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Thesis Topic: An Evaluation of Mental Health Literacy: Seeking healthcare providers and community leaders' knowledge and attitude towards people with mental disorders and effect on access to available support services in Sierra Leone

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Abstract

Background

There continues to be call for greater community awareness actions and strategies to reduce stigma and enhanced mental health literacy nationally and globally. To identify local barriers to help-seeking and perceptions around stigma, I will develop a 'mental health attitudes and beliefs' survey which will be administer in community settings in the northern, southern, eastern regions and western areas of the Republic of Sierra Leone. The aim of the results of this survey is to inform the development of framework, policy and strategy that will enhance local help-seeking attitudes that are significant to the role of age, gender and interfaith or cultural backgrounds and believes towards mental health. A total of four data collectors and one team leader will be trained and engaged to the four regions (study area) of Sierra Leone and will invite about 200 people of different demographics including age (18 years and above) , gender, social status, health practitioners, religious leaders, and community leaders to complete the survey. The data will be analysed descriptively with a focus on comparing subgroups based on age, gender, religious believes, and previous service access or experience of mental illness. Cost, stigma, cultural and religious beliefs, and mental health literacy will be look at as potential barriers to help-seeking for the overall cohort; however, the ways in which or extent to which these barriers impact on help seeking will also be determine between subgroups. Any difference and implications for practice between the subgroups will be discussed as the focus of this study

Aim

The aim of this study is to find out the understanding and current knowledge of mental health, attitudes and beliefs of healthcare practitioners, interfaith leaders, and community leaders and how these factors impact access to the limited mental support services in Sierra Leone.

Methodology

A qualitative social research methodology will be used for his study where the research instruments will be observations, focus groups and administration of questionnaire that will be developed on a 'mental health, knowledge, attitudes, beliefs, and help seeking behaviors'. A random sampling method will be used to select and survey individuals

recruited for the study. The result of this research will be analyzing descriptively and the correlation between demographic groups in terms of help seeking attitudes established.

Implication

Presently, there is little, or no study carry out on Mental Health Literacy. The intended research will be the initial research to be conducted in West Africa and particularly in Sierra Leone and it aim to provide insights into attitudes, belief and help-seeking pattern of individual affected by mental health to mental healthcare services and systems available in Sierra Leone.

Chapter 1: Background of Research

Introduction

The official name of Sierra Leone is the Republic of Sierra Leone, with its capital city Freetown. It is situated on the West Coast of Africa, latitudes 7° and 10° North of the equator and longitudes 10.50° and 13° West. It is bordered on the North and Northeast by the Republic of Guinea, on the East and Southeast by Liberia and on the West and South by the Atlantic Ocean with a coastline stretching some 300 miles (Consulate General, 2019). It is sharing boarder northwest and east with Republic of Guinea and Southeast with Republic of Liberia, Figure 1. (Rashid, 2016).

Sierra Leone is a West African country with a population of just over 7 million (50.8% female, 40.8% <15 years, 41% urban, 51% literacy, 78% Muslim (UNFPA Sierra Leone, 2018). There are currently 16 districts the country is divided into with five regions (northwest, North, South, East, and Western Auburn). Freetown, Western Urban Area, the capital of Sierra Leone is densely populated with 1.1 million people. The population of Sierra Leone has discrete cultural beliefs and practices and with 20 local dialects. The proportion of Sierra Leoneans who live below the poverty amount to more than half of the country's population (52.9%) (UNFPA Sierra Leone, 2018).

