



**Exploring Perceptions of Help-Seeking for Mental Health Care Among Young Adults in  
Maputo, Mozambique**

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## **Abstract**

The aim of this research was to gain an understanding of the general perceptions, barriers, and facilitators to seeking mental health care among young adults in Maputo, Mozambique. In the context of the pandemic, semi-structured interviews were conducted using the voice note feature on the mobile application WhatsApp. Participants were recruited using purposive and snowball sampling, with the initial participants originating from a social media-led mental health organisation based in the city. The participants' ages ranged from nineteen to thirty and all identified as female. The study employed a phenomenological approach and used theoretical models such as the Behavioural Model of Health Service Utilisation and the Social Identity Perspective to conceptualise and analyse the data.

In comparison to studies of mental health help-seeking both globally and in low to middle-income countries, the participants shared similar perceptions surrounding perceived attitudinal and structural barriers and facilitators to seeking mental health care. Participants provided accounts of the different attitudinal barriers such as stigma, societal norms, and perceptions of care. Perceived structural barriers included the availability and affordability of care, with the latter pertaining to private services. Although barriers such as stigma and cultural and religious norms did not directly affect most participants, the importance of addressing them in the broader public was acknowledged. Facilitating factors for seeking care, such as social support, financial alternatives, and access to information proved to assist help-seekers in their search for care. The benefits of the internet and social media as sources of information and network were outlined. From this research, it was concluded that multiple aspects of the help-seeking process may be improved to increase better outcomes for those who need care. Increasing public mental health literacy in a socio-culturally sensitive manner, standardising care, and creating more mental health services in clinics and places of employment or education may contribute to the ease of people's journey to look after their mental health.

## **Dedication and Acknowledgements**

I dedicate this work to Maputo, my first home, my family, friends and to the people working to make mental health care a priority.

First, I would like to thank the incredible participants who took some of their own time to contribute their thoughts and ideas on this topic; I appreciate you so much. A huge thank you to Eu, Tu e a Depressão for your help in spreading the word on this research and for being an anchor for the beginning of this work.

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## **Plagiarism Declaration**

This work has not been previously submitted in whole, or in part, for the award of any degree. Care was made to include citations and references of every author from whose work I had drawn. I hereby present this thesis as my own work.

Signed by candidate

Signed:

Date 13/08/2022

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## **Chapter 1: Introduction**

### **1.1 Introduction**

Mental health care and its coverage in Mozambique have made notable strides in the past 30 years, given the post-war context and size of the country. However, the mental health care system still faces challenges regarding financial and human resources. This poses a problem in terms of the high burden of mental health problems among the Mozambican population (Pires et al., 2020). Among the countries in the sub-Saharan region, Mozambique is estimated to have the highest rates of suicide [WHO], 2014). Research suggests that a more comprehensive look at the relationship between care-seekers and mental health services in Mozambique is needed to understand local perceptions, attitudes and help-seeking behaviour, and the ways to provide contextually pertinent interventions (Honwana, 2006; Pires et al., 2020). This study explores perceptions of mental health help-seeking among young adults in Mozambique, in the capital city of Maputo. The aim of the study was to understand how mental health and help-seeking are perceived and to gain insights into the barriers and facilitators in this process. The groundwork for these objectives was pooled from existing literature on mental health help-seeking worldwide, specifically in other low to middle-income countries. Literature on help-seeking from higher-income countries was also considered to compare the differences in perceptions towards help-seeking because of the higher availability of data from these countries.

### **1.2 Statement of the problem**

Mental health services and research faces many barriers on the African continent. Systematic reviews on existing mental health research in Africa outline a need for an increase in the research capacity in this field, including the experiences of those who navigate the current systems (Atilola, 2014). Understanding these factors may inform targeted policies and interventions that make mental health care more easily accessible, available, and preferable. These improvements may lead to better outcomes for young people who require help. Improved mental health outcomes for young people result in an overall improvement in quality of life and may translate into academic and economic capability (Mundt et al., 2002, as cited in Ghio et al., 2015).

The United Nations' Third Sustainable Development Goal under its target of "Good Health and Well-being" states that: "By 2030, to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (Mental Health Innovation Network, 2018). Due to the higher burden of mental illnesses in lower to middle-income countries such as Mozambique (Centre for Global Mental Health, 2022), it is imperative that targeted efforts are made to improve outcomes for people who live with mental disorders. Improving mental health outcomes in lower-resource settings is an essential step towards overall social development, as it directly relates to "physical health and is strongly interlinked with other development factors such as poverty, work and economic growth or peace and justice" (Votruba et al., 2016:2).

Over the past two decades, mental health professionals and researchers in Mozambique have been heading documentation and research of mental health care in the country. Although there has been a scarcity of both qualitative and quantitative data on mental health in the country, there is a movement for more research capacity. Examples of this literature include Dr Palmira dos Santos' individual and collaborative work that captures the evolution of mental health care, legislation, and service provision in Mozambique. Dr Lidia Gouveia's work has contributed to public mental health care knowledge in Mozambique, with a focus on substance abuse. Gouveia et al. (2020) recently documented the frequency of different mental illness diagnoses among services that had varying presence of mental health care, which was novel in its understanding of the pathways to diagnoses and referral. Through this study, it was also found that mental illnesses may be drastically underreported in the country and that thorough nationwide reporting of mental illness is needed. A recent collaboration between local and international researchers has successfully developed a strategy for implementing adolescent-friendly mental-health services at primary-level care in Mozambique. This study, conducted by Lovero et al. (2022), was the first to apply implementation mapping in a low to middle-income country.

In this context, this research aims to bridge the gap in understanding the perspectives of young adults who have used or have considered using the current mental health services that exist in the city.

These studies have not only provided evidence that reinforces the necessity of achieving goals in the current and past mental health policies but have paved the way for defining and solving service gaps. These include creating capacity for better national reporting systems, protective legislation, developing practical and effective mental health services at each tier, and training general practitioners and other health professionals to detect and manage patients with mental illnesses (Gouveia et al., 2020; Dos Santos et al., 2016; Pires et al., 2019).

Due to the voluntary nature of help-seeking behaviour for less severe mental health disorders, studying the perceptions of young adults towards accessing and using mental health services is crucial. Young adults' entrance and maintenance of either employment or education are also contingent on mental wellness. The synergistic effects of both may benefit the economy and overall development (Layard, 2017). The exploration of young people's relationships to mental health and the available services aims to address this knowledge gap. The information gathered may assist future research, stakeholders and mental health authorities and policy implementation.

### **1.3 Rationale and significance of the study**

Understanding the perceptions of young people about current mental health services brings into focus potential difficulties and facilitators that young people may face in their journey to seeking professional care. Young people's perceptions of different types of barriers and how they deter help-seeking is useful for contextually relevant solutions. Likewise, knowledge of facilitating factors can be used in new implementations, further strengthening models of care.

Apart from overall improved social and economic markers, the targeting of resources towards mental health care in the country benefits the individuals who use these services. Having the option of seeking quality mental health care should be an accessible right to every citizen. This form of support is especially important for current and future young adults, as they take on and maintain multiple responsibilities in an ever-changing world. Data gathered from this research may also be used to inform future interventions and policies that target young adults.

### **1.4 Main research questions**

The main aim of this research was to understand the perceptions of young people in Maputo pertaining to mental health care-seeking. The research questions are as follows:

- What are the perceptions of young people in Maputo towards mental health and help-seeking behaviour?
- What are the perceived barriers to seeking mental health for young adults in Maputo?
- What are the perceived facilitators of mental health-seeking among young adults in Maputo?

### **1.5 Research objectives**

- To gain a general understanding of young people's perceptions of mental health-seeking behaviour in Maputo.
- To explore the barriers that young people face in their desire to seek mental health care in Maputo.
- To explore factors that encourage a young person to seek mental health care in Maputo.

### **1.6 Main assumptions**

The research was based on the following assumptions. The focal assumption guiding the research question was that young adults in Maputo experience various barriers and facilitators in their decision-making to seek mental health care. It was assumed that the participants had a basic understanding of mental health and were willing to share their perspectives in relation to the research question. Due to the recent rise of mental health awareness circulating through social media globally, it was assumed that the participants would feel comfortable seeking care.

The researcher assumed that participants' attitudes to seek mental health care would be influenced by their perceptions of structural factors related to accessing services. The structural factors in question may be affordability, availability and the acceptability of the available services. The researcher assumed that participants' relationship towards seeking care is influenced by attitudinal and social factors such as societal, peer and family values that are placed on mental health and help-seeking as well as social stigma and negative associations with mental illness. Based on the researcher's understanding of the topic, the methodological assumption was that the phenomenological approach was pertinent to the nature of the research (Lincoln & Guba, 1988).

## 1.7 Clarification of concepts

**Barriers:** In this study, barriers are conceptualised as certain aspects, be they internal or external, that create difficulty for someone to access mental health care. These may be financial barriers, stigma, lack of trust or a preference for informal help (Salaheddin & Mason, 2016).

**Facilitators:** Facilitators may be conceptualised as certain structural or non-structural attributes that make it easier for someone to seek and access mental health care.

**Youth:** According to the Politic of Youth: Ministry of Youth and Sport: Republic of Mozambique (2012), youth is defined as anyone within the age range of 15–35 years. Individuals from ages 18 to 30 were invited to participate in this study.

**Mental Health:** Mental health is defined as a “state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to his or her community” (WHO, 2018, p. 1). Mental health or wellness may also refer to one’s state of psychological functioning.

**Mental health literacy:** Knowledge and skills pertaining to mental health that could help with recognition, treatment and prevention of mental health disorders (Atilola, 2014). This informs one’s familiarity with the existence of mental illness in either oneself or within their social circle or community. Mental health literacy can reduce stigma as well as encourage help-seeking behaviour (Patel, 2007). The importance of mental health literacy was an important dimension of this research as it influenced knowledge about mental health on the perceptions of mental health.

**Help-seeking:** “An internal, sequential process within the individual, moving through recognition, expression, identification of sources of help and subsequent willingness to disclose” (Mitchell et al., 2017, p. 8). In the context of mental health, help-seeking behaviour would result in the individual consulting professional help to alleviate one’s symptoms of mental health disorder. This encompasses all types of assistance within the mental health category, including primary care doctors, counsellors, psychologists, psychiatrists or similar professionals (Umbuyeyi, 2016).

## 1.8 Research design and methodology

This research employed a qualitative design, using a phenomenological approach. Purposive and snowball sampling was used to find suitable participants for this study. The participants were interviewed using the voice note feature of the WhatsApp application due to the

COVID-19 pandemic restrictions. The semi-structured interviews were conducted either in Portuguese or English. The data was transcribed and where needed; the data was translated from Portuguese to English. The data was analysed using the principles of interpretative phenomenological analysis, which is consistent with the methodological approach of the research.

## **1.9 Ethics**

Ethics in qualitative research is important at each phase of the process. “A classic definition of ethics is that ethics pertains to doing good and avoiding harm” (Beauchamp & Childress, 2001). As qualitative research involves recording data from humans, the researcher needs to make sure that these guidelines are upheld. The following ethics principles were applied to the research and are discussed in detail in Chapter 3: avoidance of harm, informed consent, privacy, confidentiality, anonymity and deception of respondents.

## **1.10 Outline of the dissertation**

The dissertation is structured as follows:

**Chapter 1:** Chapter 1 provides an overview of the entire research. It outlines the statement of the problem, research questions and core concepts of the research topic.

**Chapter 2:** Chapter 2 includes a literature review based on the themes of the research question. It describes the theoretical frameworks and policies relevant to the topic

**Chapter 3:** Chapter 3 outlines the research methodology used in the analysis of the data. This chapter describes sampling, ethics, data collection and analysis.

**Chapter 4:** Chapter 4 contains the findings of the study, including relevant excerpts from the transcripts followed by a discussion.

**Chapter 5:** Chapter 5 concludes the research, highlighting key findings. This is followed by recommendations for future research or interventions.

## **Chapter 2: Literature Review**

### **2.1 Introduction**

The purpose of this literature review is to highlight the existing research pertaining to the research topic. The literature review also aims to provide a theoretical foundation for the research objectives of this study. The topics covered include mental health-seeking in high-income and low to middle-income countries and the dominant barriers and facilitators that influence how individuals seek care, as well as the impacts of stigma and mental health literacy on seeking care. Data from help-seeking in other low to middle-income countries were included as they hold similarities with the Mozambican context regarding government spending, wealth distribution and the accessibility of social services. People in low to middle-income countries also may come from cultural contexts that do not necessarily align with the Western models of diagnosis and treatment (Osborn et al., 2020). As there are limited resources on mental health care and help-seeking in low to middle-income countries, data from higher-income countries is also referred to. To contextualise the research, an overview of mental health in low to middle-income countries is done first. This literature review also references different theoretical frameworks that inform the conceptualisation of this work, as well as the mental health policies in existence in Mozambique.

### **2.2 Mental health care in low to middle-income countries**

Worldwide, mental health concerns are growing at alarming rates. The WHO states that neuropsychiatric conditions are the leading cause of disability among young people worldwide. Untreated mental illness may lead to suicide, which is one of the leading causes of death for young people (WHO, 2022). It is for this reason that gaining an understanding of the perceptions held by those who have sought mental health care or are considering seeking mental health care is crucial. According to the WHO, to promote help-seeking in low to middle-income countries the relationship between the users and the available services, policies and practices should be explored.

Mental health literacy, policies and the levels of service implementation vary widely among low to middle-income countries. These countries have a higher burden of illness and demand for mental health care, yet have lower availability of resources than higher-income countries (Centre for Global Mental Health, 2022; Rathod et al., 2017). In the past two decades, low



and middle-income countries have been reported to comprise 85% of the world's population (Rathod et al., 2017). However, despite programmes and guidelines to minimise gaps in service provision the lack of cultural adaptability of these frameworks to non-Western contexts makes their application difficult in low to middle-income countries (Weinmann & Kusters, 2016). Contextual factors such as stigma and sparse, centralised mental health facilities present challenges in the implementation of these models. For this reason, more locally led research is needed to adapt and create working service provision models in places with lower financial resources (Weinmann & Kusters, 2016; Osborn et al., 2020).

