews were conducted in a private room in each health worker's respective health facility. No compensation was provided.

The IDI for all health providers included open-ended questions on current perceptions, knowledge, and care practices for depression and suicidality. The interview guide was designed to elicit opinions on prevalence of depression and suicidality, the causes of these conditions, and

perceptions about treatment and prevention. Interviews were conducted in Portuguese with a local research assistant conducting the interviews; the investigator was present for all interviews, asked questions for clarification, and additional probing questions when appropriate. Interviews were audio recorded, and transcribed in the original Portuguese with the assistance of the same research assistant who conducted the interviews, as well as an additional research assistant at the University of Washington. The investigator took written notes during the interviews to be considered alongside the transcriptions. The interview contained open-ended and exploratory questions such as:

- What kind of health and social problems do people talk to you about at your job?
- Can you tell me a story of someone coming to your clinic or to you personally ‘feeling low’ or (term from above)? What do you think caused this feeling?
- Can you tell me about other care providers people might go to for these conditions?
- Can you tell me a story about someone you have heard of that suffers so much that they no longer want to live and think about hurting themselves or ending their life? What do you think caused this feeling or condition?
- Does the community provide support for people thinking of hurting themselves or so sad it makes life difficult?
- Can you tell me some ideas you might have to improve health facility services for people with sadness or depression? How does the health facility staff interact with patients with mental health concerns?

This study was submitted for IRB approval as one aim in a larger health systems study in Sofala province. The protocol received IRB approval from the University of Washington Human Subjects Division and from the Mozambican Comité Institucional de Bioética do Instituto Nacional de Saúde (CIBS-INS). Additional permission to conduct this study was obtained from

the Ministry of Health, the Provincial Directorate of Health, and the Director of the Beira Central Hospital.

Data Analysis

We analyzed the transcripts for emerging themes related to assessing explanatory models, beliefs, attitudes, and practices regarding depression and suicidality. A grounded theory approach was used for data analysis.²⁵ We began with open coding and proceeded to axial coding to further narrow in on themes present throughout the data. Microsoft Excel 2007 and ATLAS.ti were used during this process. The first author completed the coding and thematic analysis. Within-case analysis was used in examining each participant's attitudes toward mental illness, and their experience working with individuals with mental illness, and how the participant perceived barriers and incentives for care-seeking. Cross-case analysis explored further the differences and commonalities present in the responses and attitudes of health care providers interviewed. The quotes used to present the results have been translated by the first author into English for the purposes of this paper.

RESULTS

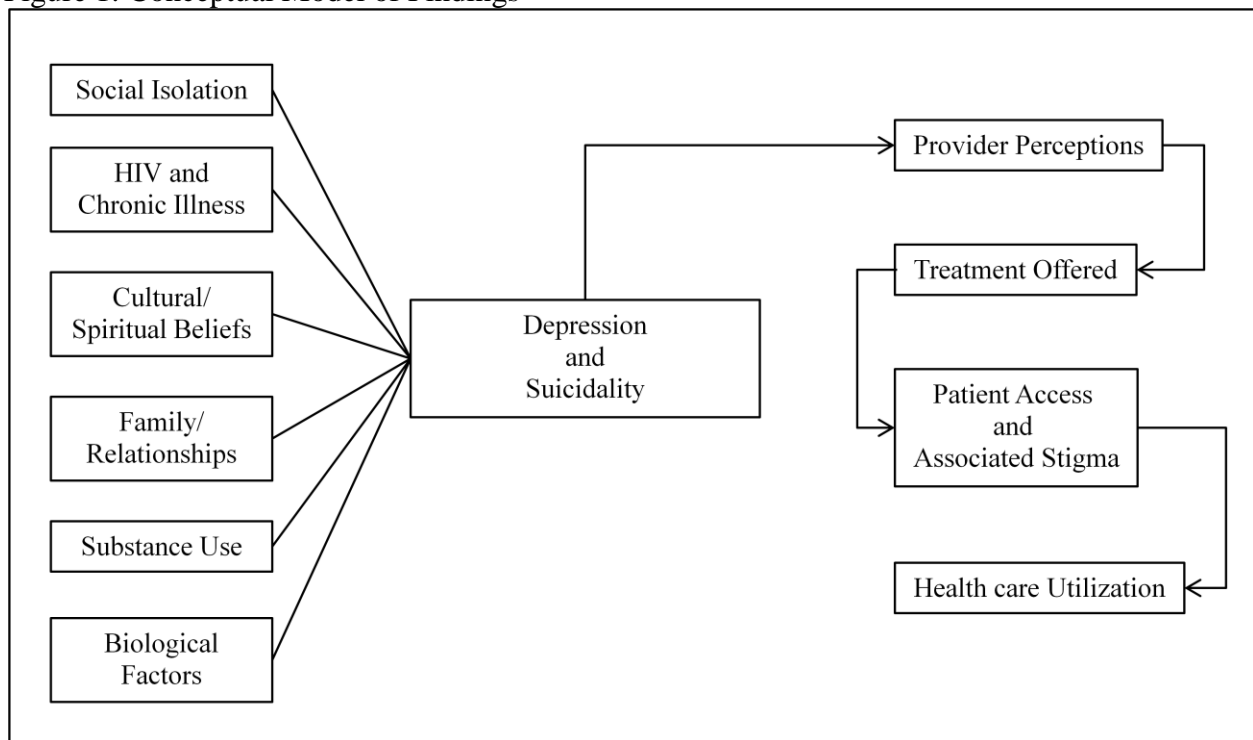
Participants included health providers from two districts in Sofala Province: Beira and Dondo. Providers worked in 7 health facilities: Ponte Gea, Chingussura, Dondo, Macurungo, Munhava, Nhaconjo, and Beira Central Hospital (HCB). Thirteen providers were mental health workers, including 6 psychiatric technicians, 6 clinical psychologists, and 1 psychiatrist. 12 providers were non-mental health workers, including 4 general nurses, 2 maternity nurses, 5 medical technicians, and 1 psycho-social support staff. Of those who agreed to complete an interview, 12 respondents identified as female and 13 as male. There were two psychiatric technicians who did not respond to attempts to schedule an interview.