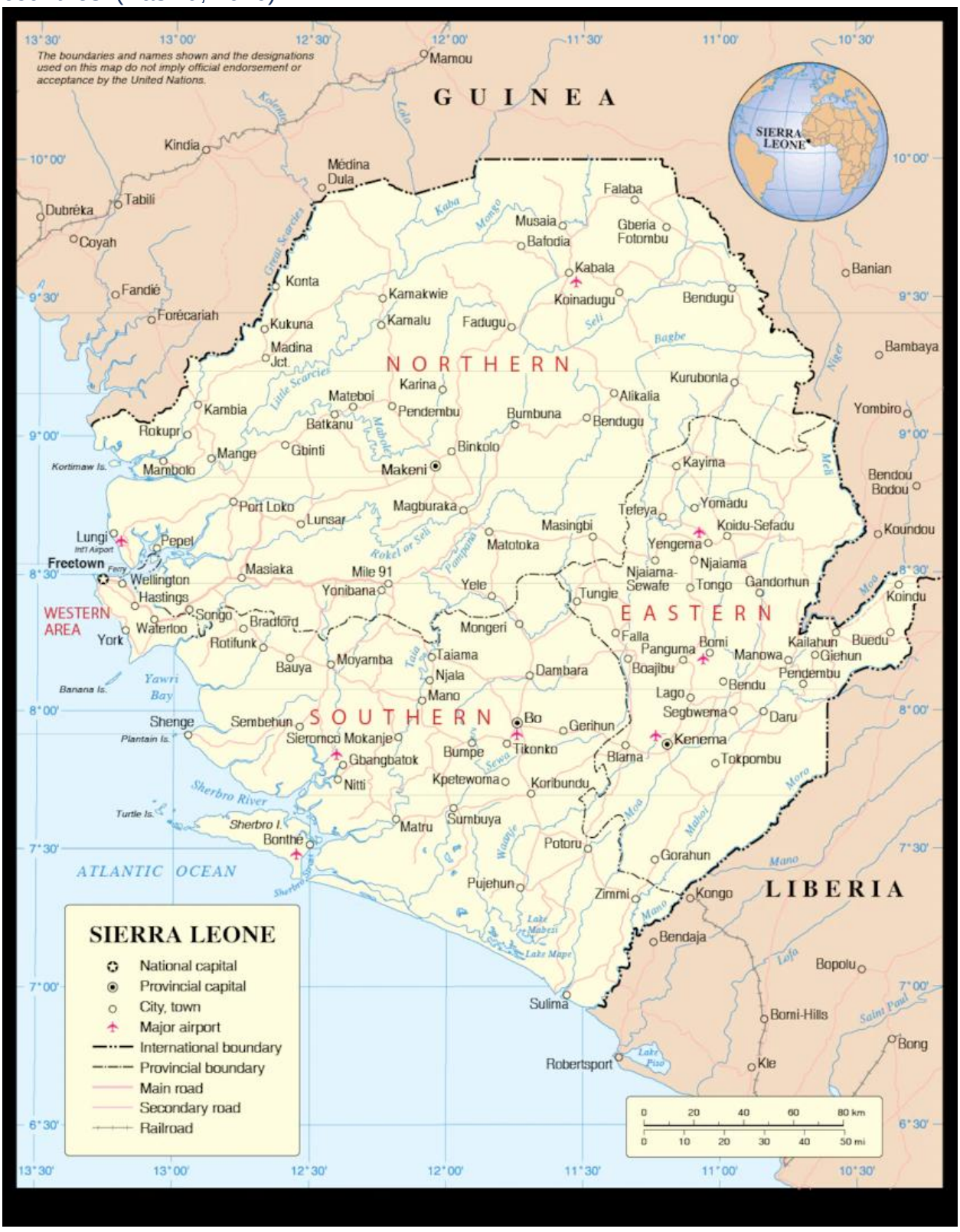
Numerous people from Sierra Leone living within or out of the country have been presented with traumatic experience that have impacted their mental health outcomes (Betancourt , McBain , Newnham , & Brennan, 2015). Sierra Leone have experienced a decade-long civil war which concluded in 2002 following cease fire and peaceful return of democratic government. Recently, in 2014 the country also experiences Ebola epidemic (Mohamed F Jalloh, 2018), followed by dangerous mudslide in August 2017 that resulted to 1,141 dead and many injuries or never recover (Bruce, 2019). The impact of mental health impact due to COVID-19 pandemic and quarantining on adults, children, and young people (CYP) living in low- and middle-income countries (LMICs) has yet to totally be researched and comprehended (Darren Sharpe, 2021).

Mental health and substance that are frequently abused Ike, alcohol, marijuana, and tramadol amount a huge burden of disease, constituting to 23% of disability-related burden (years lived with a disability, YLD) internationally and 19% in sub-Saharan Africa (Helen Hopwood, 2021). The treatment gap is peaked in low- and middle-socioeconomic states, ranging from 76.3 to 85.4%, and studies on mental health support services in these states is limited (Helen Hopwood, 2021). The gap is linked to human resource constraints, stigma, weak technology and infrastructure, lack of state administrative commitment, culture and traditional beliefs, and lack of research to guide policy formulation and implementation, Figure 2.

Severe mental health issues in Sierra Leone have an estimated treatment gap of 98% (WHO Siera Leone, 2012). Dating back to 1820, during colonial days, the mental healthcare was delivered at 'Kissy Lunatic Asylum' which was the oldest asylum in sub-Saharan Africa (Akyeampong, Hill, & Kleinman, 2015). This Centre has now been restructured as the Sierra Leone Psychiatric Hospital (SLPH), and is still Sierra Leone's single in-patient Centre, catering for up to 150 client capacities. SLPH is highly stigmatized and is grossly underfunded, with inadequate human resources, a lack of basic facilities and frequent interruptions to medication supplies. There is an urgent need to review the Lunacy Act, an outdated colonial law that is yet to be amended in the Laws of Sierra Leone, since it was enacted in 1902. This was a era wherein mental health was classified as a communicable illness and management and treatment of these clients requires exclusion from the general community and being chain and caged (Bangura, 2021).

Stigma towards mental illness is a major issue and mental health literacy is extremely low. Mental illness is viewed as something that is brought upon oneself or as the result of supernatural activity (WHO Siera Leone, 2012).