In low to middle-income countries, the average percentage of domestic general government health expenditure that goes to mental health care is 1.1% (WHO, 2020). Of these funds, most tend to be allocated towards psychiatric facilities. Chisholm and Saxena (2012) examined existing mental health systems in low to middle-income countries. Among the countries that reported their expenditure, it was found that nearly 70% of countries in Africa, as well as 50% of countries in Southeast Asia, spent less than 1% of their allocated health budgets on mental health care (Chisholm & Saxena, 2012).

### **2.3. Mental health care in Mozambique**

According to available data, funding towards mental health from the national health care expenditure has been recorded at 0.5% in Mozambique (Dos Santos et al., 2016). The Mozambican War for Independence, followed by a civil war, had devastating effects on the Mozambican population and economy. The wars massively disrupted infrastructure and foreign investment in the country (WHO, 2009). The effects of these losses on the health care system, specifically the mental health care system, are still evident today (Sweetland et al., 2014). With steady economic growth in the decades after the war, the Ministry of Health has been able to make considerable strides to build a professional workforce and increase access to health care. The Ministry of Health pledged to increase efforts in national mental health care in the Strategy and Action Plan for Mental Health (2007–2015). Although service access has improved in recent years, a lack of financial and human resources hampers the process (Sweetland et al., 2014).

Regarding the origins of mental health care in post-war Mozambique, the major task of building a national health care system was undertaken by the government soon after

independence. The government adopted a new approach to mental health, unlike the colonial government's more exclusionary measures which separated mentally ill individuals from public spaces. The new system aimed to involve the community and promote social rehabilitation for those with mental illnesses (Dos Santos, 2011). Under the guidance of the first psychiatrist in Mozambique, Dr Custodia Mandlate, the first Commission of the Coordination of Mental Health Services was created. Nationally driven mental health initiatives were mapped out (Dos Santos, 2011). In 1990, the Programa Nacional de Saúde Mental (PNSM, or the National Mental Health Programme) was approved. This programme's objectives were to create a firm network of mental health care and psychiatric services throughout Mozambique. This programme also aimed to train health care workers in different fields, increase the capacity of those who were currently in mental health-related training and increase mental health awareness and prevention of mental illness (Dos Santos, 2011; Gouveia, 2018). The PNSM, along with a section of the Ministry of Health, subsequently trained 34 health care workers to become psychiatric technicians in a three-year programme. They then were certified to prescribe medicine, provide psychological assistance, and facilitate psychosocial integration of patients in health centres (Dos Santos, 2011; WHO, 2002).

As organisational processes evolved, by 2002 it was reported that the first 34 psychiatric technicians were working throughout the 11 provinces of Mozambique (WHO, 2002). The mental health care system was originally divided into three parts: mental health care in primary facilities and health centres, hospital services including psychiatric in-patient beds and outpatient services, and traditional healers (WHO, 2002). The two advanced psychiatric hospitals based in the Maputo and Nampula provinces were functional at this time. The structure of mental health service provision has since changed in the country. Currently, public mental health care is divided into four tiers. These are the primary care centres, district-level hospitals, provincial tertiary hospitals and quaternary care at the central hospitals and the two psychiatric hospitals based in Maputo and Nampula provinces (Lovero et al., 2022). From the district level to more advanced facilities, both inpatient and outpatient services are typically found (Gouveia et al., 2020).

The progress of service provision between 2010 and 2014 showed a marked increase in the number of beds in psychiatric hospitals. The number of mental health outpatient facilities

increased from 84 to 152 in this period (Dos Santos et al., 2016). Although there has not been a drastic increase in the number of psychiatrists in the country, the estimated number of psychologists doubled during this time (Dos Santos et al., 2016). As the implementation of task-shifting to psychiatric technicians continued, it proved to be affordable and sustainable, with the number of psychiatric technicians growing from 66 to 241 by 2014 (Dos Santos et al., 2016). The increase in psychiatric technicians succeeded in reaching more people in primary care facilities all over the country (Dos Santos et al., 2016; Wagenaar et al., 2016). Although this coverage was an improvement, the current numbers of mental health specialists are still insufficient. Only 1.7 mental health professionals to every 100 000 people have been reported (Dos Santos et al., 2016; Lovero, 2022). In addition, the number of primary health care services throughout the country does not meet the population's requirements (Gouveia, 2020). According to Gouveia (2020), in collaboration with the current national policies in action, more research on the prevalence of mental health disorders, detection, affected populations and interventions is needed. This will make it possible to effectively map out the use of scarce resources, such as funding and trained personnel, to diagnose and assist as many people as possible.

#### **2.4 Young adults and mental health help-seeking**

According to the largest global meta-analysis on the age of onset for mental disorders, “the global onset of the first mental disorder occurs before age 14 in one-third of individuals, age 18 in almost half (48.4%) and before age 25 in more than half (62.5%), with a peak/median age at onset of 14.5–8 years across all mental disorders’ (Solmi et al., 2021: 285). Although there has been a global increase in mental health awareness, youth perspectives on seeking care are highly dependent on multiple factors. In higher-income countries, it was found that those who fall between adolescence and adulthood – typically individuals aged 16–30 – are the least likely to seek mental health treatment (Salaheddin & Mason, 2016; Vanheusden et al., 2008; Stunden et al., 2020). This age cohort cited barriers such as stigma, difficulty sharing their problems and the desire for self-reliance when experiencing symptoms (Salaheddin & Mason, 2016). The nature of some mental illnesses may compound these barriers, making seeking care psychologically more difficult (Stunden et al., 2020). However, Andrade et al. (2014) found that young adults were more capable of recognising the need for treatment globally, but faced more structural barriers than older adults, making it more difficult to access care. These structural barriers included limited economic resources and

employment. Young adults may find it more difficult to fund their consultations and treatment, excluding them from care (Copeland et al., 2015).

The negative effects of untreated mental disorders may seep into every aspect of a young person's life. Untreated mental health problems may induce a cycle of youth faltering academically, leading to a lack of employment. This may further mental health problems into adulthood (Fazel et al., 2014). It was found that individuals who had received medical treatment for their mental health problems showed an improvement in depressive symptoms. As a result, this led to better recovery of work, home management and social and leisure activities (Mundt et al., 2002 as cited in Ghio et al., 2015). For this reason, increasing the availability of services, as well as understanding the journey to seek care in this age group, is imperative as the implications of untreated mental health problems may have dire consequences.

## **2.5 Help-seeking in low to middle-income countries**

Studying help-seeking barriers and facilitators from low to middle-income countries draws from a pool of experiences that may extend similarly to Mozambique. This is especially relevant due to the scarcity of literature surrounding help-seeking for youth mental health care in the sub-Saharan context and lower-income countries. Contextual similarities may include government prioritisation and structures of mental health initiatives and services, as well as possible cultural and social variants that influence help-seeking by young people in low to middle-income countries.

In low to middle-income countries, mental health awareness is still considered rare and where it exists, it is mostly concentrated in cities (Patel, 2007; McCann et al., 2016). In addition, young people in low to middle-income countries may experience structural barriers such as the lack of available public services or financial exclusion of private care (Weinmann & Kusters, 2016). Globally, young people may find that cultural aspects such as family, community and traditional rhetoric around mental health negatively impact or delay help-seeking (Tamburrino et al., 2018; Scull et al., 2013; Murray et al., 2013). This may include stigmatising beliefs or social exclusion of people with mental illnesses, misdiagnosis of mental illnesses as having a spiritual cause and using treatment modalities that may not adequately address biological pathology, especially in more severe cases of disease.

According to Rathod et al. (2017), this is not always the case. In India, a low to middle-income country, 90% of people with mental illnesses live with their families. Families in India tend to be involved in the decision-making process for seeking care as well as following up on progress and treatment for the affected member. This support is especially beneficial to those with severe mental disorders. For this reason, it is beneficial to create mental health interventions locally and preferably with the input of those from the target community (Osborne et al., 2020). Interventions should consider cultural and historical contexts, incorporating the existing models of coping, resilience, and treatment-seeking (Gopalkrishnan, 2018). For this reason, increased context-based research on the perceptions and help-seeking of mental health treatment in low to middle-income countries is needed (Murray et al., 2013).

## **2.6 Barriers to seeking mental health care**

Andrade et al. (2014) presented a survey conducted by the WHO that examined the barriers to mental health treatment across 24 countries. These countries included six low to middle-income countries, six upper to middle-income countries and 12 high-income countries. It was found that worldwide, dominant barriers included a low perceived need for care and stigma. Barriers such as finance and availability of services featured more frequently in low to middle-income countries but were noted in some higher-income countries as well.

As previously mentioned, most of the available literature on help-seeking is based in Europe and North America. Most of the studies and reviews include adolescents to young adults approximately 13–25 years of age, which is close to the age range of this research. In these studies, it was found that people of this age group commonly cited barriers to seeking care of an attitudinal nature, although they may face more barriers financially as well (Munson et al., 2012). The most frequently reported barriers to seeking mental health care were the need for self-reliance, stigmatising beliefs and poor mental health literacy (Gulliver et al., 2010; Salaheddin & Mason, 2016; Rickwood et al., 2007). In a review of help-seeking behaviour for young adults in Australia, it was found that those who were currently experiencing suicidal thoughts or depressive symptoms found it psychologically more difficult to seek help; therefore, demonstrating symptoms of mental illness as a barrier (Rickwood et al., 2007). Similarly, young adults in a cross-sectional study in the UK reported that “being

unwell” and “having no one’s help to get professional care” prevented them from seeking professional intervention (Salaheddin & Mason, 2016:690). The findings of dominant attitudinal barriers such as stigma and lack of mental health literacy bear strong similarities with findings from global and Mozambican contexts (WHO, 2022; Lovera et al., 2022).

Based on a help-seeking study that included the United States, Ontario and The Netherlands, attitudes such as “I wanted to solve the problem on my own” and “I thought the problem would get better by itself” (Sareen et al., 2007) were highlighted as dominant barriers across all three locations. Along with higher-income countries, studies in low to middle-income countries have also consistently reported the desire for self-reliance in managing one’s symptoms. For example, it was found that college students in Ukraine expressed the desire to “have control” over their lives in this sense, further reinforcing a global commonality of reluctance to seek mental health care (Burlaka et al., 2014; Stunden et al., 2020; Andrade et al., 2014). In South Africa, a study by Andersson et al. (2013) examined help-seeking behaviour that included barriers and facilitators to care among people with depression in the Eastern Cape. It was found that stigma and limited mental health literacy featured as dominant barriers to care.

One of the most deterring attitudinal factors for help-seeking practices is stigma. In a study on stigma and discrimination and its role in accessing mental health care, Thornicroft et al. (2008) indicate that stigma presents as a combination of factors. These factors include limited knowledge, negative attitudes and exclusionary and avoidant behaviour toward those with mental health disorders. The authors assert that the presence of stigma is a powerful determinant of the social exclusion of people who have a mental health disorder. The levels of stigma may seep down from a societal level to an intrapersonal level, where an individual experiences self-stigma due to negative attitudes toward people who seek mental health care. Similarly, for young people who are likely to reside among family members, disclosure may not automatically mean access to emotional or financial support, as family members may be influenced by dominant stigmatising beliefs of people with mental health disorders, which could affect how they relate to the person (Barney et al., 2009).

Globally, barriers to seeking mental health care have largely been reported as attitudinal or psychological barriers (Andrade et al., 2014). However, this conclusion has its limitations, as

not enough research has been conducted in lower-income countries as well as countries with limited mental health services. Structural barriers have been reported in both higher and lower to middle-income countries. For instance, the study of help-seeking in the United States, The Netherlands and Canada revealed that The Netherlands' group reported higher rates of dissatisfaction with the quality of mental health services than the other locations. In addition to this, the United States respondents noted financial constraints on accessing specialised care (Sareen et al., 2007). In the United States, financial constraints to mental health services and treatment have been reported in a 2012 study featuring young American adults who were diagnosed with a mental health condition and were using public health services (Munson et al., 2012). Salaheddin and Mason (2016) also noted that the perception of high financial costs towards mental health care featured as highly as attitudinal barriers for young adults in the UK, but this may also be due to the limited knowledge of available low-cost or charitable mental health services. However, in low to middle-income countries such as Ukraine, focus group discussions among university students and counsellors revealed multiple structural barriers that impeded seeking mental health care. Factors such as lack of available facilities, inconvenient locations of services, time constraints, finances/cost of services, poor interpersonal skills of professionals and lack of confidentiality were mentioned (Burlaka, 2014).

Globally, structural barriers to mental health care and help-seeking are not reported as commonly as attitudinal ones. Available literature reveals that structural barriers are noted more explicitly in studies of low to middle-income countries. For instance, in a study on mental health help-seeking in Rwanda, it was found that along with low mental health literacy and stigma, individuals described low levels of accessibility and acceptability of available services as barriers to care (Umbuyeyi et al., 2016). In another study on mental health service users in Rwanda, respondents cited problems with paying for medication and transport costs as structural barriers to accessing treatment (Muhorakeye & Biracyaza, 2021). Dissatisfaction with psychological treatment was also found to be a barrier to seeking further care in Pakistan, along with a lack of social support and a preference for religious or traditional healers instead of allopathic interventions (Choudhry et al., 2021). Similarly, dissatisfaction with professional conduct among mental health practitioners was reported as a strong barrier in Ukraine (Burlaka et al., 2014).

The above review of the barriers to mental health care reiterates the current knowledge of mental health help-seeking globally, where attitudinal barriers largely dictate the likelihood of seeking care (Andrade et al., 2014). However, it has been noted that more research should be focused on low to middle-income countries, considering the differences in resources and possible cultural considerations towards the process and care of one's mental health.