| Table 1: Study Participant Demographics | |
|---|-------------------------|
| Characteristic | Interview Frequency (%) |
| Total | 25 (100.0) |
| Age of Participant (years) | |
| 20-29 | 8 (32.0) |
| 30-39 | 12 (48.0) |
| 40-49 | 3 (12.0) |
| 50-59 | 2 (8.0) |
| Education Level | |
| Nivel basico | 2 (8.0) |
| Nivel medio | 15 (60.0) |
| Nivel superior | 7 (28.0) |
| Nivel especialista | 1 (4.0) |
| Clinical Position | |
| Tecnico/a de psiquiatria | 6 (24.0) |
| Psicologo/a clinico | 6 (24.0) |
| Enfermero/a geral | 4 (16.0) |
| Enfermera maternidad | 2 (8.0) |
| Tecnico/a de medicina | 5 (20.0) |
| Asistente psico-social | 1 (4.0) |
| Psiquiatra | 1 (4.0) |
| Time at Position (years) | |
| 0-3 | 10 (40.0) |
| 4-6 | 6 (24.0) |
| 7-9 | 4 (16.0) |
| 10+ | 5 (20.0) |
| Geographic Background | |
| Urban | 16 (64.0) |
| Rural | 9 (36.0) |

Analysis of the transcriptions elucidated the perspectives and attitudes of health care providers towards depression and suicidality, highlighting believed causes of mental illness, beliefs and current practices regarding treatment, and perceived barriers and motivators to patients' care-seeking behavior. In discussing personal and perceived community attitudes towards both depression and suicidality, providers described varying levels of stigma experienced by patients with mental health conditions, and a need for further education regarding mental health and mental health symptomatology.

During analysis, a codebook was developed from common opinions expressed by providers. The researcher used these 119 codes to compile categories related to perceived causes of depression and suicidality, treatment modalities, stigma related to depression and suicidality, and barriers and incentives to care-seeking. The data was collapsed into categories, and common themes emerged explaining how these participants perceived depression and suicidality, and their beliefs and corollary treatment practices.

Figure 1: Conceptual Model of Findings



Perceived Causes, Associated Factors, and Prevalence of Depression

Most providers noted a high prevalence of depression and suicide, with both of these issues cited as a mental health concern that should be treated in clinics through the healthcare system. Several providers discussed the concept of trust and safety in relation to care-seeking

behavior, referencing need for disclosure to a friend or family member as a barrier to seeking services. Fear of disclosure and of being perceived as "*maluco*" ("crazy") was discussed as a barrier to receiving care, due to worries about isolation and mistreatment following disclosure limiting access to transportation to a hospital or clinic, and preventing individuals from accessing potential support systems. Additionally, providers indicated that many patients were unaware of mental health services within the hospital and clinic setting. One of the main cited types of mental health treatment was psychological treatment following care-seeking related to HIV, and an HIV diagnosis was commonly cited as a cause for depression and poor mental health, often caused by feelings of imminent or unavoidable death.

Providers also referred to the idea of coping ability or resilience as a factor in whether or not an individual experienced depression requiring treatment following a trauma or difficult life experience, rather than experiencing a non-clinical and more "acceptable" form of sadness.

"At times it's a common occurrence because there are persons who can't cope. They don't have a defense mechanism...what we call resilience. And they are unable to find a way out and to seek help from others. And we try to understand what that person is going through and to try to change their mindset and try to point to a positive outcome."

As shown here, resiliency and coping ability were considered to contribute strongly to depression and suicidality, indicating that health care providers perceive potential for predisposition and for certain life events to result in depression, but that this is not considered a universal or insurmountable chain of events.