Figure 1: Map of Sierra Leone showing various District and regions with neighboring countries. (Rashid, 2016)



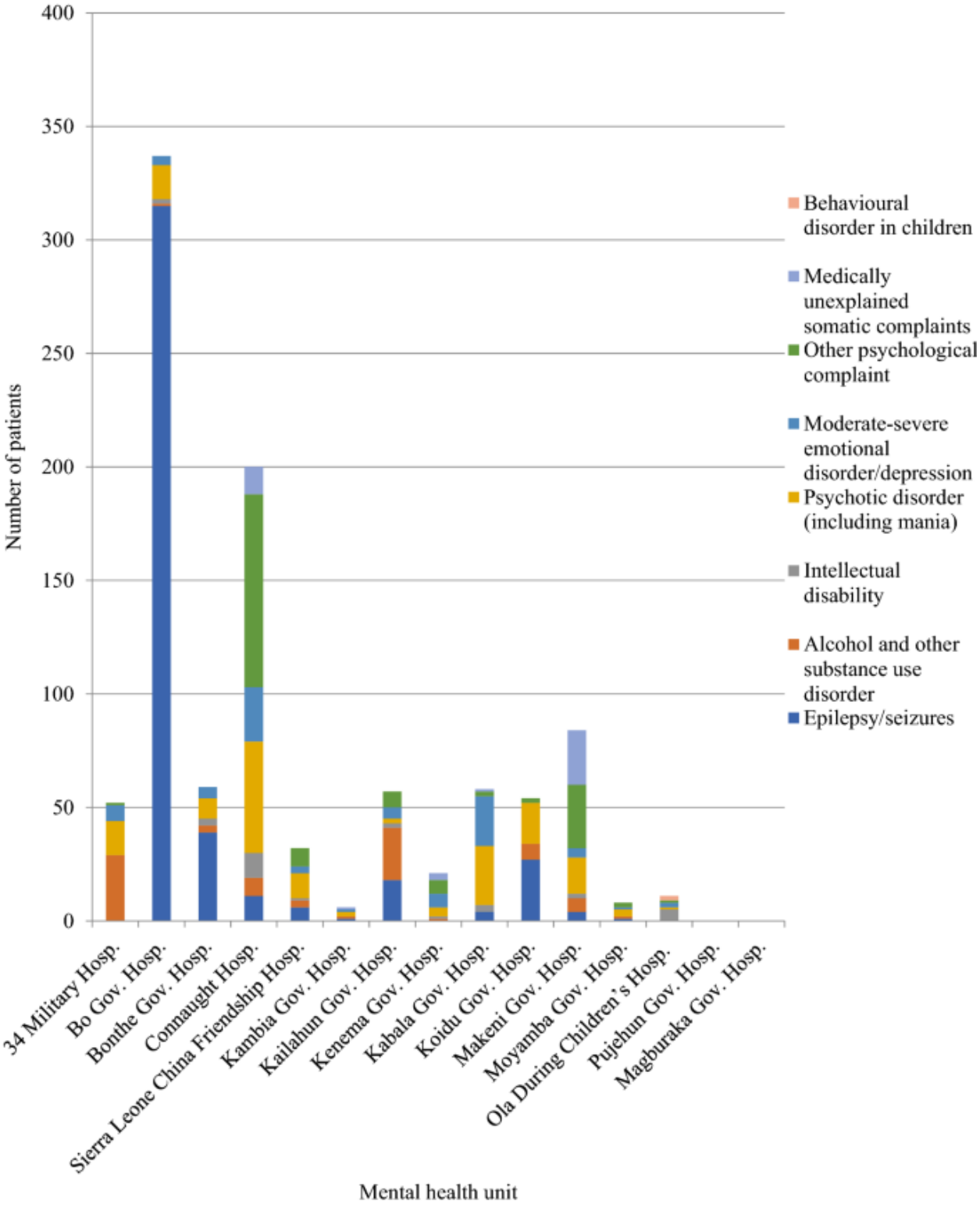

400
350
300
250
200
150
100
50
0
Number of patients
Behavioural disorder in children
Medically unexplained somatic complaints
Other psychological complaint
Moderate-severe emotional disorder/depression
Psychotic disorder (including mania)
Intellectual disability
Alcohol and other substance use disorder
Epilepsy/seizures
34 Military Hosp.
Bo Gov. Hosp.
Bonthe Gov. Hosp.
Connaught Hosp.
Sierra Leone China Friendship Hosp.
Kambia Gov. Hosp.
Kailahun Gov. Hosp.
Kenema Gov. Hosp.
Kabala Gov. Hosp.
Koidu Gov. Hosp.
Makeni Gov. Hosp.
Moyamba Gov. Hosp.
Ola During Children's Hosp.
Pujehun Gov. Hosp.
Magburaka Gov. Hosp.
Mental health unit

Figure 2: Referrals by diagnosis and mental health unit—number of referrals to all mental health units in 2015 and 2016; by diagnosis (Helen Hopwood, 2021)

A person exhibiting symptoms of mental illness may be called 'crezman' or 'ful ful' (pejorative terms indicating that the person is crazy or a fool). By the time patients present to formal mental health services it is usually after considerable investment at home or with one of the 45,000 traditional healers in the country (The New Humanitarian , 2019).

Rationale of the Study

My best childhood friend had died recently from mental health related issues in Sierra Leone. Prior to his death, I was intending to carry out a study in 'health literacy' covering communicable and non-communicable diseases including mental health.