## **2.7 Facilitators to seeking mental health care**

Globally, less is known about facilitators or factors that encourage help-seeking for mental health care. Although it is crucial to analyse the barriers to accessing care, some researchers have argued that facilitators are generally under-researched (Gulliver et al., 2010). However, based on mental health help-seeking literature, the most common theme revolves around social support as a facilitator to seeking care (McCann et al., 2016; Gulliver et al., 2010; Waumans et al., 2022). Social support may include the recognition of symptoms and encouragement of treatment by significant others, friends and professionals (Kantor et al., 2017). For younger adults, social support would include trusted family members and established relationships with potential care providers, such as general practitioners (Rickwood et al., 2007). For older adults, partners and friends would be included in peer support (Rickwood et al., 2007). However, Wilson et al. (2011) found that for young adults, or those between 18–25 years of age, parental attitudes toward formal help-seeking had implications on whether their adult children would choose to seek care or not.

In some cases, social support may be preferable to formal interventions. In a review on help-seeking among Filipinos, both in the Philippines and abroad, it was found that there was a preference to seek out informal mental

health support through one's friends or communities, instead of seeking professional care (Martinez et al., 2020). Although it could be hypothesised that those from more collectivist cultures prefer informal to formal care, a study on multicultural participants in the United Kingdom found that socio-demographic factors did not necessarily drive formal or informal help-seeking. Instead, the severity and complexity of the mental health symptoms were the determining factors on whether formal care was sought (Brown et al., 2020). This finding is consistent with the highest reported facilitator in the Philippines' review, which was the case of perceived severity of mental health problems as a motivation to seek professional care (Martinez et al., 2020).



Another prevalent theme reported as a facilitator is the experience of trust in mental health service providers. This includes having trust in a service provider's professional expertise, a sense of confidentiality and previous positive experiences of the help-seeker. These factors were described as facilitators to seeking mental health care by users of these services (McCann et al., 2016; Rickwood et al., 2007). According to a review conducted in the United States, young adults who have had positive experiences with mental health care displayed a strong likelihood of seeking care in the future if the need arose (Li et al., 2016).

In a study on factors influencing help-seeking in Turkey, it was found that people's belief in the effectiveness of the available psychiatric services, as well as having high levels of trust in practitioners, facilitate people's desire to seek help. This could mitigate common feelings of mistrust towards practitioners or overcome the cultural barrier of not sharing private matters outside of the family (Topkaya, 2015). The upholding of values such as confidentiality and patient satisfaction is especially important in places where mental health services may be scarce. For instance, the highest reported structural barrier for Ukrainian college students to access mental health care was the perceived incompetence of professionals. Students also reported breaches of confidentiality, especially within the university community (Burlaka et al., 2014).

In primary health care settings, it is important that general practitioners can recognise symptoms of mental ill-health and appropriately refer the patients to mental health services (Lovera et al., 2022; Gouveia et al., 2020). In Malawi, a quantitative study on the use of health services revealed that those with common mental health disorders had a higher mean number of visits to primary health care settings. For this reason, primary health care workers' increased training in recognition and referrals would assist patient mental health outcomes (Udedi et al., 2013). Having a therapeutic alliance with one's general practitioner facilitated appropriate referrals to mental health services (Waumans et al., 2022).

Another important facilitator in mental health care is mental health literacy. Mental health literacy is defined as the knowledge and skills pertaining to mental health that helps with the recognition, treatment and prevention of mental health disorders (Atilola, 2014). Almanasef (2021) asserts that mental health literacy has the potential to be promoted throughout various sectors of society. This includes governmental campaigns, stakeholders, health care

professionals, academic curriculum creators and the media. Through increasing mental health literacy, positive societal perceptions of mental health and mental health professionals would encourage more people to access care (Almanasef, 2021). For this reason, given the focus on traditional and cultural dimensions of healing in mental health, developing well-rounded and culturally sensitive interventions to increase mental health literacy in low to middle-income countries can provide powerful benefits in the increase of the use of both traditional and allopathic healing systems. Kutcher et al. (2019) studied the effects of mental health literacy programmes for youth in Malawi and Tanzania, the first of their kind in sub-Saharan Africa, and outlined the short-term benefits of media and school curriculum-based interventions for increasing mental health literacy. The implementation of the awareness and mental health literacy programmes provided positive outcomes for the youth in these aspects (Kutcher et al., 2019). Although more research must be conducted on the effects of these short-term interventions, it is important to note that contextually relevant interventions are the most effective and non-invasive form of increasing the conversations around mental health and its care (Osborne et al., 2020).

## **2.8 Theoretical framework**

### **2.8.1 The Behavioural Model of Health Services Utilisation**

The Behavioural Model of Health Services Utilisation is primarily used to understand the relationship between individuals and their use of health services. This model was developed in 1968 by Ronald Andersen, a health services professor at the University of California Los Angeles. Initially based on a quantitative health service use model, Anderson's model has undergone many revisions for its applicability to current health service use phenomena (Lederle et al., 2021). The model aims to examine the various motivations, factors and barriers that a potential service user encounters in the context of available care. The current model of the Behavioural Model of Health Services Utilisation presents categories that may affect the outcome of care-seeking, such as predisposing characteristics of the patient (Myers et al., 2011). Predisposing characteristics may include people's demographics, as well as attitude-belief variables about their ailment and if medical intervention is necessary. These are mainly factors that exist before accessing medical intervention. The model also uses enabling factors, which refer to the ability to obtain health services (Myers et al., 2011). These factors include affordability of treatment, geographic accessibility to the treatment, patient awareness of health services and the presence of psychological or cognitive services.

The most recent revision of the model includes factors such as health behaviour and outcomes (Lederle et al., 2021). In this study, contextualised predisposing characteristics and enabling factors were used to conceptualise and design the research including the guidance of the semi-structured interview questions. The model also provides a basis to analyse the motivations and potential barriers to using existing mental health care systems from the participants' accounts.

### **2.8.2 The Social Identity Perspective**

The Social Identity Perspective, as outlined by Klik et al. (2019), aims to categorise how social identity theory may be applied to the context of mental health and group relationships. Social identity theory illustrates that humans experience a collective identity that is tied to their membership in specific identity groups, such as gender, nationality, race and sexual identity (Tajfel & Turner, 1989). According to the theory, people's experiences of self-identification within their social group may determine their relationships toward "entering" or identifying with another social group. The Social Identity Perspective guided the articulation of predisposing factors in the questionnaire. It also provided a method for critical analysis of participants' personal barriers and facilitators towards seeking mental health care, especially related to self-identification with culture, nationality or value systems and how these interact with the identity of care-seeking for mental health concerns.

## **2.9 Policy and legislation**

### **2.9.1 The National Health Policy Guidelines**

Legislation on mental health care in Mozambique is guided by the Department of Mental Health at the Ministry of Health. Although national activities and organisations have been guided by the National Mental Health Plan, the advent of context-based research in the country catalysed the goal of improved mental health services in the country. Mozambique's first Mental Health Strategy and Action Plan and National Health Policy Guidelines' (2006–2015) were implemented (Gouveia, 2018). The aim of these guidelines was to highlight the importance of the need for a greater human resource capacity, implementation research, advanced training, enhanced service delivery, community engagement, and monitoring and evaluation (Sweetland et al., 2014). The document included aims to develop a mental health component in primary care, human resources, involvement of families and patients, advocacy and promotion, human rights protection, quality improvement and monitoring existing health

care systems. The National Health Policy Guidelines, in turn, inform the Mental Health Strategy and Action Plan. This policy propels service delivery, community involvement, tackling substance abuse (including alcohol and tobacco), violence, HIV/AIDS, epilepsy, schizophrenia and other chronic conditions (Sweetland et al., 2014).

### **2.9.2 The Strategy and Plan of Action for Mental Health (2016–2025)**

In 2015, the Strategy and Plan of Action for Mental Health (2016–2025) was launched in Mozambique (Gouveia, 2018). This plan was created to improve mental health services and their utilisation. The aims include strengthening the management (planning, organisation and financing) of the national mental health programme, offering psychiatric services and quality psychosocial support that is relevant, integrated and comprehensive in the national health system (Sistema Nacional de Saúde, SNS) from primary health care to more specialised services. It also aims to implement strategies for the promotion of mental health as well as prevention of mental health concerns, fortify information systems and research on mental health, increase public awareness in relation to mental health and reduce stigma and discrimination. Lastly, this also aims to increase community involvement in mental health promotion and to promote and protect the human rights of those with mental illnesses (Gouveia, 2018: Ministério da Saúde, n.d.).

Although creating new policies and legislations is crucial for setting objectives and protecting patients and practitioners, more targeted laws are needed to protect help-seekers and service providers. The Department of Mental Health is responsible for upholding the legislative processes related to quality supervision, professional development and ethics (Dos Santos, 2011). Targeted mental health laws that protect those suffering from mental health conditions, specifically alluding to those in tertiary health care spaces, have not yet been passed (Dos Santos et al., 2016). However, the existing policies are key for the improvement of services in the country. Not only do these policies uphold the values of high quality and decentralised mental health service provision, they also promote the values of dignity and social inclusion.

### **2.10 Conclusion**

This literature review outlined the context of mental health in low to middle-income countries, including Mozambique. Research on the factors that affect help-seeking behaviour

for mental health concerns was presented, including global barriers and facilitators to mental health access and help-seeking. On a global scale, not enough research has been conducted on low to middle-income countries in mental health services and how people interact with them. However, on inspection of the literature that exists in both low to middle-income countries and globally, dominant themes such as stigma, low mental health literacy and cultural or religious considerations were found to be important factors in influencing how individuals, including the youth, access mental health care. The theoretical frameworks used to conceptualise the data collection tool and assist the analysis of the findings were outlined. The policies surrounding mental health in Mozambique were also presented. In the next chapter, the research methodology used for the study will be discussed.

## **Chapter 3: Methodology**

### **3.1 Introduction**

This chapter discusses all aspects of the research methodology, including the research design, sampling and population, data collection approach, ethical considerations, as well as the instruments used for the data collection and its processing. The rationale of the research design and its components will be covered, as well as the procedure used for data analysis.

### **3.2 Research design**

Qualitative research is conducted to capture subjective realities and experiences of people in the context of an investigation (Creswell, 2003). This research project employed a phenomenological approach (Creswell, 2013). The phenomenological approach describes the investigation of phenomena as they appear in our lives, the way these phenomena are perceived, as well as their roles in our subjective experience (Smith, 2018). This approach was chosen to understand the perceptions towards mental health seeking and to weave together commonalities in these perceptions of the concepts of mental health and help-seeking. The study also incorporates elements of a descriptive study, as participants who had both acquired and not acquired care were interviewed based on what their perceptions were on help-seeking behaviour for mental health. From gaining an understanding of participants' relationships to the objectives in the study, new understandings grouped by common themes may be understood and studied based on the research's qualitative design. This study employed this approach as emergent themes gathered from participants' accounts may create a preliminary understanding of the perceptions and journey of help-seeking in Maputo.

### **3.3 Population and sampling**

In the research context, a population consists of a complete group of people who share the same characteristics. This group contains more well-defined characteristics or traits of interest to the research inquiry (Banerjee & Chaudhury, 2010). Through the sample of people taken from a population, conclusions may be applied to the accessible population or the group from which a sample closely resembles.

To select the study population, "the research question or purpose of the study will suggest a suitable definition of the population to be studied, in terms of location and restriction to a

particular age group, sex or occupation” (Banerjee & Choudhury, 2010, p. 1). The target population in this study were young people in Maputo who have considered seeking or had received mental health care. These participant profiles were consistent with the research topic. The participants in the study were thus young Mozambicans between the ages of 18–30 who reside in the city of Maputo. Candidates were to have had an interest in seeking mental health care or who received mental health care or treatment within Maputo, Mozambique. It was not necessary for the participants to have been diagnosed with a mental illness to participate in the research. Using the template for a screening interview and distress protocol from Draucker et al. (2009), the researcher screened potential participants to make sure that they were not under distress, nor in an activated or emotionally sensitive state before the interview. This protocol was developed for the mitigation of harm to participants and may be used by researchers.

Purposive sampling was used to access participants. Purposive sampling was used as it centres the participant as a contributor to a deeper understanding of the phenomenon being studied, adding a “unique, different, or important perspective” to the subject matter under investigation (Robinson, 2013:25). Purposive sampling was used to investigate the different experiences of group participants with similar characteristics (Smith et al., 1999). To reach an appropriate number of participants, snowball sampling was also consecutively used to connect with others who were open to sharing their perceptions. Before this process, permission to conduct the study was granted by the Department of Social Development’s research Committee, which granted ethical approval for the study. No compensation was paid to participants as it was advised that the study should be voluntary.

To initially locate participants, the researcher followed a mental health-related page on Instagram, targeted toward Mozambicans. To further procure participants, the researcher worked in collaboration with an organisation called ‘Eu, Tu, e a Depressão.’ (You, Me and Depression). Eu, Tu, e a Depressão. is a new organisation based in Maputo, Mozambique, which is run by a collective of mental health activists. At the time of data collection, the organisation’s goals were to increase awareness and discourse around mental health in Mozambique. They conducted events surrounding mental health and education on common illnesses, including panels with psychologists and other mental health-related professionals. A request was made to the founder of the organisation to use the organisation’s social media

platform to recruit participants and a formal letter of permission was provided by the founder (see appendix). An invitation poster was distributed online and interested participants reached out through their phone numbers. The application WhatsApp was used to communicate both before the interview and to conduct the interview. Exclusion criteria involved those with a diagnosed severe mental illness due to risk factors related to the ability to consent and participate in the research. Participants who were experiencing acute mental health symptoms or acute distress were not included as well due to ethical reasons. After a participant was confirmed based on the inclusion criteria, a detailed consent form was sent to the participants, and they participated after digitally confirming their consent to the study. This was done through written confirmation of participation either through email form or through a WhatsApp message.

As noted, the sampling methods used consisted of purposive sampling, where participants were selected on the abovementioned criteria. In a similar study on the perceptions of mental health care in Kuwait, it was found that a suitable number of participants for the nature of this research was 10 people, as it was likely to reach data saturation beyond this figure due to the repetition of common themes and ideas (Scull et al., 2014). The total number of participants in this study was 13. All identified as female. Although all qualifying youths could participate, a low number of male participants could be expected due to the differences in mental help-seeking between the two genders, where males are less likely to seek care for their mental health (Wendt & Shafer, 2015). The researcher found this to be a factor in her recruitment where only women responded to participate. This was to be expected due to the higher number of profiles who followed the social media page appearing to belong to people who identify as female. However, both sets of participants – those who had sought care and those who did not – were almost equal in the sample.