Isolation and Substance Use

Isolation was cited by the majority of providers as both a cause and outcome of depression. This included physical isolation in a more rural setting and isolation within a community, due to factors such as social stigma and status. Providers also noted the potential for a correlation to exist between managing a chronic illness and feelings of sadness. This was in

line with the more general association which arose between depression and the experience of daily stress or specific stressful events. Several providers also associated depression and suicidality with alcohol or drug use. Drugs and alcohol as a cause of sadness and poor mental health were cited by close to a third of the providers.

Familial and Relationship Conflict

Other frequently mentioned causes were family problems, financial problems within a household, and instances of domestic violence and sexual violence. Relationship problems was one of the highest perceived causes of depression, in terms of conflict within existing relationships, the dissolution of a relationship, or the inability to obtain a romantic or sexual relationship. Not having success romantically alluded to not fulfilling a masculine role within society, which resulted in seeking out treatment for depression.

“I think that, more or less, that’s the case that I just described: of that young 19-year-old student who said that after the relationship ended - because she loved the guy, she liked the guy - the world for her ended. She went to the market and got rat poison, went home and ingested it.”

Several providers described the end of a relationship when asked to discuss an example of a patient coming to them with sadness or suicidal thoughts. The end of a relationship, infidelity, and other forms of relationship conflict were discussed in detail in relation to both depression and suicide attempts.

“In the past, suicide happened or could happen when the patient would experience the loss of two or three family members in a dramatic way. Not that taking your own life makes sense, but in the past the motivating factors were much stronger, nowadays it could be related to a fight with a romantic partner...”

This provider indicated that there has been a shift in causes of depression and suicidality, and believes that previously they were caused by more "severe" losses. They argue that people now are moved to suicidal thoughts or actions by a fight with a partner.

HIV and Associated Stigma

Another highly mentioned cause for depression was in the form of sadness related to HIV. This was grouped together in coding when reference was made to an HIV diagnosis leading to depression, the ongoing stress of HIV treatment leading to depression, or the disclosure of a partner's HIV status. Many of the participants discussed HIV and its impact on mental health, but only one of the providers interviewed worked explicitly with individuals diagnosed with HIV.

“Nowadays mental health is being affected in many cases by HIV status. For example, a young married mother who tests positive for HIV. She cannot bring herself to speak about it with her husband. So she starts to suffer from mental stress thinking about her dilemma...if she informs her husband, he would do what? He would reject the marriage. So she comes to us with great psychological stress.”

In the above quotation, one can see how the intersection of HIV stigma and mental health plays out in this population, with fear or shame of disclosure of HIV status resulting in worsening mental health and increased stress within an intimate relationship.

“The person gets tested and blames HIV. This person, unless they have good pre and post HIV testing counseling, would suffer, get stressed knowing their HIV positive status. And it's not the disease itself that would harm their health the most, but the mental stress of perceiving their life as limited or ending because, in their minds, the HIV virus equals death.”

Providers also referred to the importance of how an HIV diagnosis is delivered and what education accompanies informing a patient they are HIV positive, in order to reduce the initial shock and potential negative reaction based in misinformation. The notion that HIV is equivalent to death, so suicide does not seem like an unreasonable option anymore, is brought up by this provider. Again, below is the idea of a patient's world ending when they receive a positive HIV diagnosis.

“I can think of many that at a certain point already thought about suicide because of the diagnosis [HIV +]. For them, the world ends after being diagnosed HIV +. There is nothing more for them.”

Depression and Suicidality As Mental Illness

The providers interviewed consistently indicated that they considered depression and sadness as a mental health concern. While more severe forms of mental illness were brought up, with references to psychosis, delusional thinking, and epilepsy, among others, providers consistently referenced the concept of sadness as a mental health condition when asked about mental health in general. When asked specifically to address depression, providers stated that depression impacts a person's daily life and often requires treatment in some form, regardless of what generates its onset.

This participant outlines their framework of what constitutes poor mental health, including depression-related symptoms such as isolation, not communicating with others, and feelings of sadness. The mention of talking to oneself as an indicator of poor mental health was mentioned by different providers, indicating a certain amount of association between mental health and psychosis or signs of visible mental distress.

“But I can tell you that when mental health is not good, you can see it. We can see the person being isolated, looking sad, not talking with anyone, not wanting to communicate with anyone, being in a corner alone and talking to themselves.”

Again, the idea of discouragement and intense sadness arise as something that can overtake a person's mental health to the point where they feel powerless:

“Weakness, we are talking about a state of discouragement, of intense sadness that leaves the person feeling powerless to do anything all the time.”

A majority of providers noted depression or sadness as commonly occurring, and also frequently cited depression as one of the most common concerns or afflictions they see and treat in their clinics, along with sexual violence, suicide attempts, and HIV and epilepsy. In addition to a perceived high prevalence of depression, the providers interviewed also indicated a

perceived high prevalence of suicidality, pointing towards the health system's limited ability to address or minimize the occurrence of attempted and completed suicides.

“It’s very common [suicide]. It’s a pity that the health care system can’t address this, but there are many suicides, many attempted suicides, and many completed suicides linked to marital relationships.”