In Sierra Leone, mental health issues are generally believed to be caused by 'witchcraft or demons. That's why people refer to those presented with mental health problems as "noto ospitul sik" (an expression in Krio local language) – an illness that cannot be treated in a hospital due, supposedly, to its transcendental or spiritual nature (The New Humanitarian , 2019).

The knowledge of Mental health Literacy is limited, and services are also very few and outdated in Sierra Leone, irrespective the great demand for mental health care. Moreover, there are only two working psychiatrists, and the first psychiatric nurses in the country were only recently trained. People presented with psychosocial disabilities are usually ostracized from others in their communities, and human rights abuses are also common (Mental Health Coalition, 2021).

Sierra Leone has experienced over the past three decades, two big humanitarian crises: a ten-year civil war (1991–2002) and an Ebola virus disease epidemic (2014–2015). Furthermore, the capital of Freetown experienced a mudslide affecting thousands of people in 2017 (Hélène & Brink, 2019). Very recently is the COVID 19 Global Pandemic directly or indirectly impacting the people of Sierra Leone and their loved ones. As a way of responding to these emergencies, global aid agencies showed an increased interest in supporting and implementing mental health and psychosocial support interventions. Irrespective of these measures, the mental health service delivery of the country remains to be substantially poor. Specifically, systemic improvements in the implementation of evidence-based mental health care for children and adolescents appear to be lacking.

Health literacy (HL) is about healthcare practitioners talking to people in a way that meets each person's needs, and not using medical jargons and terminologies that may confuse people or be misunderstood (Healthy North Coast & phn, 2021).

The concept of Mental Health Literacy (MHL), arising from Health Literacy, and is also evolving. Traditionally MHL was conceptualized as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Kutcher, Wei, & Coniglio, 2016) later this concept is redefined to comprise of knowledge that benefits the mental health of a person or significant others involving : knowledge of how to prevent a mental disorder; recognition of disorders when developing; knowledge of effective self-help strategies for mild-to-moderate problems; and first aid skills to help others

Hence, the concept of Mental health literacy broadly covers:

- Capacity to identify mental and physical health conditions.
- Ability to understand what professional support is available and how to access it.
- Understanding risk factors and causes of mental health, and how to find mental and physical health information.
- Attitudes that promote recognising of mental ill-health and appropriate help-seeking behaviours.

Health data can be difficult to understand if the communities are not trained in health literacy. The right mental health support services can be hard to access. If individual and communities lack knowledge in Mental Health Literacy, they cannot help people to improve their health or stop their health getting worse (Healthy North Coast & phn, 2021).

The research therefore will seek to listen to people who have a lived experience of mental ill-health, their immediate communities and their caregivers and kinsmen, to understand their experiences, attitudes, beliefs, their understanding of mental health and help seeking behaviours. The information gathered and analysed outcomes will be useful to workshopped with people with a lived experience of mental ill-health and healthcare providers to come up with a range of ideas to improve their experience. Community Mental Health Literacy education and training activities will then be developed for healthcare providers, tertiary institution to improve their competencies in mental health literacy based on the outcomes this study.

Current Information - Literature Review

Limitation of Mental Health Literacy (MHL) Study Intervention

Taking note on how to adequately determine the effect on MHL has been an ongoing issue with the application of MHL programs and activities. However, currently , most review of MHL interventions identify in the literature have not squarely addressed all the components of MHL, which is debated can be measured concurrently, as these

components are so closely linked within the defined rubric of MHL. (Kutcher, Wei, & Coniglio, 2016) It is still unknown which types of interventions currently being utilized may be expected to most comprehensively improve MHL, rather than just address a limited number of components of MHL. Further research should be designed to help answer that question.

Other gaps look at MHL measurement instrument themselves. One of the authors recently studied and analyzed the literature, found out over 400 MHL research studies (including those that focused on knowledge, attitudes, and help-seeking respectively) and reported that most have not look at assessment instrument of adequate psychometric properties. This makes it challenging to adequately address the authority of the results reported. Moreover, many of the measurement instrument used nowadays to evaluate MHL may not adequately capture all the components of MHL. Those research that has used the diagnostic vignette approach popularize (Kutcher, Wei, & Coniglio, 2016) where participants are provided brief vignettes about people with depression or schizophrenia (sometimes also including attention-deficit hyperactivity disorder or anxiety disorder) and are asked to identify the disorder and answer questions about its etiology or treatment. Hence the whole sphere of what makes MHL cannot be evaluated by this strategy which looked at a small number of disorders, does not consider mental health promotion, and neglects the importance of being able to distinguish a mental disorder from a mental health problem or even the experience of daily distress. The popular application of these diagnostic vignettes as study outcome instrument does not provide evidence that those strategies can be considered to have acceptable MHL. Study using other review skills such as true or false answers to questions covering diverse spheres of MHL are less prevalent but may produce a quicker re view of the whole MHL construct. However, further study is needed to explain this significant issue