### **3.4 Data collection method**

The initial data collection method for this research was face-to-face interviews. This process was halted when in-person data collection had to be suspended due to the COVID-19 pandemic and related lockdown measures. To comply with the national and university requirements, the platform of the cell phone application WhatsApp, with the voice note feature, was used. This medium was used due to the lower data usage of voice notes. It also had the advantage of the ease of recording the information and transcribing it. In addition to



this, participants could record their answers without the chance of connectivity problems which are common with data-based phone calls. Recent research using WhatsApp has demonstrated it to be a successful and accessible tool for data collection (Gibson, 2020; Kauffmann and Peil, 2019). Due to the online modality of the interview through the WhatsApp application, participants may feel a greater sense of privacy and anonymity when answering questions through a phone call (Holt, 2010). By using WhatsApp voice notes instead of phone calls or texts, participants were able to provide in-depth responses and the researcher was able to pick up vocal cues through the recordings. The use of voice notes also permits the participant to take their time before sharing information (Gibson, 2020), allowing for more reflection and thus richer data as a result. Voice notes may mimic the rapport that can be achieved through a telephone call. Due to the unpredictable mobile networks, voice notes permitted clear communication and prevented having to interrupt the interview due to network issues. In addition, due to being in the same age group as the participants', achieving rapport was easier through the application as it is a common or even preferred mode of communication among youth (Gibson, 2020).

### **3.5 Data collection instrument**

The data collection instrument took the form of an interview guide (see appendix). The interview guide was created by the researcher to gather information about the chosen phenomena in a structured and coherent manner. Semi-structured interviews were conducted through the WhatsApp application, using the voice note function and questions encouraging open-ended responses were included in the interview schedule (Creswell, 2014).

The data collection instrument was designed based on the existing literature to guide the collection of data for this study, as this topic is broad in nature. To create a valid instrument, a combination of the Behavioural Model of Health Service Utilisation used in similar studies, as well as contextualised literature on this subject were used to structure the questions. The Behavioural Model of Health Service Utilisation describes the modalities that reflect help-seeking and thus the perceptions of accessing care. Over the years, many versions of this model have been used to conceptualise help-seeking for other health concerns, globally. To further contextualise this model for this study, literature regarding mental health help-seeking in low to middle-income countries contexts was used as a frame of reference. This subset of countries, i.e. low to middle-income countries, was chosen due to the scarcity of research

surrounding the topic in the sub-Saharan region and more specifically the Mozambican context. However, preliminary research on the contextual meanings of mental health in Mozambique was used as a reference to inform the nature of the interview guide (Bäckström, 2015). It was important to maintain the open-ended aspect of the questionnaire, as well as to shorten its length. This was done so as not to tire or overwhelm the participants, given the medium of voice notes for data collection. To verify the questionnaire, it was presented to a local mental health professional, as well as to the founder of the organisation, for a basic review and comments or advice before the start of the data collection process.

The focus of the interview was to provide an understanding of the perceptions of mental health and the perceived barriers and facilitators for seeking mental health care in Mozambique. The interview guide included questions pertaining to the role of structural, attitudinal and psychosocial factors that may affect one's perceptions of seeking care based on the predisposing and enabling factors identified in the Behavioural Model of Health Service Utilisation. There were 12 questions in total. The questions were created to elicit responses that would allow for a better understanding of these aspects of mental health care-seeking behaviour according to the participants' perspectives (De Vos, 2002).

The data recording for this research was accomplished through the voice note function of the WhatsApp application. Participants were given a clear explanation of the measures taken for privacy and confidentiality before the beginning of the interview. During the interview, the researcher sent voice notes and message prompts of the questions and the participants were encouraged to record their responses using the voice note function. The participant had unlimited recording time for their answers. Upon completion of an interview, the researcher asked follow-up questions related to the answers given in the interview. Member checking was done with a few participants to clarify or expand on quotes of interest from the initial interviews (Birt et al., 2016). Transcriptions of the voice notes were password-protected.

### **3.6. Data analysis**

To analyse the data from the interviews, interpretative phenomenological analysis was used. This method, which aligns with a people-centred philosophy, allows “broad-based knowledge to be contextualised within the socio-cultural context” (Charlick et al., 2016:205). This method of analysis was used as it offers a “methodological approach that considers an

individual in a local context” (Charlick et al., 2016: 205). The steps from this framework were followed based on the adapted analysis guide by Charlick et al. (2016: 210) and were applied to the data from the transcribed interviews.

The analysis progressed as follows:

Step 1: The first transcript was read multiple times and semantic concepts were noted in the margins of the hard copies. At this point of the analysis, all the emerging brackets of data or concepts were regarded as equally important. The second step was to connect any corresponding ideas and group them into themes, making sure to check in with the overall transcript so the context was not lost. The third step was to integrate the relevant themes. After this blueprint of themes was constructed from the first transcript, the other transcripts were subsequently analysed using the same theme brackets from the first. Any new relevant information was noted down. The fifth step involved integrating the similarities in themes throughout the collection of interviews.

Once this was done, the dominant themes and correlating sub-themes were grouped into a table.

The researcher then went back to the transcripts and analysed these themes separately, making sure to note down the corresponding quotes from each transcript. In the write-up of the findings, relevant literature and quotations from the participants’ accounts were used to produce in-depth analyses or discussions on the emerging themes.

### **3.7. Ethical considerations**

**Avoidance of harm:** The avoidance of harm is central to ethical research. Due to the in-depth nature of qualitative research, special care should be taken to avoid harming the participant during the process (Arifin, 2018). In this study, there was a risk that talking about mental health and help-seeking seeking care may cause the participants feelings of distress. To mitigate this, questions were created in a manner that did not require the participant to elaborate on upsetting or personal experiences. The questions were, therefore, kept broad and general. Participants were also given a thorough explanation of the nature of the interview and how their data would be used. This was to ensure that a complete understanding of the nature of the study was achieved before the participant consented to participate. However, if

support was required post-interview, the participant would be referred to the appropriate services through the guidance of the organisation. After the participants expressed interest in the study, they were screened immediately before the interviews using the adaptation of Draucker and Martsolf's 'Screening Interview and Distress Protocol.' (2009: 347)

**Informed consent:** Informed consent involves the delivery of information to the participant on the scope of the study, their involvement and the benefits and risks of participation in the study. In research, a participant must be competent to decide on their participation (Shah et al., 2020). According to Creswell (2003, p. 94), informed consent forms "are those that participants sign before they engage in research. This form acknowledges that participants' rights will be protected during data collection". Before participating in the research, the participants were briefed on the research topic. They were informed of the nature of the questions of the study. Before the interview began, the participant was sent a detailed consent form through email. After receiving the consent form, the participant was then asked through text message to provide consent to being interviewed and to affirm they had read the consent form. Participants were given assurance of complete confidentiality and privacy. The researcher also provided contact details for queries and concerns. The researcher was aware to note cues of distress or emotional stress as the participants sent their voice notes. As this is a voluntary study, the participants were assured that they may leave at any time without consequence and their data would be deleted and excluded from the study.

**Deception of respondents:** In some research projects, to preserve the experiment or data collection process, behavioural scientists may omit or obscure the nature of their study to their participants. After the data collection process is complete, the participant is then debriefed on the nature of the deception and why it was done (Krasnow et al., 2018). For example, "the researchers might obscure their hypotheses to minimise participants' attempts to conform to them; and so forth" (Krasnow et al., 2018, p. 1175). In this study, as there would be no compromise to the data if the participants knew about the nature and the aims of the study in full, any deception of participants as described by Krasnow et al. (2018) was excluded. The questions directly alluded to the experiences and perceptions of the participants on the research topic. By adequately informing the participant of the scope of this study, they were reassured of its full purposes and their participation therein and successfully provided data relevant to the topic.

**Confidentiality:** "Confidentiality pertains to the understanding between the researcher and participant that guarantees sensitive or private information will be handled with the utmost

care” (Bos, 2020, p. 154). This means that any information shared in the data collection process should only be known to the researcher. The student was the sole researcher collecting and handling the data and took care to avoid any information being shared outside of the research setting. As participants used their personal cell phone numbers to volunteer in the research and to carry out the research, each number was saved under an alias. During the transcription stage, random numbers were assigned to each transcript to further separate the data from the participants’ identities. No information from the interviews, including demographic identifiers as well as subject matter that was discussed or provided by the participants, was shared with anyone. To ensure this, the researcher stored files directly on their computer and password protected the information. No identifying details are included in this dissertation as well.

**Privacy:** “Privacy refers to the right of individuals to limit access by others to aspects of their person that can include thoughts, identifying information and even information contained in bodily tissues and fluids” (Plaza & Fischback, 2022, p. 1). The privacy of the participants and their accounts was upheld throughout the entire research process. As the medium was communication through WhatsApp, the information gathered was directly received by the researcher, whose phone was password-protected. No form of identifiable information about the participants was shared outside of the research. The WhatsApp application ensures messages from the participant are encrypted. According to Creswell (2003), measures towards confidentiality and anonymity reinforce participants’ privacy and since both were upheld in the research, participant privacy was further enhanced.

**Anonymity:** Anonymity can be conflated with confidentiality but refers more specifically to an ideal separation between the participant and the data shared about them (Saunders et al., 2015). Due to the direct interaction between participant and researcher, true anonymity could not be achieved as participants came into contact either through email or phone numbers with the researcher. Both modes of communication, the cellphone and email accounts, were however password-protected. As a measure of overall confidentiality and anonymity, upon first contact, the participants’ cellphone numbers were saved as an alias. The only information that was used directly from the interview is the participants’ age, location, occupation and whether they had or had not been diagnosed with a mental illness. When transferring the voice note data into transcript form, each transcript was numbered to identify each interview. Anonymity was upheld throughout the process, with the immediate assignment and name aliases and numbers assigned to the transcripts.

**Actions and competence of researchers:** The competence of a researcher is an ethical responsibility. Researchers must display awareness and execution of the research process, especially in relation to human research (Mooney-Somers and Olsen, 2017). The researcher adequately informed and assured the participants that their data would be handled with the utmost confidentiality and that their identity would not be traceable. The researcher answered any questions or concerns the participant had and anticipated any issues before they arose.

The researcher did not proceed with the interview without the explicit consent of the participant and assured participants that they were able to leave at any time without consequence. The researcher also assured the participants of her role as a student researcher and the conducting of the research with relevant supervision.

### **3.8 Limitations of the study**

Due to the restrictions posed due to the pandemic, the researcher was not able to make social connections with potential participants from various social groups or communities in Maputo. The research was limited, therefore, to consulting with only one organisation that was able to assist at the time. Because of recruiting through one mental health organisation, there is the possibility that the perspectives of the sample group are likely to be similar and more diverse perspectives may have been excluded. Although homogenous characteristics within a sample are a feature of phenomenological analysis, there may have been a greater variance in experiences had there been participants from different economic backgrounds or religions. Finding willing participants to talk about their views or experiences on mental health and help-seeking was also difficult due to the personal nature of the topic.

Also due to the pandemic, the researcher was not able to host in-person data collection methods due to the restrictions of the pandemic. This limited the amount of rapport that could be achieved with the participants, especially given the nature of the topic. Although the data collection method allowed for a certain level of engagement and discussion, the level of rapport achieved was not as pronounced as in a face-to-face interview. This aspect has the probability to diminish the depth of the data, as voice note data collection does not have the same level of comfort as an in-person conversation. Midway through the interview process, some participants answered the questions very quickly to answer the next question, which suggests that these participants wanted to quickly complete the process; therefore, also

compromising the depth of the data collection. Additionally, because the topic has to do with mental health, participants may not have spoken as freely, which might have been compounded by the lack of rapport or trust that accompanies face-to-face interviews. Despite these factors, the researcher was able to gather rich data that provides valuable insights into the perceptions of youth about accessing mental health in Mozambique.

### **3.10 Reflexivity**

Reflexivity involves examining one's own role and experience as a researcher in relation to the topic. In the context of research, it involves critically reflecting on the ways in which the relationship between the subject and researcher influences the research process (Haynes, 2012). For this study, the researcher wanted to investigate how other young adults in Maputo city perceive mental health and help-seeking. After witnessing an increase in mental health initiatives as a student in South Africa, the researcher wanted to understand the ways in which people in her hometown interact with or feel about seeking help with the available services in the city. Through this research, the researcher wanted to gain an understanding of those who had an interest in mental health and what the factors were that facilitated or prevented them from seeking mental health care. Through the qualitative nature of the research, understanding these attitudes, barriers and facilitators to seek mental health care from young people may help to conceptualise and define possible gaps or benefits in mental health service provision. In addition to informing future interventions of the pathways towards seeking care for young people, the data from this research may be used to modify existing interventions. Dependability refers to how the research is received by peers or other scholars in the community. Having a peer researcher confirm realities related to the work increase the trust of the internal and external validities. Confirmability relates to the researchers' aim to achieve as much objective truth as possible through qualitative research (Stahl & King, 2020).

**Trustworthiness:** Due to the nature of qualitative research, the aspect of validity in the research process is not easily achievable. However, researchers should strive for trustworthiness. In other words, the readers must have the impression that the research was carried out appropriately in the context of the subject matter (Stahl & King, 2020). Lincoln and Guba (1988) illustrated four aspects of trustworthiness: Lincoln and Guba (1985) conceptualised this approach to trustworthiness. These are credibility, transferability,

dependability and confirmability. Credibility refers to the internal validity of the work as it situates itself in the context of the research. This may be done through various forms of triangulation, through confirmation with stakeholders or research participants, as well as using multiple modalities to collect data (Stahl & King, 2020). The second is transferability. Transferability refers to a certain degree of replication that may be used for other systematic inquiries. This seeks to increase the generalisability and external validity of one's findings (Stahl & King, 2020).