Suicidality was referred to frequently as related to depression. One provider explicitly stated that suicidality is a result of: *“That matter of dismay, it becomes depression. A deep depression.”* Nine of the providers discussed suicidality as a symptom of poor mental health, and among providers who did not label it a mental health problem, it was still mentioned in association with depression. Some providers specified that they perceived suicidal behavior to be impulsive within their community, and only one provider made reference to perceiving suicidality as attention seeking.

Suicidality, like depression, led to discussions around the need for increased mental health care and trained staff. This participant drew a correlation between depression and suicide, implying that not only do they believe untreated depression to be a cause of suicidality, but that they believe this progression could be prevented through increasing treatment availability in the health care system.

“But if we had the means and the conditions, like enough staff, we could offer more to that young woman who needed psychological support, even some off-site support, so that she wouldn’t get into such a deep depression that could lead to suicide. To offer more to help to create the conditions for her to get out of the hole, to open up.”

Providers mentioned many different causes they believed may lead to suicidality, the most frequently mentioned being suicidality related to an HIV positive diagnosis, relationship problems and infidelity, family problems, and being unable to fulfill a role (often familial), and lack of resources. Means of attempted suicide when discussing specific cases were often

unmentioned or vague, however, five providers cited Ratex (rat poison) as a common method of attempting suicide.

A handful of providers explicitly linked depression with the idea that women lack autonomy within Mozambican culture, and this is a cause of depression and suicidal behavior linked to conflict and mistreatment within relationships and greater levels of daily stress. A lack of access to mental health resources, as well as lack of available mental health resources within the health care system was also cited by about a third of the providers. Few providers cited biological factors as contributing to depression, but this may have been implied with comments made referring to predisposition.

As described previously, isolation was mentioned as both a cause and a symptom of poor mental health by about half of the participants, and providers discussed increased isolation as leading to depression and leaving someone at a higher risk of suicidality. Other commonly mentioned symptoms when describing poor mental health were a lack of appetite, low self-esteem and negative thoughts, not taking care of oneself, poor hygiene, and not wanting to do anything, similar to the "Western" profile of depression.

Stigma and Community Attitudes

A majority of respondents expressed knowledge of, or experience with, community stigma toward mental illness in general. Several respondents identified depression as stigmatizing. Similarly, several respondents spoke to stigma surrounding suicide, particularly associated with the family surviving an individual who has completed a suicide attempt. Providers shared attitudes that while the community at large holds stigmatizing views, they do not as healthcare providers.

“Yes, yes, we can accept the normality of this illness. We can all carry this illness, but we don’t know when it might express itself. Any one of us can have it, no? The manifestation of the illness depends on the sensibility of the person, no?”

One provider noted that depression is "normal" because it could happen to any of us, describing it as a sickness, and stating that as with any other sickness, you never know when you might get sick. The provider captures the idea that some people are predisposed, but everyone is susceptible to poor mental health.

Community stigma was brought up repeatedly through the use of the word "*maluco*" ("crazy") to describe individuals suffering from mental illness. Many of the respondents made reference to community members labeling individuals as "*maluco*," a label which implied an element of dehumanization and generalization of mental illness. Some providers used this word themselves, in reference to those they considered to be more seriously mentally ill than individuals seeking treatment for depression.

“Many perhaps think that way of people in psychiatric services. They think that psychiatry is only to treat 'malucos' ('crazies'), no? Without acknowledging that anyone might need a consult visit to psychiatry. So I think that this myth ruins many things.”

In general, providers espoused the opinion that community members are not accepting of mental health. However, this lack of acceptance was often cited as being due to a lack of knowledge regarding depression and its etiology.

“Well, very often the community doesn’t have the scientific knowledge about the matter. They judge, pass judgment, based on what they perceive, what they see. They pass judgment, criticize and have opinions about what should or shouldn’t be and they fail to see the interconnection of the physical, social, psychological, and biological parts of the individual. And instead they [the community] make a judgment based only on their direct, narrow perception.”

The need to educate community members about depression repeatedly came up in the context of community stigma and stigma reduction as well. This participant argues that there

needs to be increased community awareness of depression, in order to increase community support available for individuals experiencing depression or suicidal thoughts, and potentially result in preventative actions that reduce an individual's sense of isolation and lowers their risk of attempted suicide.

“I feel that the community needs to be made aware that depression happens so that people are not judged and perceived as people who are at fault. And thus, help them feel supported and prevent them from feeling isolated.”

In addition to stigma related to misperceptions and lack of knowledge of mental health issues, providers frequently mentioned a strong stigma associated with depression and suicidality stemming from older cultural superstitions. The following provider references mental health patients previously going to traditional healers and being isolated and tied to trees, but notes that now traditional healers are referring to the hospitals more often.

“Yes, we do have a connection [to the traditional healers]. When they can identify one of their patients as having a psychiatric condition, they send them to us. They don't just hide them as before. Because it was common occurrence to find one of those patients tied to a tree, they would tie them and give them anything. But not now, when they [traditional healers] receive that type of patient, they soon refer them here to the hospital.”