Gaps in Mental Health Service Delivery in Sierra Leone

In Sierra Leone, mental health support services are short supply and limited, despite the great demand for mental health care. In 2002, the World Health Organization projected that 500,000 people were impacted with mental health issues; 2% of the country's demographics were suffering from psychosis, 4% serious depression, 4% substance abuse issues, 1% psychosocial impairment, and 1% epilepsy (Pearson, Eaton, Sesay, Campbell, & Pearson, 2015). Due to long-lasting violence of the 1991–2002 arm conflict left post traumatic stress disorder on the nation's psychological well-being. More recently, the country experiences a horrific and terrifying Ebola virus disease epidemics, which has also had a serious effect on the well-being of individuals and communities and recently the COVID 19 Pandemic. Current Mental Health services are limited to one psychiatric hospital, do not meet the needs either for specialist care or in terms of accessibility for most of the country. When measured using disability-adjusted life years, neuropsychiatric

disorders represent the most disabling conditions among non-communicable diseases. Looking from the lenses of economic and social factors, there is major evidence based that this has a catastrophic effect on a country's development and is a major barrier to achievement of the global development objectives .

Irrespective of the endorsement of the Convention on the Rights of Persons with Disabilities by Sierra Leone in 2010, persons with psychosocial impairments are often excluded from their communities, and human rights abuse and discrimination like those in other areas of the West African region, such as chaining or lack of access to evidence-based treatment, are common (Pearson, Eaton, Sesay, Campbell, & Pearson, 2015). Traditional beliefs and treatment approaches that attribute mental illness to spiritual causes and often blame the person living with the mental health problem contribute to these realities. Lack of community awareness and negative attitudes surrounding mental illnesses underlie high levels of stigma and discrimination against people with mental health problems in Sierra Leone.

Mental Health Governance and Leadership in Sierra Leone

At present, there is no discrete mental health budget line item at the level of the ministry of Health and Sanitation (MoHS) or the District Health Management Teams (Dawn Harris, 2020). Psychotropics are added on the procurement of essential medications, however these have not normally been included on the medication list by the MoHS; most mental health medication in the country are given by aid agencies. The limited provision of mental health funding and an acute supply of mental health medication at the district level are major barriers for accessing treatment. Limited choice and control at all levels hinder the provision of quality services and the retention and motivation of mental health workers (Dawn Harris, 2020)

The national Mental Health Policy was launched in 2012, with a revised Mental Health Policy and Strategic Plan in progress of completion by 2019 (Dawn Harris, 2020). Mental health has always remained to be the Basic Package of Essential Healthcare Services and various other national strategic policies and plans.

The directorate for Noncommunicable Diseases and Mental Health was formed within the Ministry of Health and Sanitation (MoHS) in December 2016 to managed services and oversee partnerships with mental health services delivery and provision (Dawn Harris, 2020). The Directorate has also been in the process of formulating a new mental health legislation with the aim of protecting the human rights of people with mental illnesses and freedom from abuse and exclusion from community. District administration are being set up to act as advocates for mental health in their local area.

Status of Mental Health Workforce in Sierra Leone

The World Health Organisation projected about 10% of the seven million population of Sierra Leone are presented with mental health problems. Moreover, due to the undeclared number of undiagnosed cases, the actual data on depression, anxiety, or post-traumatic stress disorder (PTSD) may be much greater. For many years, there was only one psychiatrist practising in the country. Recently, the country now has two practicing psychiatrist and he standard practiced of treatment in the only psychiatric hospital before these times involved restrictive practice of patients using chains due to the unavailability of psychotropic drugs. Consequently, almost 99% of those impacted by mental health go undiagnosed adequately and untreated. Instead, spiritual beliefs drive those in need into the shrines of the country's 45,000 traditional healers (The New Humanitarian , 2019).

About twenty-one mental health nurses were confers with either certificate- or diploma-level qualifications in 2012/13 from the College of Medicine and Allied Health Sciences (COMAHS) in Freetown (Dawn Harris, 2020). Two nurses out of this cohort died, leaving nineteen in clinical practice. Two further mental health nurses have trained abroad. There is a second batch of eight nurses who started their mental health training with COMAHS in January 2019. Furthermore, eight healthcare professionals have completed an MSc in child and adolescent mental health (CAMH) in Nigeria. However, only one nurse continues to practice solely as a CAMH specialist. Diploma in counselling psychology is currently being offered at the University of Makeni.

One can conclude that, there are less than 100 health care professionals who are trained in Mental Health in Sierra Leone. None of these mental healthcare practitioners have received specific training in Mental Health Literacy (MHL).

The two Sierra Leonean psychiatrists who returned to the country after finishing their specialist training in 2016: one is appointed as the medical director at SLPH and the other who is a military officer works at military medical services- 34 hospital (Mohamed F Jalloh, 2018). Unfortunately, there are no clinical psychologists or psychiatric social workers in public service in Sierra Leone.

Sierra Leone currently do not have capacity for training staff and skills sets to resources staff for growing number of mental health cases. The limited supply of educational opportunities and academicians for training and supervision is a challenge. Sierra Leone lacks the capacity and systems to run specialist training of additional psychiatrists that

may be required at regional and district levels. Moreover, many of those who finished the certificate/diploma training may have not gained the professionally recognised and added on payroll as mental health nurses. A curriculum has been revised for specialist community health officers (CHOs) however training is yet to commence. CHOs deliver most of the primary health care services and they are critical for planning the future mental health workforce.