### **3.11 Conclusion**

In this chapter, the methodological process used for this study was discussed. This chapter presented the use and rationale of the qualitative and phenomenological research design, sampling methods, target population, data collection approach and ethical considerations. Using a semi-structured interview guide, a thorough understanding of the perceptions around mental health-seeking behaviour among young people in Maputo was achieved. Using interpretative phenomenological analysis, emergent themes were identified and analysed. The findings that emerged from this research may be useful for governmental and non-governmental initiatives for mental health care and the creation of its awareness. In the next chapter, these findings from this study are discussed.



## Chapter 4: Findings

### 4.1 Introduction

In this chapter, the findings of the research are presented. It presents the participant's views of the perceptions of mental health help-seeking behaviour through the framework of analysis that emerged from the data analysis. Participants were asked open-ended questions about their own lives as well as to comment on their perspectives of broader social perceptions of mental health and help-seeking. The framework of analysis aligns with the objectives of the study and consists of relevant themes and subthemes. These are discussed with reference to the findings and include direct quotes from the interviews. First, a profile of the participants is presented in the table below, which is followed by a description of this information.

### 4.2 Figure 1: Participant profile

Participant	Age	Gender	Occupation	Lives with family (Y/N)	Received care for mental health reasons
1	25	Female	Employed	Yes	No
2	24	Female	Employed	Yes	Yes
3	25	Female	Employed	Yes	Yes
4	22	Female	Employed	Yes	Yes
5	30	Female	Employed	No	Yes
6	26	Female	Employed	Yes	No
7	26	Female	Employed	Yes	Yes
8	22	Female	Student	Yes	Yes
9	23	Female	Student	Yes	Yes
10	20	Female	Student	Yes	No
11	25	Female	Employed	Yes	No
12	19	Female	Student	Yes	No
13	24	Female	Student	Yes	No

#### 4.2.1 Participant description

The age range of the participants was 19–30 years, with the majority falling between the ages of 22–26. This age range falls under the stipulated definition of youth as stated by the Politic of Youth from the Ministry of Youth and Sport (2012) in Mozambique. This age range was chosen as it represents those who are either in tertiary education or employment. It was found

that all participants identified as female and, therefore, may only represent the opinions of this gender. There was difficulty in finding male participants for the study. Participants were also asked to share their occupation and the demarcation was made between employed or at a tertiary institution. Eight participants were employed and five were in university. All but one participant lived with their families. Seven participants had sought care for their mental health, although one participant was receiving counselling online from abroad. Five participants did not seek care.

### 4.3 Framework of analysis

Themes	Sub-themes	Categories
General perceptions of health-seeking behaviour	Personal views toward mental health and care-seeking	Importance of looking after one's mental health
		Motivation for care-seeking
		Minimisation of symptoms of mental ill health
		Self-reliance and low perceived need for care
	Cultural, religious identity and seeking help	Religious identity and help-seeking
		Cultural identity and help-seeking
	Help-seeking and perceptions of existing services	Perceptions of public health care
Feedback on care received		
Barriers to seeking mental health care	Stigma	
	Lack of mental health literacy and support	Effects of low mental health literacy
	Financial exclusion from access to care	
	Need for decentralised support centres	
Facilitators of mental health care-seeking	Emotional and social support	Family support
		Peer support
	Financial support for seeking care	
	Media campaigns	National campaigns to increase mental health literacy
	Social media as a multi-pronged tool for help-seekers	Increasing awareness
		Source of information about mental health
		Platform to connect care-seekers to professionals
	Bringing care closer to young people	Existing centres at universities Increasing centres in various neighbourhoods

In this section, an exploration of the perceptions towards mental health and help-seeking is presented based on the themes and the sub-themes and their categories.

#### **4.4 General perceptions of health-seeking behaviour**

This theme identifies the participants' general perceptions of mental health-seeking behaviour. Participants gave their personal views of mental health seeking in which they reported that they regarded looking after one's mental health as highly important. The concepts of looking after one's mental health manifested through different sub-themes and their categories as follows:

##### **Personal views about mental health and care-seeking**

###### **4.4.1. The importance of looking after one's mental health**

The participants' perceptions of the importance of mental health were expressed in various ways. Some participants felt that having sound mental health could allow them to deal with day-to-day problems and situations. Others pointed out that neglecting one's mental health could result in damage or the reduction of quality in other aspects of daily life. The following comments illustrate:

*Our resilience and our attitude toward the world depend a lot on our mental health. It affects all areas of our life, with no exception, and without us even realising it. Because – it manifests in our actions, and not in physical terms, like the flu, for example. (Participant 13)*

*It is extremely important, because when we are mentally not well – nothing is alright (laughs). So, when our mental health is – a little bit bad, of course, the other areas also will not be physically speaking, emotionally speaking – so mental health, to me, is extremely important. (Participant 5)*

Some participants mentioned the negative consequences of not looking after one's mental health. One participant described the potential of poor mental health in affecting one's productivity and relationships. She stated:

*Yes, it is, after all, if your mental health is not looked after properly, obviously, it does impact your day-to-day life, it impacts the way you think, and it affects the way you go about certain things. You're not going to be as productive as you are in a great state of mind.*

*(Participant 1)*

Another participant mentioned that suicide was a possible consequence of not taking care of one's mental health, as she states:

*There should be a balance between mental health and physical health – if one of them is not okay, our lives run a risk. If someone is mentally unstable, they can harm themselves or harm other people. Someone can be unstable enough until the point of committing suicide ...*

*(Participant 3)*

More than half of the participants drew comparisons between looking after one's mental health to taking care of one's physical health. They regarded mental health with the same level of importance as physical health.

*If you are not well, it is the same thing as having a problem with your body, and you look for a doctor to solve the problem. (Participant 12)*

*Yes, I think it's important to look after one's mental health, just like how we look after our bodies, um, the physical, right? We exercise, and we eat well to be healthy. It's important that we exercise our mental health – um, and us, as people aren't detached from our mental health, it's important. It can also affect our physical state, for example. (Participant 8)*

Although they did not elaborate on personal experiences, the participants spoke about the effects of poor mental health on other aspects of life, such as productivity and relationships. These findings were also consistent with other studies on the effects of poor mental health in young people, which cited aspects such as the loss of identity, low academic functioning, limited career development and relationship problems because of the symptoms of poor mental health (Leavey, 2005).

#### **4.4.2 Motivation for care-seeking**

When asked about the importance of mental health, some participants mentioned that a motivator towards maintaining good mental health was that it would benefit their interpersonal relationships. The following comments illustrate:

*I think looking after your mental health is very important, because it's for you first, to be fine with the people around you. You must be fine with yourself. If you're not fine emotionally, you won't transmit, well, for instance, you will be transmitting what you are feeling...so I think mental health is a very important point because it's for you to deal with people, you should be well, emotionally, so that you transmit good energy. (Participant 10)*

*I think that it's extremely important... looking after one's mental health, because, it ends up affecting so much...of your surroundings, your living situation with people...Um, many times, the people around you don't know, or might not know, that you are going through a difficult thing or an emotional problem, or just everything in general, and many times we don't communicate this to the people around us ... (Participant 9)*

This motivational aspect may act as a key role in help-seeking. Poor mental health has been recorded as a factor in the deterioration of personal relationships (Leavey, 2005). Not only does seeking mental health care improve the quality of one's interpersonal relationships, but doing so increases the likelihood of their loved ones seeking care as well (Stice et al., 2004).

#### **4.4.3 Minimisation of symptoms of mental ill health**

Participants alluded to personal attitudes that may prevent one from seeking help. Two participants stated that a lack of seeking care for one's mental health stems from the minimisation of symptoms or expressions of the more common mental illnesses, such as depression and anxiety disorders. Participants' examples of normalisation of mental health symptoms have been noted from their families as well as from society as presented below:

*But in general, they don't consider depression as a severe illness, they consider it as 'A sadness – it will pass, it will pass – and it doesn't pass. Yeah – here, one cures depression with prayer, yes – not with a psychologist, generally. I have never identified a severe case of depression. The depressions that we have are those that are camouflaged, that with time, I think the person resolves it themselves, alone. It was never verified by the family that 'Hey,*

*the person is doing badly, is depressed, and needs to be followed up or seen to.'*

*(Participant 3)*

*Because truly, I think that there used to be quite a bit of ignorance in society about things spoken about, like 'Oh, what for, your depression and anxiety? Everyone goes through this ...*

*(Participant 5)*

The following quote also demonstrates that seeking mental health care is perceived to be reserved for those who display more severe forms of mental illness and that it is perceived as out of the norm to seek help otherwise:

*... inform more people, because people think that when a person goes to the psychologist because one goes crazy...I don't know what – they have a very wrong way of thinking about what going to a psychologist is for...So I believe that we need to spread more information about mental health, what it is to go to a psychologist and when to go to a psychologist...*

*(Participant 12)*

#### **4.4.4 Self-reliance and low perceived need for care**

Of the participants who did not seek treatment, the characteristic of low perceived need for mental health care emerged. Low perceived need for care was found through expressions of self-reliance. Although the feature of self-reliance may be interpreted as psychologically beneficial, in this context, participants alluded to how it may hinder one's perceived need for care, as illustrated below:

*Cause ... at the end of the day, I've always dealt with things myself and I've always gotten myself out of horrible situations ... so that's what happened eventually ... so yeah.*

*(Participant 1)*

*It was these habits that were instilled in them [my family] since their childhood, and basically they lived the popular term of 'suck it up and move on' – that's how they were raised ... and at home, each person takes care of themselves ... we don't have the habit of taking care of each other. (Participant 13)*

*And there were situations that ... I went through things that messed a lot with my head – psychologically. And it's because of this that I learned, um – to search for more things that could help me with this ... I never went to a professional ... because ... for personal reasons that – but I read about this and learned to help myself. (Participant 10)*

The theme of self-reliance was challenging to articulate as it may be a result of multiple factors. One's personality, upbringing and wider sociocultural norms may influence this characteristic. As mentioned, the characteristic of self-reliance is also perceived as a positive trait in the management of one's mental health. However, in the literature, the low perceived need for care and self-reliance featured as significant sources of reluctance toward mental health seeking care (Bruffaerts et al., 2011).

#### **4.5 Cultural, religious identity and seeking help**

One's self-identification with existing cultures and religions is a varied and complex process. For most participants, existing cultural and religious values did not directly affect them or their immediate families, but statements reflecting broader public rhetoric on this connection were noted. It was important to note how cultural and religious affiliations toward mental illness may play a role in how one perceives mental health and its care.

##### **4.5.1 Religious identity and help-seeking**

A few participants spoke about how religious identity and beliefs may have overshadowed the need to seek mental health care. Those who spoke of religious perspectives referred to the Christian faith.

*Sometimes very religious people have the perception that 'With God, everything ...' 'These things don't happen ... the person is depressed because they have a lack of God – give your life to God' and things like that. Some of my family, with very strong religious beliefs, um, end up ignoring, or choosing, ignoring this part of depression, etc. – until they have the symptoms of anxiety or depression, and now they are in a bit of denial with what's going on, they prefer to ignore it, and because of that, they don't look for help. (Participant 5)*

*I was part of a very toxic church group, which kind of like – made it seem as though one ... prays their mental health problems away, so that was difficult. (Participant 7)*

*Definitely culture, definitely religion. I don't really know the extent, but it's very true. I feel like a lot of people really feel like they can pray mental illness away. (Participant 2)*

Descriptions of depression and anxiety as a “lack of God” or a sign that one should pay more attention to their religious experience were noted. Some participants noted, for example, that their families encouraged prayer to deal with periods of distress. In Mozambique, the role of the church in dealing with mental illness is at times carried out as an intervention in response to a spiritual attack placed on a person by someone else, but this is seen in more severe cases (Bäckström, 2015). However, even those who experienced mental illness after non-spiritual events, such as accidents, have approached the church for alleviation of symptoms (Bäckström, 2015).

Although views of treatment of mental health disorders solely through the church or consulting authority figures exist in more fundamentalist spaces, misattribution of psychopathology to religious causes also affects those in less strict social settings; for instance, those who do not strictly adhere to religious beliefs (Peteet, 2019). Stigma in religious communities may present poor mental health as a sign of spiritual weakness and surrendering one's mental health to God is perceived as the only solution (Geneva.edu, 2018). This approach may further alienate or delay sufferers from getting medical or psychological intervention if needed.

#### **4.5.2 Cultural identity and help-seeking**

Cultural meanings were also enquired on through the lens of the nuclear and extended family. Participants also commented on general societal rhetoric around mental health and culture. From most participants' accounts, cultural factors did not personally feature as a barrier to seeking care. However, they addressed wider societal meanings and responses to mental health disorders and what it would mean for younger people to seek out allopathic models of treatment in the context of those meanings.

*Maybe not religion, but culture, yes. We are African. So, apparently, the Africans don't have these problems, but we are human, so in practice we have problems. (Participant 3)*



*Culture too, our African culture, now it's changing, but this is said – ' Ah, [the person has] which depression or anxiety? – it's because of the lack of work – because we don't suffer because we have the culture of 'who wakes up, works, is a worker, doesn't have this sort of thing. Also, there is a lot, a lot more, as one says, lots of discrimination, culturally speaking. (Participant 5)*

In the next two excerpts, the participants expressed that talking about, or seeking mental health treatment was perceived as a “white person thing”, or a Western solution that does not relate to the values or realities of many who live in the city.

*... you can't really talk about that because you know, we don't talk about these things because 'we're a strong people, or this is a rich person thing – this is a white person thing, or this is just not an African thing,' so it becomes very, very difficult for people, I think. (Participant 7)*

*Another thing I've heard is that it's something for white people. There's this thing that I've heard – that white people spend money on frivolous things, on things that don't matter. (Participant 2)*

It is also important to note that even in contexts where the availability of biomedical intervention is high, people still tend to prefer alternative care for their mental health (Patel, 2011).