Many providers held and referenced a non-stereotyped view of depression and suicidality. Participants referred to life experiences resulting in low self-esteem and depression as a natural part of life, pointing to external factors influencing mental health, rather than focusing on an individual's predisposition to developing depression or assigning fault to individuals.

“There is a natural tendency, for example, for people with very low self-esteem to fall into depression because of life's dynamics.”

The majority of providers were very accepting of depression and suicidality as mental health conditions. This participant delineates between the experience of feelings of sadness as

opposed to experiencing symptoms that significantly impair daily functioning and result in isolation.

“Experiencing [sadness] is very normal. What wouldn’t be normal is that after this one couldn’t function. Let’s say, for example, that just because I’m down I would stay home, stop going to school, that wouldn’t be normal.”

The following participants both make clear statements arguing that mental health should be addressed and treated in the same way as any other health concern, stating that "diseases are diseases." They also refer to predisposition and resiliency, again implying that they consider individuals impacted by depression or suicidality to be influenced by a combination of factors.

“Diseases are diseases, but depending on the particularities of each individual, they affect people differently. Some people are stronger, more tolerant than others. That’s life.”

" Let’s give a simple example, the death of a loved one. One is going to be shocked, feel pain. We can offer sympathy and support for the pain. But, this pain could become so deep and overwhelming that we could call it a pathology and the community can blame the individual for being weak. But, they [the community] cannot see what’s happening internally with this particular person, what is making the sadness stay for longer than normal. The community doesn’t have the knowledge to understand this pain when it has become a pathology."

Over half of those interviewed indicated that there is silence around mental health, and believed that individuals often do not disclose feelings of depression or suicidality due to concerns about stigma and how they will be perceived within the community. Many providers mentioned that community members and other providers hold stereotypes about mental health, and indicate that this can be a deterrent for seeking treatment. Nine of the providers interviewed stated that they considered depression and suicidal thoughts to be abnormal or unnatural.

Treatment

Traditional Healers

There was a commonly expressed belief that depression requires some form of treatment. Providers reported and acknowledged that patients generally seek treatment from traditional healers prior to coming to a clinic or hospital setting. Some stated that traditional healers provide valid treatment to an extent, but then need to recognize when the illness needs to be handled in a medical setting, and there were discussions around how to engage in trainings with traditional healers to address this.

“The traditional healers do play a role, they do their treatment in their setting, but that illness that is beyond the capacity of the traditional healer to handle, should be referred by the traditional healers to the hospital.”

Across the board, participants stated that traditional healers cost more, but patients still prefer going to them for treatment due to feelings of trust and affection not present at clinics. Some providers mentioned a formal linkage between traditional healers and the health care system, known as AMETRAMO (*Associação dos Médicos Tradicionais de Moçambique*), but also indicated that, in practice, these two systems do not work collaboratively regarding patient care. While it is unclear on how regularly this happens, multiple providers mention a referral pathway in which patients seek out traditional healers, and traditional healers then refer to the hospital.

Clinical Setting

The majority of providers felt that depression and suicidality should be handled in a clinic setting, and that collaboration existed between providers in these settings. There was mixed commentary on the efficacy of these collaborative processes, and less than half of those interviewed made reference to receiving or making a referral to another provider related to depression or suicidality. When asked about other possible places for treatment, or other places

to go or be referred, most providers mentioned the Central Hospital. When asked about other options for mental health care, providers generally offered up other nearby clinics or occasionally referring to community leaders.

“Well, we have the central hospital as the referral place for this health center, the “mother” hospital. We have psychologists in different districts... and we have some other people that can provide support. But in case of greater needs for services, we can make referrals to the central hospital.”

Medication and Psychotherapy

About half of respondents cited medication as a necessary component to treatment, and everyone interviewed indicated either direct psychotherapy or the availability of clinical talking and support as the best course of treatment. While descriptions of psychotherapeutic practices were not always consistent with standard techniques, these interventions were frequently discussed as useful therapeutic approaches for treating both depression and suicidal ideation.

“In those cases we do what we call cognitive behavioral psychotherapy. What does it mean? Cognitive: it generally includes attention, concentration, memory, and other egoistic structures. In relation to behavioral interventions we support the individual to change their way of thinking in regards of how they feel at that moment. For example thinking that after I had been raped no one will need me. So we have to help the individual to go from a negative train of thought to a positive one.”

This provider specifically mentions the importance of working with client beliefs within any clinical treatment provided:

“Therefore I have to find a way that takes into account her beliefs when talking to this person. Only in this way I can offer counseling and achieve that something happens.”

Community and Family Support

Community support and family support were the most commonly referenced non-clinical forms of treatment or components to a successful recovery listed by providers. The importance of community support was identified by all but one participant, and almost all providers highly stressed the need for family support in order for patients to improve.

“The important thing is the level of support that these people have within their families. In addition to this, there should be family support groups that help them return to a normal life.”