Research Design and Methodology

Aim of the Research

The aim of this study is to find out the level of Mental Health Literacy, the understanding and current knowledge of mental health, attitudes and beliefs of healthcare practitioners, interfaith leaders, and community leaders and how these impact access to the limited mental support services in Sierra Leone

To address this aim, the proposed study will seek to answer the following research questions.

1. What is the current knowledge and understand on how to recognize, Identify mental illness and symptoms?
2. What is the current knowledge and understanding of the causes, risk factors of mental illness?
3. What is the current knowledge around options for self-treatment and seeking professional treatment, and sources of information about mental illness?
4. What are the attitudes and behaviors about mental illness, sufferers, and help-seeking?
5. What are some mental health education programs and activities that are relevant and suitable for demographic age groups?

Methodology

This research proposal is intended to understand Mental Health Literacy in Sierra Leone. Therefore, responsible factors such identification of signs and symptoms of mental health, risk factors, beliefs, attitudes, and help seeking behaviors are needed to be identified. To collect the necessary data from the target demographics, I will apply a qualitative research framework focusing on qualitative interviews using in-depth questioners, focus group and observation. Before my fieldwork begins, contact will be established via email and telephone with agencies providing mental health related services. These organisations will be identified using the researchers' networks in in Sierra Leone as well as indirectly through the knowledge of mental health and organizations such as; Sierra Leone Psychiatric Hospital (SLPH), The Mental Health Coalition - Sierra Leone (MHC), Ministry of Health and Sanitation (MoHS) for ethics clearance , Ministry of Youth and Sports, the

Inter-religious Council of Sierra Leone (IRCSL), the Council of Churches in Sierra Leone (CCSL), Motorbike Riders Associations and Traditional healers and leaders tht are associated to mental health . Contact has already been established with some key Academic staff members from Njala University and College of Medicine and Allied Health Sciences (COMAHS), University of Sierra Leone. It is important to note however that these organizations and individual are not partners/or collaborators to the project, but researcher aim to interview individuals from these organizations who are willing to partake in he study to seek their knowledge in mental health literacy and to obtain primary and secondary data from them with their informed consent.

A team of five data collectors comprising graduate from Njala university will be recruited and trained to collect data ethically and with integrity.

The fieldwork research methods will primarily involve he administration of semi-structured face-to-face interviews with individual participants in the qualitative tradition. Approximately 200 participants will be asked open-ended questions to gain valuable insight into their understanding of mental health literacy. The interviewing will involve a 'ground theory' method (Tie, Birks, & Francis, 2019), utilizing semi-structured, open questioning designed to elicit responses from interviewees on the key research issues. Ground theory methodology is particularly well-suited to research into social phenomenon where there is little or related research. The research questions administration will vary according to participants and situations and will be developed in the light of the findings of the research in progress but will be based upon standard interview questions set prior to my fieldwork.

Method of recruitment

Given the scope of this study, not all district of Sierra Leonean will be involved in this research. Instead, this research will focus on selected participants through community organisations listed above, and they will form the total population of my research. In this study I will conduct face-to-face individual interviews with participants from ages ranging from 18-65 years.

These participants will be invited to take part in this study voluntarily through advertisements on the Lalor Community Library noticeboard and through local asylum seeker and aid agencies. The interviews with the participants will last between thirty and sixty minutes and will be conducted in a place where they feel comfortable, for instance Community Library or Centre. Information will be also given to each participant explaining the nature of the study and will be informed that the interviews will be audio-recorded. Interviews will be digitally recorded, and written notes of interviews will also be taken. Translators will be used where necessary. Interviewees will be informed that, to protect their identity, they need to provide an assumed name. Each participant will be provided

with a consent form in English and a withdrawal form stating that they might withdraw from the study at any point if they feel apprehensive

Inclusion and Exclusion criteria.

Inclusion Criteria:

- Male and female adult (at least 18years old) Mental health survivors. Mental health Survivor status will be confirmed by the presentation of their hospital discharge certificates.
- Conventional including Mental healthcare providers and traditional healers that are involved in providing care to people presented with Mental Health issues.
- Individuals in the transport industry and motorbike riders
- Community and traditional leaders
- Interfaith and religious leaders

Exclusion Criteria:

- Mental Health Survivors presenting with post traumatic disorder (PTSD) that make it impossible to accurately provide information or participate in the study. For instance, those presented with cognitive impairments and other disabilities
- Anyone who do not consent formally to the study.
- Where there is significant conflict of interest identified.
- Interviewee who is not able to verbally express themselves as this study do not cater for sign interpreters
- Children under the age of 18 years
- Individuals that are physical ill, distress or aggressive

Data analysis

All interviews conducted will be transcribed and then descriptively analyze and the correlation between demographic groups in terms of help seeking attitudes, behaviors and beliefs established. Interviewers' impressionistic notes will accompany the transcription to record some sense of what is not said, and how it is said, alongside what is said. The empirical data collected through my fieldwork will be analysed progressively and comparatively in the light of successive fieldwork in the different studies in other parts of the world.