*Let's say, they will give more credibility to traditional medicine than conventional medicine, in this case, health professionals. Some cultures, too, may look at the mental health problem as not a problem that can be solved by conventional medicine to exclude conventional medicine, and become more focused on traditional medicine. Because this society was raised to be familiar with traditional medicine or it has grown by solving all those problems that arise from normal health, as well as mental health. They learned – their culture – they grew up solving everything that is a problem through traditional medicine, not conventional medicine. (Participant 6)*

In the excerpt above, the participant outlined that for some, the familiarity of traditional medicine made it a more viable and trusted option for treating symptoms of mental health

disorders. This is due to the frameworks already in existence within the many facets of traditional medicine that aim to diagnose and intervene in cases of severe mental illness in existence, before the arrival of biomedicine (Patel, 2011).

#### **4.6. Help-seeking and the perceptions of existing services**

The participants were invited to talk about their perceptions of the available mental health care in or around the city. Within both sets of participants, those who had used mental health services and those who did not, more than half of participants expressed limited knowledge of or concern about available services. Half of the participants who had sought help were satisfied with the care they had received, although most of this subset did so through private care.

##### **4.6.1 Perceptions of public tertiary care**

Public psychiatric services were negatively perceived. When asked about mental health services in the country, a few participants immediately referred to a prominent treatment facility on the outskirts of the city. In reference to this health facility, it is important to note that it holds the majority of in-patients who experience more severe forms of illness within the Maputo province, such as epilepsy, schizophrenia and advanced substance abuse (Dos Santos, 2011; Dos Santos et al., 2016).

*Just now, we saw the news about a family that had a son that was being treated there and he was beaten and tortured by a nurse, and that scares us. Or, I'm sorry, that scares me. For example, I visited the psychiatry [hospital]of [area], and it was shocking to me to see that they treated drug addicts and schizophrenic patients in the same ward – I don't think one has anything to do with the other. But they didn't have the care to separate them, they were all treating them in the same ward. (Participant 13)*

*Psychiatric wards are a terror – there is no attention to the specific needs of the person – their needs, so I think there should be reform, on the part of the Ministry of Health, in which we think on these aspects. Because what exists is very sad – we have almost no public institutions dedicated to the care of people with mental health issues, and the conditions that currently exist are extremely precarious, so I think there has to be this reform. (Participant 4)*

Unfortunately, this institution holds the perception of being overcrowded and improperly managed. As this institution provides the main quaternary in-patient care in Maputo province, its reform would vastly improve the quality of care for current patients (Dos Santos, 2011), but may also begin to change public opinion on the state of mental health care for those who have moderate to severe mental illnesses.

The participants shared their perceptions of the public mental health services available in the city. Their accounts were as follows:

*Um ... the professionals of mental health, in the public services, are usually very full [booked] – I have never gone myself, but people complain about this, that the timings are inflexible – there are too many people and too little time. There is not a lot of time for the consultations.*  
(Participant 5)

*I had to go get psychiatry appointments, at the central hospital, at the special clinic ... it always felt very cut and dry, didn't spend any time asking, about how I was – I mean, I would wait two hours for an appointment, and only be in there, like –10 minutes or less, so ... in my case, I was prescribed something that wasn't – [it] made me worse, but instead of replacing that, he just added something new – so it didn't really help me, it kind of left me in a state of like – ridiculous – and manic. So ... I was not really satisfied with what I've received so far.*  
(Participant 7)

Participant 5 described the difficulty of securing a consultation from public services. She mentioned that due to many people using and being referred to these services, receiving adequate time for a consultation is difficult. Participant 7 recounts their negative experience of changing medication through the special clinic at the main public hospital.

#### **4.6.2 Perceptions of superior quality in private care**

Participants' perceptions of public psychiatric services were contrasted with perceptions of private services to emphasise perceived disparities and poor services in care in the public spheres.

*And the quality, I think we are evolving, the professionals who have more quality are the professionals that are more expensive, and consequently, the low-income people, or people who have no way to pay ... these people end up being the most affected. (Participant 4)*

*But, what we hear on the news, and from what I said, at some point, there is this – disconnect ... I think the level of professional accessibility, in the realm of mental health – uh in private terms – I think the cost is high ... So, I think there is this difference – when you are in private care, you have accessibility, and you have the quality of service but the high cost. Now when you are in public care, you will have availability, accessibility, and the cost is low – but I think that the quality is not very good. (Participant 11)*

#### **4.6.3 Feedback on care received**

Of the participants who had received care, three had reported low satisfaction with their experiences and the other three reported that their experiences with mental health professionals were positive and beneficial. One participant was receiving care online from a neighbouring country and, therefore, could not be included.

*Hmm, for the quality and for the price I paid, I was very satisfied, it helped me a lot – in the resolution of the problem I was going through. So yes, extremely satisfied. (Participant 4)*

*I don't have much to compare with, it has been very helpful for me, it has helped me understand things about myself, like how to deal with it, and how to rationalise it in a way that is compassionate to me and others ... I feel like having more continuity with them, absolutely, but I wanna know what it's like to work with other professionals. I would like to work with other professionals too. (Participant 2)*

*I have now seen ... I think five health professionals? I was saying – with some of them, I wasn't satisfied, um, I wasn't satisfied at all, I simply didn't like it. Um, but I think this varies from person to person. So, with two psychologists I didn't really like the interaction, so I had to change them. Then I had found [inaudible], but it's difficult to find psychologists that will approach the meeting in a way that I would hope for. (Participant 9)*

Two of the participants described feeling judged by mental health professionals.

*Um, to be sincere ... with the psychiatrist, I was super satisfied ... with the psychotherapist, not much, I felt a little bit of judgement ... the person wasn't very neutral, yes ... they gave their best at the consultation, it was good but – there were moments that I felt – a [strange] facial expression, sometimes some kind of comments, like that person was judging me a bit (...)*

*And of course, our professionals should be professional – that they don't get emotionally involved, who don't judge people – I have heard many, many, many talks – people complaining about this point, and I also went through this. (Participant 5)*

*Honestly ... I hated it, mostly 'cause, I feel as though I was getting a judgement, or not, total understanding or, the lack of judgement you'd expect from your therapist. I felt like ... I don't know, it wasn't necessarily an open place for me to be, and we weren't necessarily working on root causes or whatever, and – you know the solution to my problems shouldn't be like 'Just leave then ... if you can.' (Participant 7)*

#### **4.6.4 Concerns of non-confidentiality**

A few participants expressed concern regarding practices of confidentiality by health professionals, as is shown below:

*I would not feel confident, for many reasons ... Such as confidentiality. There have been many situations in the past, I have seen doctors, on social occasions, talk about patients, and mention their names, and that was an ... eye-opener to me that made me not trust the health care system. (Participant 13)*

*I also think that people might be scared to at least find someone locally – if they share their stories with other people because I feel, you also hear stories about doctors not adhering to patient confidentiality and talking about cases, which, you know – Moz is really tiny and I feel like it would be very easy to kind of figure out who's who if you hear part of a story. So that – that is a big deterrent to seeking care locally. (Participant 7)*

The fear of lack of confidentiality by health professionals strongly causes hesitancy towards seeking mental health care. Not only is lack of confidentiality harmful to the patient, but concerns of non-adherence to this crucial aspect could deter many from feeling comfortable enough to seek care for their mental health problems (Scull et al., 2014; Almazeedi &

Alsuwaidan, 2014). This factor was emphasised in private health care as there is a smaller number of private mental health practitioners in the city. Similar studies indicate a reluctance of youth to seek help for their mental health within their communities for the apprehension of breaches of confidentiality (De Anstiss & Ziaian, 2010; Burlaka et al., 2014).

## **4.7. Barriers to seeking mental health care**

### **4.7.1 Stigma**

#### **Societal (public) stigma**

Participants expressed views of various levels of stigma as barriers to seeking mental health care. Some participants commented on expressions of the “othering” of those with mental illness on the public scale. In this excerpt, the participant describes this factor of those who look for care. This is illustrated through the socially shaming behaviour of those with mental health disorders:

*... or even in the old times because this has been here for so long ... People think that looking after [one's] mental health is something for people who are unwell or to use the saying on the streets 'nao bate bem na cabeça' (they are not well in the head) ... There is a situation in this society to look at mental health as a 'target of ridicule,' I could say it that way ... A target of contempt, of preconception. It's normal that because of this a lot of us don't look for help to care for our mental health. (Participant 11)*

*Because, I feel that so many people have preconceptions, for example, that one who goes after professional help is very crazy, or things to do with gender, while in reality, it's not like that! (Participant 8)*

It was noted that in a more general understanding of seeking treatment, there is the potential of being labelled as “crazy” or being socially excluded for experiencing mental health problems that require assistance. In the remarks above, the participants make the link between hesitancy towards looking for treatment and the negative public connotations of doing so. This type of stigma was also documented in communities of the global south abroad, where admitting to having a mental health issue or displaying abnormal behaviour leads to social exclusion by one's own community (Linney et al., 2020).

### **Interpersonal stigma as a barrier to seeking help**

In the excerpts below, some participants alluded to the potential criticism they would have from seeking care. This came from friends, family and even perceived ridicule from clinicians, indicating another layer of stigma.

*Um. I would say that it [stigma] affected me one hundred percent, and my decision one hundred percent ... I felt that I would be ridiculed. As you know, my friends and family, in the beginning, wouldn't take me seriously. I thought in some way that maybe the psychologist would ridicule me as well. You could say it was the real reason why I chose not to seek help. (Participant 1)*

*Because before, I noticed that my social circle of friends, well – okay, some of them – had the same discriminatory opinions, a lot of ignorance and lack of information, saying 'Ah, [mental illness] is a lack of this – a lack of God – a lack of whatever ... you are spoiled – oh, you're depressed? – you take pills for anxiety?' – and I don't know what else. That kind of complete discrimination, that kind of stigma. (Participant 5)*

The two accounts above detail the attitudes portrayed in their social circles in relation to mental illness and how this would make them uncomfortable to seek help. In the account below, one participant explained how their family's fear of disclosure of mental illness of a relative had impeded his ability to access care. This is consistent with literature that outlines the occurrence of stigmatisation for families who disclose mental illness and, therefore, choose not to seek care to avert negative attention from the family unit. However, this means that family members who need care are left more vulnerable, as they cannot access medical intervention and may not be able to access them without support (McCann et al., 2011).

*That's what they say ... It really is something that, you know, usually happens to other people – and it's happening to us. So, there's like secrecy, they don't want outsiders to know. There's a lot involved in that. I wonder how that kind of shame stops or makes it difficult to help my [relative]. For example, if my [relative] needs to go to the facility in Zimpeto – what if he needs to go there? So, in my family, because of shame, or because of the need to please others outside, they won't send him there, to a place that could make him better. (Participant 2)*

Interpersonal stigma is a powerful structural deterrent to seeking care, as it catalyses feelings of self-stigma for those who experience mental health problems. (Hatzenbuehler, 2016) Being perceived as mentally ill or in need of mental health assistance by a young person's relatives or friends may create feelings of inadequacy for the person with mental health problems. This is due to interpersonal stigma creating feelings of personal failure or flaws of willpower in those who are experiencing mental health problems (Heflinger & Hinshaw, 2010). Most of the participants, especially those who had successfully seen a mental health professional, described lower incidences of stigma in their own searches for care. However, both groups noted that stigma is a significant barrier for many people struggling with symptoms of mental health disorders.

### **Expressions of self-stigma in participants**

Themes of self-stigma also featured in a few participants' accounts, pertaining to its effect on their perception of seeking care were also noted.

*So, there is this situation where people look at it with prejudice – I also look at it with prejudice myself, but this is because we have been hearing for a long time that there are instances where you think mental health is something for people who are crazy.  
(Participant 11)*

*So much that, when I did look for help, it was just because people told me – to do so, but no, no – they insisted very much – I made a few changes, but ... I ended up agreeing and searching for help but, it was never a thing of feeling one hundred percent comfortable with doing so ... and why? Why, well, I don't know, it was a little bit of shame, of trying to overcome this thing alone, or thinking I could overcome it alone, without help. (Participant 9)*

According to literature, self-stigma is defined as reduced self-esteem or self-worth due to thoughts of being socially unacceptable by society (Vogel et al., 2007). Self-stigma has been shown to have a relationship with public and interpersonal stigma (Subu et al., 2021). Although this does not imply causation, it does draw on the effects that public rhetoric may have on the feelings of people who live with mental health disorders. This reiterates the importance of public anti-stigma interventions as a way to mitigate occurrences of self-stigma within communities and families. This aspect is important, as self-stigma is a notable



hindrance to seeking mental health support. Even with the existence of mental health literacy, for instance, being able to recognise symptoms of depression, the presence of self-stigma is strong enough to impede someone from seeking care (Cheng et al., 2018). The participants alluded to their own feelings towards mental illness and how admitting that one has a mental health problem could echo public discourse of being “crazy” or not being capable of looking after oneself without professional assistance.

From the accounts above, all participants agreed that stigma was a barrier to seeking help for either the participant themselves or other people in general. Although some participants did not directly experience stigmatising behaviour pertaining to mental health-seeking, they acknowledged that it was a strong barrier to other people in society. Participants’ accounts demonstrated that stigma was expressed in various ways and at different levels – from negative public associations to mental illness and help-seeking, as well as examples of stigmatising discourse from people close to the participants, to impacting self-stigmatisation.

#### **4.7.2. Need for mental health literacy and support**

##### **Effects of low mental health literacy**

Some participants described the effects that low mental health literacy may have on the identification and treatment of mental health problems. They referred to how this aspect affects the way people seek care, as follows:

*Okay – the perception of society on this topic – I think that there hasn’t been much discussion, yes, not in a formal way, or in our own conversations that bring up this subject ... there is no such talk, if there is no such information, it could happen that a family member goes through this problem, and it’s ‘I don’t know, I don’t know how to deal with it.’ Because in truth, many people do not know how to deal with this situation. It may happen that a family member or a brother or a husband goes through this type of problem, and doesn’t know how to solve it. Even if the problem is not very serious, but due to not knowing the right points and the proper follow-up, the person can aggravate the problem. If we know how to handle the situation properly, then we can follow up or be able to help our brother or our husband or our friend. (Participant 6)*

*So, here in Mozambique, people don't take the topic of mental health seriously because there is no knowledge on this topic, for some, it's just not that important. This varies from person to person. There are people who (pause) only live and believe that mental health – if the person looks fine right now, [the person] shouldn't look for care because ... this is a thing for 'crazy people'. (Participant 10)*

These excerpts both demonstrate the implications of the societal perceptions of mental health on the support of people with symptoms of illness. In the first excerpt, the participant outlines the effects of limited mental health literacy on the family members of someone with a mental health problem. She outlines that the lack of recognition of it being a mental health issue that requires attention indicates that the family may not be able to assist the person in the hypothetical situation. In the second excerpt, the participant mentions that due to limited mental health literacy, seeking help for mental health problems is societally reserved for those who are perceived to be “crazy”, possibly with more overt symptoms of a mental health problem.