Providers also commented on the importance of working with family members in addition to patients in order to improve mental health outcomes:

“We also had to interact with the family. She has a mother and brothers and they also should be included in a process that we call psychotherapeutic or be included in family psychotherapy to be able to deal with the frustrations and to provide more support, not with the intention to judge her daughter or their sister, but to help her turn into the right direction.”

When it came to discussing community support, some providers held stronger attitudes than others regarding its importance for mental health treatment. The following participant stated that advocating that the clinic is the best or only place to provide mental health care does a disservice to community members who offer and provide support throughout the community, as well as the direct work that they do to support the patient throughout their struggle with depression or suicidality.

“To say that the best place is the health unit to tackle mental health issues would leave the community leaders powerless in this regard. I even think that it’s easier to tackle things in the community and that’s why the health professional has to work directly with the community. It’s there that you see results, because at the health unit level the patient only comes through, but at home the patient has to listen in his daily interactions with others about what should be avoided and what should be embraced and the patient starts to understand this.”

Need for Increased Mental Health Care

Seven providers felt more mental health care is needed, and this sentiment was echoed in comments made by other participants regarding a need for more preventative care. Several providers also suggested incorporating home visits, stating that they could help patients have a better recovery by assessing daily stressors.

“It would be possible to go in the patient’s home and see the living conditions, see how

people interact with him, I could even have conversations with everyone who lives with him, even with people in the community where he lives. To try to understand if there are other people with similar problems linked to mental health.”

In a similar vein, one provider illustrates a lack of follow-up when people come in to seek care from rural areas, indicating an area of possible health system improvement.

“I feel I couldn’t finish that matter. I don’t know, for example, how he [the patient] is doing nowadays. That’s the drawback of them [patients] coming here for some business in town and then coming in for a consultation, but never coming back for follow-up. I don’t know if he sought any help when he returned since he had to go back the same day. Therefore, I couldn’t follow up this person.”

Most importantly, the majority of providers strongly felt that depression and suicidality can be treated, and that people's symptoms improve with some form of treatment. Summed up well in this quote is the idea that some patients may need ongoing treatment. The provider speaking discusses a patient who they believe will always have suicidal thoughts but is not currently acting on them, and comes for regular counseling to maintain stable mental health.

“As he tells his story, he was suicidal because he had lost lots of money in a failed business affair. It was hard to lose that amount of money and he decided that it was preferable to take his life rather than to start from scratch. We tried providing counseling for about two weeks, but he still felt the trauma of the failed business and he didn’t want to talk to anyone. But, he stuck around for some more counseling and after 4-5 weeks his condition improved. He didn’t recover completely, he improved. But the idea of committing suicide was still hanging within himself.”

Community Education

The perceived high prevalence of depression and suicidality was tied into a voiced need for increased education of community members around mental health.

“Health talks are common, despite not being common yet in regards to mental health. And because of the need for greater understanding here in our communities in Sofala or Beira, we go out every Thursday and give talks, and we hold discussions sometimes at the health units during regular health talks every morning.”

One provider interviewed had worked within the mental health care system since its inception. She noted that health workers have done significant work around community education, and attributes a reduction in stigma around mental health to these education efforts.

“At the beginning of the work in mental health, when we came in 1995, it was difficult to say we worked in psychiatry. There was a perception we were crazy. But, we worked hard. We had to go to every district so that people knew that, for the first time, there was a mental health program. There was psychiatry at the time, but it didn’t reach the community. So we started to create new tools in each district. There was someone who was responsible for this program and we worked at the community level on mental health issues.”

Several providers described the ongoing need for community education around issues of mental health, citing the importance of education to reduce stigma, as well as the need to increase knowledge of services available for individuals in need of mental health care. This participant alludes to the high numbers of attempted suicides in the community, and puts forth the idea that if more community education and community lectures and workshops run by mental health professionals took place, individuals would be more likely to access services and less likely to "reach that state" (referring to attempted suicides) in their mental health.

“There should be talks in the communities. There are communities now that have many people committing suicide. I think this is a problem reflective of a lack of help. Many talks could take place in the communities, health staff could go to the communities, give a talk, reach out to the people so that people don’t get to that suicide critical phase.”

Providers who had specific training in mental health indicated that they believe there is a need for more education for non-mental health providers regarding identifying symptoms of and providing treatment for depression and suicidal ideation. About half of the respondents also discussed a need for increased psychoeducation for patients receiving mental health care regarding their symptoms, and depression as a health matter rather than a personal failure.

Several providers mentions that patients often came to them being unaware of the existence of treatment for depression.