Proposed Research Outcome

This project proposal for the evaluation of mental health literacy is a well-designed, innovative study that will provide the understanding of the current knowledge of mental health, attitudes and beliefs of healthcare practitioners, people with lived experience, interfaith leaders, and community leaders and how this impact is used to addressing their healthcare needs.

It will provide insights to a health condition of international significant, which will receive enough research attention.

The project will provide outcomes to inform relevance to policy makers, mental health educators, and clinical stakeholders in similar countries like Sierra Leone

Proposed Research Beneficiaries

Policy makers, Mental health law reform in Sierra Leone, Universities, medical educators, and clinical stakeholders providing care to people affected by mental health and survivors of mental health illness will benefit from this research.

Resources required conducting the research

Resources for this PhD research project is partially provided by scholarship obtained from enrolment at Atlantic International University (AIU) and from personal investment as savings of Researcher.

The University will provide me with technological infrastructure and facilities to support my research including libraries, online platform, zoom access for thesis presentation and defending, academic advisers and supervisors, ethics approval letter, platform (student blog) to publish paper and many more resources. These resources will facilitate much of the regular collaboration by email, video, and telephone conferences.

Ethical Considerations

An application will be made to Atlantic International University Human Research Ethics Committees for an approval to conduct the research. This research will be based on Mental Health Literacy in Sierra Leone, therefor data will be collected in Sierra Leone by recruited and trained data collectors.

A Research ethics application will be made with the appropriate regulating body (Ministry of Health and Sanitation) in Sierra Leone before data collection can commence. As part of the application, it will be explained that participants in the research will be given written and oral information about the study, as well as confidentiality and the ability to withdraw consent. Participants will be observed during the interviews for signs of distress and reassured that participation and discussion will be confidential and will not affect their status. All the participants will be treated in accordance with the ethical guidelines approved by the Human Research Ethics Committee of the University. The privacy and confidentiality of the informants will be firmly observed during the research. Furthermore, I will explain to all participants selected to take part all the details of my study, particularly the problems inherent. I will not misuse the data provided by the participants by using them for non-academic purposes. At the beginning of the interviews, I will have to explain the process of the interview to the participants. In brief, the participants will be informed of this research and that they have the right to stop during an interview at any time if they

feel uncomfortable and they will be referred to local community counselling agencies for help.

Researchers aim to have an informed consent of each individual participating in the research. Hence, for illiterate participants, the rationale and aim of the research will be explained in creole (–Sierra Leone common language spoken on the streets) before asking their consent to participate. Signing and thumb printing (for illiterate participants) the consent form will be consider as an expression of their willingness to participate. In the rural areas, written consent from married female participants will not only be obtained from her but a verbal consent from her husband or an elder in the community will be first sought. Also, verbal consent from community leaders/elders and written approval from local healthcare authorities especially in rural areas is required prior to commencing the study in that such areas. Meeting with community stakeholders to inform them about my research is important to ensure the smooth running of my interviews in these areas.

To maintain confidentiality, information obtained from interviewees will be kept in a secured file on computer that is password-protected, and survey responses will be anonymous with each interviews given a unique number to identify them instead of their details. Moreover, contact details such as names, address, phone numbers and date of birth of participants will not be collected, and no potential risk or discomfort will occur to those that participate.

Data type, where it is kept and participant Privacy and Confidentiality

Re-identifiable and non-identifiable data will be sauced at the point of data collection. The rationale for collecting this kind of data is to make follow up on issues I may need further clarification.

All data collected will be coded to make it non-identifiable. Data will be kept in the following formats.

- Electronic/digital recording,
- Handwritten notes,
- Paper questionnaires/Surveys and
- Transcripts of tapes/recordings.

My academic supervisor and I will have access to the unprocessed information.

To ensure confidentiality, data collected from participants will be stored in a secured file using a password protected computer It will also be stored in a password protected online AIU data storage platform called Merlin Media center which is the place where all the AIU content is compiled for easy access, powered by an algorithm. All data collected for this project will be destroyed after five years of publication of the findings (31/11/2027)

Survey responses will be anonymous with each participant given an identification number. Also, the names of participants will not be collected, and no potential risk or discomfort will occur to those that participate.

The name of participant will not be mentioned in the recordings during the focus group discussion sessions and in-depth interviews. For the focus group discussion, a mutually agreed place such a town hall or community hall or classroom at a school, college or university that is quiet and with no distractions. For the survey, coded data will be used for data analysis and publication.

For qualitative data collected, the identity of participant will only be known by me and my supervivors as well are relatively high for me to identify participants but not possible for anyone as only analysed and summarized results are going to be made public. Also, the name of participant will not be mentioned in the recordings during the focus group discussion sessions and in-depth interviews. To maintain participant privacy, and confidentiality, only coded aggregate data will be published or share to the public.

Possible Risk Harm to Interviewees

Emotional discomfort as Mental Health patient, careers and relative, community members can reflect on their post traumatic experience during interview session. Remembering their physical and emotional traumatic experience during the ten-year-old civil war, Ebola epidemic, mudslide, substance use effect and impact of recent COVID 19 Pandemic. Some individuals would have been admitted to mental health word or hospital and post discharge are presented with physical and emotional impact, stigma, isolation, and discrimination they faced from their families' communities and some cases healthcare professionals. Remembering their experience or answering questions pertaining to those sensitive issues would likely cause some emotional discomfort.