#### **4.7.3 Financial exclusion from access to care**

Most of the participants expressed that seeking mental health care was not financially accessible to most of the population, especially for private care. This barrier was mentioned in both the group that had sought help and the group that did not.

*Okay, so I believe only a class group here really gets help when it comes to mental health because it is costly and expensive – and the way that our society is here ... a lot of people are worried about survival. So if people are worried about survival, or living cheque to cheque – daily ... it's very hard for them to worry about mental health ... If you did a survey, only part of the people, upper and middle class are worried about that.*

*(continued) Another thing is the prices ... (sigh) it's known that 80% of Moz citizens are poor. (Participant 2)*

*First, it is very expensive – firstly – and there are only a small number of them. Second, they are quite expensive. Third, there are still a few who do pro bono consultations, but I only know of two centres. The rest ... it has a cost, and it is quite high. (Participant 4)*

One participant mentioned that she was only able to access psychological services through her university's subsidised services. Otherwise, the typical prices in private care would have been inaccessible.

*For example, speaking from my experience, when I was looking for a psychologist, it was a little bit difficult, firstly because I only found psychologists who were in the clinics ... And at the clinics, the prices, at least for myself, are high, right? The consultations, as they are 2 500, 3 500 meticais, and this is per session – it's ... a bit too much. (Participant 8)*

Below, a participant who did not seek treatment explained how her insurance plan did not cover consultations for mild to moderate mental health problems. She outlined how the existing services are too costly:

*Something weird that I've noticed. I have insurance. And for some reason, the insurance company does not really cover a psychologist. It only does if it's an emergency case., like if you have schizophrenia or any other type of mental disorder. They will see you if it's escalating beyond help – if you can put it that way. But if it's depression or anxiety or something that they consider as a minor thing, something that is not that serious in their eyes ... I would just say that it's not affordable, just a hint. But yeah, I think that's my impression, at least. (Participant 1)*

#### **4.7.2 Need for decentralised support centres**

A few participants mentioned that creating more posts or support centres for mental health services may increase access to care for those who may live far away from the main centres.

*Make the health care system more accessible to others by creating centres, by having more professionals in that area ... (Participant 13)*

*... that there should be more clinics, or posts, or a support centre, such as, for example, the social-psychological centre, it's at [university name], I think they charge a minimal fee, I think. (Participant 4)*

By placing more mental health resources in primary care clinics around the provinces, the barrier of spatial access to care may be reduced. Within the province of Maputo, health care

tends to be centralised within the city. This would mean that help-seekers who live on the outskirts of the city may not have the same level of access in their own neighbourhoods and thus must arrange transport to seek access to care. In addition, care may not always be readily available at public health outposts in the city.

## **Factors that encourage mental health care seeking**

### **4.8.1 Social support**

#### **Family support**

An important theme that emerged from the data analysis was the significance of support as a facilitator in mental health care. This included family support, peer support and financial support. Some participants described feeling comfortable enough to discuss their mental health with their family and said that seeking care was generally regarded as acceptable. This was noted in the following accounts:

*Maybe I should mention my family at home, yes, we talk about it ... as I mentioned, and it is something that is not a taboo. So, there is communication on this subject, everyone is aware that it is important to seek professional help when necessary. So, we are at least aware of the issue. (Participant 4)*

*It's a subject of extreme importance, that we shouldn't ignore in any way. And that ... when one observes, uh, any problem related to this subject ... We will deal with it in a careful way. In a specific way, taking lots of care so that if any member of the family goes through this situation, they won't feel excluded, and they won't feel stigmatised – just for going through this difficulty or for having this problem. The conversation around these ideas is that it is important to give [mental health] proper attention. (Participant 6)*

The participants who experienced less openness from family members around conversations on mental health at home remarked that they would ultimately receive support from their families if they decided to seek professional help.

*Okay, I feel like my family would support me, if they've seen how bad I was. I'm pretty sure they'd support me all the way ... because, well, I'm their family (laughs) and they would want to see me thrive and see me in a better place. (Participant 1)*

*Um, I believe that yes, I would receive support from my family and friends, knowing that it would do me good. And because they would have the notion that this situation could be better if I were to have a situation where – with some kind of mental health problem – that I would improve. So, I believe so ... that I would have all the support and aid. (Participant 11)*

Almost all the participants reported that if they decided to seek professional help, their families would support their decision, emotionally or financially. Family openness towards conversations around mental health featured more frequently in the accounts of those who had sought care than participants who did not.

Although not all participants had families who openly discussed mental health at home, they acknowledged that they would be financially and emotionally supported if they decided to seek professional help. The role of a supportive family is pivotal for a young person, enabling the emotional and financial resources to seek mental health care. For both young people who live and do not live with their parents, having strong family support for mental health-related matters facilitates the process of seeking care.

### **Peer support**

Some participants reported that their friends were comfortable talking about mental health and care-seeking which served as significant support for them. In a few instances, the support of friends directly led to participants seeking care for their mental health, as they expressed below:

*My friends have always, always supported the idea of looking for help, looking for psychologists, at least. The people around me have always shown openness towards this topic – and I, even some of them have looked for help. Yes, yes – I think the support of my friends gave me the strength to look for help. I think it was more so because of their support ... I will say that I had more strength because of my friends than at home, from my family. (Participant 9)*

*As far as friends go, I've been lucky enough to have a friend group that is very aware of mental health issues, and matters of wellness, and like all that jazz. So it's very, very helpful to have that social support – especially 'cause I had a roommate who was like 'Hey! You should get help cause – you seem to be unravelling a little quicker than usual.' Which was*

*true, so it does help. Like, if you have understanding ... understanding people around who are there to support you and not make you feel like you're getting judged for getting the help you need. (Participant 7)*

In these instances, the participants' friends recognised the need for intervention and provided support to seek help. Peer support may act as a powerful facilitator in seeking mental health care for young people (Sanghvi & Mehrotra, 2021). In these instances, participants' friends directly encouraged them to seek care.

#### **4.8.2 Financial support for seeking care**

Of the participants who accessed non-public mental health professionals, most were able to do so through having health insurance, university services and subsidised consultations.

*But, services do exist – what I use now, for example, is the psychological service office at the [university], where the patient chooses the amount they have to pay, and the way they can pay. So, if you don't have enough luck to know someone – or have used, or are using the services at the [university name], probably you wouldn't go to ... um. You wouldn't go to someone at these [private] services, also due to the prices, or not knowing people who are using this service. So yeah, it's more or less like this. (Participant 8)*

*I knew I wouldn't get help financially so I got this doctor, she makes seminars or workshops, and she used to do like group therapy. That's cheaper than her normal prices. So I could pay that, so that's how I started going. (Participant 2)*

These participants described the benefit of having lower-cost options, which would encourage those from lower-income economic backgrounds to seek mental health care provided at a subsidised cost. Due to the lack of available public health services or low perceived trust towards them, individuals and families sometimes resort to private care, which may create financial strain. This may deter someone from seeking care altogether (Chisholm et al., 2019). The participant below mentioned that lower-cost services may appeal to families of those who are interested in seeking care.

*... is to have campaigns, I don't know if I would say campaigns but yes, to promote, for example, family therapy ... and paying a fair rate, too. Or even not paying, as it's something*

*new, right? It's like this, it would be good for those parents who don't ... how to say? Who don't give support, they don't believe in it much, or they don't give importance to mental health. (Participant 9)*

### **4.8.3 Media campaigns**

Some participants mentioned creating mental health awareness campaigns to reach more people with messages on mental health and seeking care.

*But, I think we should promote – like the same campaigns that are promoted for sexual and reproductive health, there should exist the same for – mental health because there are a lot of people who ... unfortunately suffer quietly because they don't know how to deal with it and there is a lot of stigmas, still. (Participant 4)*

*... but to make some newspaper campaigns, I think it isn't that expensive. I think that if we, as a society, can help make these campaigns, we are successful. If we can do campaigns for beer, alcoholic beverages, drugs, [inaudible] and general health ... if we can do campaigns of liquid soap, then we can also have mental health campaigns. (Participant 11)*

The Ministry of Health in Mozambique and other collaborating bodies are well versed in using television, radio and social media for other health-related campaigns (Kelly et al., 2007). Existing campaigns related to mental health, such as epilepsy, included general information as well as anti-stigma rhetoric. This was guided by the government as well as partner organisations such as the WHO (Gouveia, 2018). Using existing methods of disseminating information may create familiarity with the subject matter of mental health topics, thus increasing help-seeking behaviour.

A few participants provided ideas on the different channels through which the public is reachable by campaigns, as mentioned below:

*Television debates, on the radio, and on digital platforms ... I think it is these talks, at the level of all schools. I say – from primary level until university. Bring out those kinds of conversations, and gather opinions and information on this subject. (Participant 6)*

*So, I think it's a step, the newspaper campaigns and, more Mozambican psychologists who can talk a little about this, but more attention on television in this aspect. (Participant 11)*

The recipients of messages from media campaigns need not actively seek information on mental health topics, such as online searches using keywords. Instead, people are made aware of them in a passive way, on the chance of encountering these messages while consuming media (Wakefield et al., 2010). This would also facilitate the expansion of mental health awareness towards other groups that may not necessarily use social media, nor actively seek information on mental health on social media.

#### **4.8.4. Social media as a facilitator for help-seeking**

Some participants described social media as a powerful tool for awareness campaigns, information-seeking and as a source of help.

#### **Social media to connect to health care professionals**

A few participants mentioned the creation of online tools that could assist people with receiving psychological assistance directly through professionals.

*... visibility, social media. When Covid started – like what I was saying, there were campaigns for some psychologists, who published on Instagram, that they were giving consultations, free consultations – via Whatsapp, video call, and there they left their contact details so that people could call. In fact, I don't know if the people called, but I assume – a person who really needs help can call, or someone who is very worried about the person can look at the number and call, so social media can help a lot with this. (Participant 3)*

*But, from a certain fear, or stigma, people are kind of hesitant to go to the hospital, this kind of thing – and I believe that if there was availability – to log into a site, where you can speak to psychologists, where you could have consultations, it would be a lot easier for people, right? (Participant 12)*

Based on the responses above, the anonymity of this type of service is a powerful factor for help-seeking, as participants would not have to risk being seen entering a mental health service or navigating around stigma from family or friends. It is also more convenient due to distance from a facility, as well as transportation costs to use them.



## **Online acquisition of mental health information and resources**

A few participants alluded to the great information-sharing potential of social media.

Through accessing information online, young people can equip themselves with knowledge of their symptoms and available services.

*And yes, pretty much, there has been a big change in the attitude towards mental health, and I think a great deal has to do with social media because we are highly, highly influenced by it. And this[mental health] is a subject that constantly comes up there and it's highly debated so, I think that was one of the positive contributions that social media brought to us ... we can not only seek information, but share information and this helps a lot of people in the sense that, it gives people a sense of privacy, because sometimes people are ashamed or embarrassed to seek or ask for this information in person, so they try to solve their problems in their own way, by themselves and, that is a start. (Participant 13)*

*So I think that very good, and targeted information – even if it's very earnest, and honest – like WhatsApp and Facebook Lives about like mental health, and certain conditions, and what they are, and what they aren't, especially, would be very beneficial. (Participant 7)*

### **4.8.5 Bringing care closer to young people**

Some participants mentioned that creating posts of care in institutions such as schools, universities, colleges and workplaces would facilitate access for young people.

*... so sometimes, maybe once a month, a group of psychologists can visit a school and have free consultations or leave their phone numbers because – arriving and sitting, and saying 'Look, we have free consultations,' many young people may not go there because of shame. So maybe with this contact, or, I don't know if it's possible to reach more young people if the doctors went to the schools. (Participant 3)*

The centralisation of mental health care facilities may deter young people and people who live on the outskirts of cities from getting help. Many of the participants remarked that having posts of care in schools, tertiary institutions and technical colleges may increase the likelihood of young people receiving help if needed. To reach those who do not belong to an institution or place of employment, prioritising decentralised clinics with mental health posts

is another possibility. In addition to more centres, subsidised fees as an option for these specialised services may further increase access to care for younger people in both scenarios, as this would remove the financial burden and can circumvent disclosure from having to ask for financial assistance from family.

In addition to this aspect, the need for larger numbers of mental health professionals, which has recently been made through task-shifting towards other health care workers (Gouveia: 2018; Dos Santos et al., 2016), can ensure that treatment is available to those who cannot access more specialised care for their mental health. This aspect has greatly expanded the reach of mental health care throughout the country and has undoubtedly improved the prospects for many.

#### **4.9. Discussion of the findings**

This section will entail a thorough discussion of the findings in this chapter.

##### **General perceptions towards seeking mental health care**

Regarding the participants' general thoughts and perceptions towards mental health care, several findings emerged. All participants placed high importance on looking after one's mental health. The interconnectedness between physical and mental health was commented on by most of the participants. This echoes the earlier theories of mental health care, which made use of the link between mental health problems and biological factors to explain the causes of illness. Based on the biomedical model, this perspective suggests that genetic or neurochemical imbalances are the primary causes of mental illnesses (Thachuk, 2011). Proponents of mental health awareness, though not overtly, used this approach to reframe mental illness as not a product of personal inadequacies, but rather as a biological problem out of someone's control. This explanation sought to reduce the stigma toward those with mental health problems (Lam et al., 2005).