DISCUSSION

This qualitative study addressed the need for more information on current attitudes of health care providers in Sofala, Mozambique regarding depression and suicidality to inform health system improvements around mental health, and specifically around suicidal ideation and depression. The study highlighted how stigma and lack of information about mental health and mental health services at the community and provider level creates a barrier to seeking care. Our findings show that providers working in various levels and areas of the health care system perceived a high prevalence of depression and suicidality. This finding indicates that it is necessary to conduct additional research to determine an accurate representation of how often, and under what circumstances, these mental health conditions occur. Half of the providers interviewed worked explicitly in mental health care, yet the majority of providers expressed concern regarding lack of available treatment and resources related to mental health, indicating that the small allocation of Mozambique's health budget allotted for mental health is reflected in perceptions regarding available services. These findings strengthen previous research, reiterating that health care providers believe mental health training is important to their work, and often have limited knowledge regarding depression and suicidality.¹⁴

While health care providers in this study largely did not show negative attitudes towards people seeking treatment for depression or suicidality as found in previous studies,^{16,17} there was unsolicited feedback regarding more severe mental illness, as well as strong acknowledgement of community stigma regarding mental health. While we cannot establish whether the Hawthorne

effect, or social desirability bias, could have impacted our findings of low stigmatizing attitudes by health workers, our findings that healthcare providers are interested in treating depression and suicidality, and that they consider these common and treatable disorders is a positive foundation for increasing efforts in this area. The concerns raised regarding the need for community and patient education warrant significant attention as a means of stigma reduction.

The relationship between HIV and mental illness reflected findings in Zambia wherein stigma associated with mental illness was partly due to the belief that it can be transmitted, similarly to HIV.²⁰ Associations between mental health and other stigmatized conditions such as being HIV positive, paired with lack of knowledge around how one develops mental illness, could lead to increased fear and stigma, prevent care-seeking, and lead to further ostracizing and isolation of individuals experiencing depression and suicidal thoughts. The results of this study indicated a stronger risk of depression and suicidality related to HIV, in part due to living with a stigmatizing chronic illness, often with little information or resources regarding the illness. The impact of an HIV positive status also tied into the effect of relationship conflict and infidelity as contributing factors for depression and suicidality. Sadness and suicidal ideation related to HIV often incorporated elements of fear related to disclosing a positive status to one's partner, as well as negativity and feelings of betrayal when someone had contracted HIV following a partner's infidelity.

The frequency with which conflict within intimate relationships was cited as a cause for both depression and suicidality was an unexpected result, and was not reflected in previous literature from Sub-Saharan African countries. Stressful life events, particularly conflict in family relationships and romantic relationships, have been found to be contributing factors to impulsive suicidality among adults and youth in other countries.^{26, 27} It is difficult to determine if

these are actual direct causes without interviewing patients directly regarding their experiences. Relationship conflict may be considered an acceptable cause for depression due to high value being placed on romantic and family relationships, and therefore be reported instead of alternative explanations in order to reduce feelings of shame or stigma. However, this is an interesting area for further research focusing on relationships and intimate partner violence as it pertains to depression and suicide in the Mozambican context.

The study findings point to a need for increased education among all providers in order to reduce stigma and improve efficiency of identifying symptoms and collaborating with specialists for treatment implementation, and increased education among community members to reduce stigma, increase community support for individuals who do not make it to a health center, as well as increasing positive health-seeking behavior for community members regarding mental health conditions.

As previously identified in Kenya, traditional healers are frequently sought out as a first resort for treatment but do not often have the training needed to identify and effectively treat common mental illness.⁸ These healers are in a strong position in which to act as first responders when it comes to depression and suicidality, which indicates this is a key area for linkages and education around depression and risk factors for suicide in order to improve the referral system and encourage health system utilization. Additionally, links between depression and HIV and family conflict indicate that HIV and maternal and child health services are prime areas in which to strengthen mental health ties and roll out depression screenings and preventative programming. Increased psycho-social support for HIV positive patients around disclosure and relationship maintenance may be another for implementing mental health treatment and education. Two providers mentioned a substance use support group while discussing mental

health, and a third of participants correlated substance use and depression. It may be worthwhile to address the ways in which clinics handle substance use disorders and ensure they are addressing comorbidity with depression and drug use as a potential risk factor for suicide attempts.

Participants specifically cited that monthly community and provider workshops to provide education and peer trainings in community and clinical settings would be beneficial. Providers also proposed increasing outreach through home visits to ensure that patients follow up with treatment, and reduce barriers to medication adherence and psychosocial support. Incorporating traditional healers and community health workers into training and outreach efforts may be an approach for implementing these broader proposals.

Limitations

Interviews were conducted primarily in the city of Beira, with some interviews from surrounding health facilities, making this sample more representative of Beira than of the larger Sofala province. Interviews were conducted in Portuguese and analyzed in both Portuguese and English, but some nuances may have been missed in translation from Portuguese to English.

Participants were primarily interviewed at health facilities, and may have felt some pressure to speak highly of current services in order to reflect well on themselves and their places of employment. Supervisors were generally aware that participants were being interviewed, and this may have resulted in more positive responses regarding current services in health facilities, as participants may have felt a reduced level of anonymity. Similarly, letters of approval from upper-level hospital and ministry of health administration may have influenced providers' willingness to participate.

While healthcare providers were asked about their clinical experiences as well as community experiences, they primarily cited cases involving direct patient care, resulting in interactions and beliefs regarding patients who have sought care and utilized the health care system for mental health, which may be significantly different from interactions with individuals who do not seek or receive services. There are also possible differences in attitudes between providers who have been trained in and work in mental health in comparison to those with less training or differing specialties, which are not analyzed in this paper.