Mental Health and psychosocial disabilities including subject such as Mental Health Literacy seems to be a taboo and as such most people do not feel comfortable to talk about such topic.

Proposed ways to reduce and/or manage the risks

- Firstly, interviewee will be appropriately advised in the introductory remarks that the interview session will be stopped during the interview if anyone feels uncomfortable or experience emotional distress.
- Data collectors will stop interview session if an interviewee begins to be uncomfortable or experience emotional distress and continue when he/she feels comfortable to continue.
- In a case of medical distress, interviewees will be referred to the nearest public health facility. If serious, an ambulance will be called to take participants to the nearest public hospital. Any Ambulance fee will be incurred by researcher

- If individuals who are excluded from the study, will be offered an appropriate psychological or social service referral located at the Ministry of Social welfare, gender, and women's affair.
- The telephone screening guide will be developed to include a brief wordings informing individuals experiencing "significant stress or severe emotional distress" not to participate because the subject might be sensitive and may cause interviewees to recollect.
- A brief intervention including asking four loosely structured questions to determine whether individuals were experiencing significant stress, severe emotional problems, abuse in a current relationship, or thoughts of harming themselves.
- In addition, participant will be asked of any prescribed psychiatric medications and recent psychiatric hospitalizations.
- Every participant will be asked: "Are there any reasons you can think of that might make participating in interviews about your experience as an Mental Health survivor or caregiver/family/community members too stressful for you?"
- Another risk mitigation strategy is that interviews are going to be conducted in a mutually agreed location where participants feel comfortable and safe to respond and discuss issues pertaining the research.
- Data collectors will create a reflective journal to document a reflection of their experiences throughout the interview process. This will be used as a source of feedback on how the interview process can be improved.
- Also, I will setup debriefing meetings via zoom or facetime with data collectors at the end of each session to get immediate feedback on how the process went to identify areas that can be improved.

Foreseeable risk to researcher and team, and extenuation approaches

There are situations where research volunteers and research team members can become expressive based on responses received from interviewee and their safety to be compromised. These foreseeable risks will be discussed with interviewee before data is collected. To reduce such risk the following approaches will be implemented:

- Through by effective communication strategies, (email and telephone) contacts will be made to individual to ascertain their capacity and ability to participate in the study. Some factors to consider will involve; place of resident, his/her social and economic circumstance, previous mental health experience. These factors will be considering when deciding where interviews will be conducted. In cases, where research team members feel it is unsafe to conduct the interview at the participant's home, a public venue will be

suggested. It is recommended to interview healthcare practitioners at their workplace during their spear time.

- Research Team members will use public transport to travel to areas where interviews will be conducted.
- Research Team Members will stay over in comfortable hotels/guest house/motels with a good safety record and amenities including access to wifi and reliable electricity when conducting studies outside of the capital city Freetown.
- Before carrying out the research, research team member will meet local 'community leaders' to explain the research and gain their acceptance.
- For smaller communities a contact to the local police command will be made in writing about the purpose and conduct of the research and asking for a contact telephone number.
- Research Team will be trained in awareness of the local culture, tradition and custom that may influence the conduction of research in general. For instance, verbal consent needs to be sought from the husbands of married women in rural areas.
- My volunteers and I will use a more relaxed schedule for collecting data. The essence is that researchers are more alert to risk and better able to handle incidents.
- Before conducting of interviews, Research Team members will be informed that interviewees response may trigger emotions leading to distress and in such situation, a brief intervention is required.
- Interview can be scheduled for some other day or other interviewee can be sourced

Limitations of Study

- Financial Constraints to do a large-scale study
- COVID 19 Pandemic and national as well as Global restriction on international travels (Researcher will not be present during data collection)
- Lack of reliable and high-speed internet facilities in most part of Sierra Leone for easy communication
- Use of paper questionnaire and not electronic questionnaire like survey monkey that can easily analyze data.
- Mental Health Literacy subject is a taboo for most communities in Sierra Leone and as such people do not feel comfortable most times to discussed.

Research Paper Activities and Status

Research Activities	2019 (Year 0)		2020 (Year1)		2021 (Year 2)		2022 (Year 3)	
	S1	S2	S1	S2	S1	S2	S1	S2
Developing Research question								
Research Integrity Course works								
Gathering relevant Literature Review								
Research Proposal								
Developing Research Methodology								
Ethics Clearance								
Undertaking Data Collection								
Data Analysis, and manuscript writing and publication								
Thesis writing								
Viva Preparations and Presentation of Thesis								
Thesis Amendments								
Thesis submission								

S1 = Semester 1, **S2** = Semester 2. This project is **presently at S2, 2021 (Year 2)**

Green = Activity actioned

Yellow. = Activity partially actioned

Red = Activity not yet actioned

Note: Colors use in timeline is based on Australia Traffic Management System

Each Semester has two terms

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