Despite these limitations, this study had strengths in that it created an open dialogue around mental health, primarily depression and suicidality, while acknowledging that these issues are often kept in silence. This served to enhance our knowledge of provider perceptions of depression and suicidality, as well as creating a platform to discuss community stigma around these issues, and point to specific areas for further research on care-seeking behavior, comorbid conditions, and stigma reduction. These providers were able to convey the importance of increased education around mental health for themselves, community members, and patients seeking care.

Conclusion

This study examined attitudes towards depression and suicidality and the impact this has on treatment seeking and associated stigma in Mozambique. Providers held generally positive perceptions of people with depression and suicidal ideation and did not think people with suicidal ideation were attention-seeking or unable to recover, and believed depression is a common and normal component of mental health. The explanatory models for depression and suicidality were in line with these being seen as a "disease", and providers did not hold

stigmatizing attitudes towards patients presenting with these symptoms, although they reported that the community does. It appears as though HIV is strongly linked to depression and suicide, so programs addressing both should be considered in the future. The findings from this qualitative study are consistent with research on care-seeking practices for mental health treatment starting with traditional healers prior to utilization of the health care system, and barriers to care related to lack of services available and community stigma towards mental illness in similar country settings. This study suggests that additional education is desired and needed among both providers and community members. Hopefully this study encourages further research into stigma reduction by means of community education around mental health care, treatment seeking and engagement, and health care provider knowledge of and comfortability addressing depression and suicidality in Mozambique and other low-resource settings. As a nation with alarmingly high rates of suicide, increased resources for prevention and evidence-based interventions, including routine depression screening and reducing barriers to treatment such as stigma, are vital components to combating the impact of depression and suicidality.

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APPENDIX A: Semi-Structured Interview

1. **What kind of health and social problems do people talk to you about at your job?**
 - a. How do you help? Are there places you send people for help when you don't think you can provide appropriate help?
 - b. What do people tell you is the cause of these problems? What do you think is the cause of these problems?

2. **What does the term "mental health" make you think of?**
 - a. What about feelings of stress, discouragement, intense sadness, "thinking too much," so intense that they make daily life difficult?
 - b. Would you give these occurrences a name? What would you call that?
 - i. How common are these conditions?

3. **Please describe an image of positive mental health (or insert language from above) and/or poor mental health (or insert language from above)?**
 - a. What are the symptoms of poor mental health?
 - i. How common are these symptoms in your community?
 - b. Is there any way you can tell if someone is suffering from poor mental health just by looking at them?

4. **Can you tell me a story of someone coming to your clinic or to you personally 'feeling low' or (term from above)?**
 - a. What do you think caused this feeling?
 - b. How common is this condition in the community / your work?
 - c. How normal or acceptable do you find this feeling/condition? How does the community feel about it?
 - d. What did you do to help them, and what do you think they should have done?
 - i. Was this care effective?

5. **Can you tell me about other care providers people might go to for these conditions?**
 - a. How might curandeiros, church leaders, or profetas treat this person?
 - b. Are there connections between your clinic and these traditional healers?

6. **Can you tell me about the greatest challenges for patients to seek care for 'feeling low' or (term from above)? Can you list all potential places people would go to for help?**
 - a. What do people in the community think or say about people suffering from sadness?
 - b. Why would people choose from these different providers?
 - i. Which are most effective?
 - ii. Which are most expensive?
 - iii. Which are most trusted?

7. **Can you tell me a story about someone you have heard of that suffers so much that they no longer want to live and think about hurting themselves or ending their life?**
 - a. If yes, what would you call this feeling?

- i. What do you think caused this feeling or condition?
 - ii. What can clinics, nurses, or doctors do for a person with these feelings or thoughts?
 1. Where else would you suggest a person suffering from these feelings go for help?
 - iii. How common is this in your community? How common is completed suicide?
 - b. If no, do you think this is possible in your community? What do you think might make someone feel that way?
 - c. Do you think someone might feel this way and not tell anyone?
 - d. Do you think their suffering is normal or acceptable?
- 8. Does the community provide support for people thinking of hurting themselves or so sad it makes life difficult?**
- a. Do you think these feelings are better addressed in a health-facility or in the community? Are there other ways to help with these feelings?
- 9. Can you tell me some ideas you might have to improve health facility services for people with sadness or depression?**
- a. How does the health facility staff interact with patients with mental health concerns?
- 10. Can you tell me about yourself? Where did you grow up?**
- a. Can you tell me about your job, roles, and responsibilities?
 - b. Can you share anything about your religion or your spiritual beliefs?
- 11. What made you choose to work in this profession?**

Closing Questions:

1. Is there anything you'd like to ask me about this study or otherwise?
2. Is there anything we haven't talked about today that you would like to tell me?
3. Are there other people that you think I should talk with that may have valuable perspectives and experiences surrounding this topic?