Contrasting the theoretical reliance on this model for creating awareness and reducing stigma, Thachuck (2011) argues that it does not adequately consider the individual within their environment, thus reducing the cause of illness to only a biological nature. The bio- psychosocial model – which implicates how one's environment, lifestyle and genetic factors contribute to mental health disorders – provides a more holistic lens. This model outlines

multiple factors that may cause mental illness, instead of solely focusing on biological causes (Canadian Health Service Research Foundation, 2013).

Participants described their motivations for help-seeking. The responses suggest the theme of perceived consequences of mental problems affecting one's responsibilities and interpersonal relationships are a motivating factor. These consequences have been documented in earlier literature, where the effects of untreated mental health problems negatively impacted academic work and future employment, ultimately leading to worsening mental health in later adulthood (Fazel et al, 2014; Hoagwood et al, 2001). In addition, it was found that participants prioritised looking after their mental health to improve or maintain healthy interpersonal relationships. This factor is corroborated by the literature and extends further, with the potential to inspire others to seek care for their mental health problems (Stice et al., 2004).

The nuances of when it is considered appropriate to seek care were raised by a few participants. Normal reactions to life stressors may not warrant psychological or medical intervention. However, pathological expressions may be interpreted as normal reactions to difficult situations, thus not warranting professional help (McCann et al., 2017). The attribution of symptoms of generalised anxiety disorder as "general life stress" offers an example of minimising mental illness (Paulus et al., 2015). This may lead to increased delays in help-seeking or not seeking help at all (Paulus et al., 2015). In this study, self-reliance was based on a desire to uphold the personal or societal value of self-sufficiency, as all participants reported that they placed moderately to higher importance on their mental health.

From one angle, the expectation of self-reliance may inhibit individuals who are not able to manage mental health problems from seeking treatment. This may stem from fears of seeming "weak" or spoiled, as illustrated by multiple levels of stigma. (Hatzenbuehler, 2016) These individuals may suffer as a result, either through experiencing delays upon seeking help or never seeking help at all. The participants had not searched for professional care but may have incorporated the features of self-reliance in relation to their mental health. Self-reliance often translates to a low perceived need for care (Bruffaerts et al., 2011). The WHO reported that globally, a low perceived need for care was recorded as one of the main

attitudinal barriers to seeking mental health care among patients with low to moderate mental illness (Andrade et al., 2013).

With reference to the multiple cultures that have shaped Maputo, it was important to explore how certain belief systems interact with the pursuit of mental health care. For example, the historical presence of war with traumatic repercussions led to the use of multiple healing modalities. As they were available and reliable, families across the country sought traditional healers for physical, mental and spiritual ailments (Igreja, 2003; Mlambo, 2012). However, a few of the participants expressed that talking about mental health or seeking Eurocentric forms of mental health care challenged attributions of one's African identity. It was alluded to that in some way, seeking medical help cannot co-exist with one's cultural identity, through methods of coping with one's struggles. Cultural influences, especially in countries of the Global South, may not align with the process of seeking medical treatment in favour of local belief systems and coping mechanisms (Ilondo, 2017). Similarly, Bäckström's (2015) study of the rhetoric of mental illness in Maputo indicated that mental illness was commonly perceived to result from substance addiction or having had a curse or spirit placed on one through witchcraft (Bäckström, 2015; Pires et al, 2020).

However, the data suggests that cultural factors did not directly affect participants' help-seeking process. What featured more prominently were the participants' experiences of being directed towards religious modalities for mental health struggles. Connections between both cultural and religious identities and stigmatising beliefs have been documented in literature based particularly within Southeast Asia and Africa (Ilondo, 2017; Rathod et al., 2017). Besides cultural or spiritual explanations for poor mental health symptoms, the stigma of having a mental illness and using medical treatment may be so strong that alternative means of diagnosing and treating the issue through other channels, such as religion, are seen as more acceptable by society.

Most participants affirmed that religious approaches to mental health issues and help-seeking may hinder or delay individuals from seeking mental health assessment and treatment. This connection was present in more than half of the participants' accounts. Some reported that culturally speaking, seeking standard mental health treatment has the potential to be seen as

un-African. A few reported that their mental health symptoms were perceived by others as a lack of religious presence in their lives.

The themes of help-seeking in relation to identity and social grouping may be analysed using the Social Identity Perspective (Klik et al., 2019). The contextual framework of identities and social norms may be combined with this theory to further understand one's relationship to help-seeking. This perspective illustrates the power of how one self-identifies within a social group, such as one's gender or nationality, and the ways this identification may enforce meanings associated with belonging to these social groups. Using this framework, two suggestions emerge. The premise of the Social Identity Perspective is that a person's sense of identity is based on their group memberships and psychological connection to these groups (Klik et al., 2019). In relation to one's "membership" to a social or cultural group, having a mental illness and seeking treatment is potentially at odds with the normative identity content (for instance, social norms and behaviour) belonging to those social groups (Klik et al., 2019). Seeking mental health treatment may be difficult for those who strongly identify with cultural, religious, community or family norms that are not inclusive towards members with psychological or psychiatric illnesses.

On the other hand, it was found that self-identification of having a mental illness and, thus, entering the "mental illness social group" can provide the motivation to seek treatment and get better, eventually "exiting" the "mental illness group" (Klik et al., 2019). It was also found that through seeking treatment, people may feel more prone to stigma as they would feel directly associated with being part of the "mentally ill" cohort. Interestingly, this may also play a role in why someone would not want to seek professional help, due to the desire to "disengage" from the label (Klik et al., 2019).

The participants who sought care also expressed differing experiences when seeking mental health care. Positive patient experiences with available mental health care create the motivation to seek follow-up care, along with cultivating public perceptions of trust. Adequate trust in a provider's professional capacity is associated with factors such as increased clinic visits, adherence to medication, fewer emergency room visits and, overall, better mental health outcomes (Dorn et al., 2006). Satisfaction with the care received from mental health services was described by half of those who sought care. Participant 2

mentioned that she would be willing to work with other professionals in the future due to her positive experience of seeking care. However, negative experiences were also commented on by some of the participants, such as feeling judged by the health care provider, incorrect guidance on medication, as well as not finding a good “fit” in terms of talk therapy. If perceptions of service quality are low, as illustrated by Amazeedi and Alsuwaidan (2014), young people are much less likely to seek care.

Barring personal differences with professionals such as psychologists or counsellors (for instance, a patient not being a good “fit” with a professional), it is important for the quality of care to be of a high standard in both public and private spheres. A third-party regulatory body for professionals, especially those who provide talk therapy, would ensure that practitioners in the public and private practices maintain a high quality of services as well as sufficient resources to do so. Not only is this beneficial to the safety and well-being of those currently in treatment, but it may also build trust for potential help-seekers.

As mentioned previously, due to the subjective nature of seeking mental health care and the varied modalities in the field, certain differences between patient and provider may not necessarily reflect on the quality of the care. However, consistent, high-quality care nurtures feelings of trust in patients. In addition to getting access to treatment, studies have demonstrated that trust in the health care system adds a psychological benefit to users (Ahnquist et al., 2010).

Although quality service regulations in public mental health care are carried out by the Department of Mental Health, there are no external regulatory bodies to monitor the services. Private mental health care is not regulated (Dos Santos et al., 2016). Apart from the public health regulations and revisions, there are collectives through which practitioners in the mental health field discuss matters related to mental health in Mozambique. For example, the *Associação de Psicólogos Mocambique* (Association of Psychologists in Mozambique) was founded in July 2004 for the promotion of the field of psychology in Mozambique, upholding quality, human rights and comment on disciplinary cases of those involved in the association, among other objectives (*Associação Psicologia*, LinkedIn, n.d.). The association seems to be intermittently active through their Facebook group page, where announcements and requests

for additional care in response to incidents are published. In the past, they have hosted events and talks related to mental health topics and plans within Mozambique.

In addition to this, the Centro de Psicologia Aplicada e Exames Psicotecnicos (Centre of Applied Psychology and Psychotechnic Exams) hosts a blog which features an online magazine, Revista Psique (Magazine 'Psych'). Revista Psique is a six-part publication presenting local psychological research. The blog format allows for open discussion among professionals and to keep updated with literature based in Mozambique. The creation of these initiatives by existing professionals demonstrates the desire to evolve the network and knowledge about mental health in the country.

### **Perceived barriers to seeking mental health care**

Participants detailed the effects of perceived stigma as a strong barrier to seeking care. The multiple forms of stigma may greatly inhibit young people from seeking treatment for their ailments or greatly delay their first contact with a professional. In turn, this would cause the person with a mental illness to internalise feelings of being weak or being a failure (McCann et al., 2016). The participants expressed different forms of stigma, for instance societal, interpersonal and self-stigma. These forms suggest that social attributions of sufferers of being flawed or incapable further push sufferers away from looking for treatment, as doing so would display an admission of having a mental health issue (Heflinger & Hinshaw, 2010). Thornicroft et al. (2008) describe the social exclusion of those who experience stigma. This is especially true as stigma may affect a help-seeker at various stages of the process. It is often an outcome of limited mental health literacy. This was evident as limited mental health literacy within public rhetoric was commented on by most of the participants. Although the participants themselves were familiar with the topic of mental health and help-seeking, they described a general lack of conversation around mental health within public discourse.

Low mental health literacy leaves people “unable to recognise signs of distress in themselves or others, which can stop them from seeking support” (mentalhealth.org.uk, 2021:1). Almost all the participants emphasised a need for more public discourse and education around mental health. With limited mental health resources available, increasing mental health literacy is crucial for one to recognise the need for intervention, seek available networks of care and make use of available resources (Atilola, 2014; Okasha, 2002). The combination of stigma

and low mental health literacy has been well documented as dominant barriers, both on the global scale and the within the context of Mozambique (WHO, 2022; Lovero et al., 2022). The perceived importance of looking after one's mental health also runs parallel to mental health literacy, as is documented in the review of help-seeking in India by Sanghvi and Mehrotra (2021). This was illustrated through a study in which people with schizophrenia who had knowledge of their symptoms and condition sought help much earlier than those who did not have the same levels of mental health literacy. This finding was also reproduced for those suffering from symptoms of depression or anxiety disorder. For those with less exposure to mental health literacy, worrisome symptoms of depression or anxiety were attributed to stressful life events and thus not regarded as important. They delayed their help-seeking due to the lower perceived importance of rectifying their symptoms (Sanghvi & Mehrotra, 2021).

Over half of the participants commented on the stark economic inequalities' effects on those who cannot afford private care. A few participants outlined the sentiment that being able to afford mental health care is only reserved for those within the middle to upper-class economic groups. The financial barriers to accessing higher quality care may especially prevent young people from seeking help (Munsen et al., 2012). This is compounded if the general perception of mental health care is that of being very costly, although mental health services accessed through the National Health Service charge minimally. In addition, psychotropic medications are dispensed at a low cost, but sometimes there are shortages in these dispensaries (Lovero et al., 2022). Coupled with other barriers, such as the low perceived need for care and stigma, the prospect of paying costly fees on mental health care and medication may be discouraging for many. For this reason, it is important that the government increases resources for mental screening and referral at the primary care level, increasing service provision and creating campaigns promoting the use of public services (Gouveia et al., 2020). The existence of reduced-cost options creates an alternative to the perceived high pricing of mental healthcare, thus making help more accessible to help-seekers. Reduced-cost options geared to younger adults may also include reduced wait times as compared to public facilities. For example, Eduardo Mondlane University in Maputo created the Centre of Counselling and Psychological Support (Centro de Aconselhamento e Apoio Psicologo; CEAP). This centre provides accessible care to university students and is also available for public use (UEM, 2020). The Polytechnic University in Maputo also



created a subsidised option of care for students and the public through the ‘Gabinete de Atendimento Psicologico’ (Office of Psychological Service). They rotate trainees and clinical psychologists and have had a presence on campus, in a secondary school, primary school and at a women-centred non-government organisation.

Having lower-cost or free services may also help young people who are financially dependent on their families. For those who do not have emotional or financial support to pay for professional help, these services are beneficial as they do not require having to enquire for help or resources and queries can be made in private.

### **Facilitating factors for seeking mental health care**

Participants also alluded to several facilitating factors to seeking mental health care. Almost all of the participants highlighted the perceived social support they would receive if they decided to seek care.

Social support includes both material and emotional resources that a person gains through interpersonal contact. Material and emotional resources undoubtedly create a foundation from which an individual navigates seeking care for mental health, especially where resources are considered scarce. Sanghvi and Mehrotra (2021) found that people who experienced higher levels of support from both friends and family were more likely to seek help for mental health conditions than people who did not. Sanghvi and Mehrotra (2021) also describe the potential for interventions at the social stage – using one’s friends and family’s positive care experiences as catalysts for help-seeking. As was found in India (Rathod et al., 2017), families would often try to support family members who seek mental health care, regardless of the openness surrounding the topic at home.

However, the power of social support may also extend to peer networks, as sharing experiences of help-seeking may motivate peers to seek help for themselves (Therriault & Colman, 2017). This was noted in this study too, with some participants citing the support of their peer groups regarding seeking mental health care. In a few cases, participants’ friends suggested they seek professional care. There is a need for developing help-seeking intervention components that target and enable informal sources of support such as family and friends. This may assist people with knowledge and skills to appropriately support

someone in their family or social circle with their mental health and help-seeking process. Along with a focus on improving knowledge and attitudes toward mental illnesses, an emphasis on the complementary roles of informal and formal sources of support may be helpful in the creation of interventions.

The participants mentioned the many uses of the internet and social media regarding seeking care. Social media is one of the channels through which the organisation *Eu, Tu e a Depressão* increases awareness, hosts campaigns and helps connect help-seekers to resources. With the initiation of the pandemic, an initiative from the Eduardo Mondlane University provided free telephonic psychological counselling services; this information was shared on social media through various channels. This access allows help-seekers to contact professionals directly. However, telehealth phone lines such as *AloVida* (Hello Life) provide clarification and information through a hotline, bulk SMSs on urgent health notices and an interactive database with basic topics and resources for health concerns. *AloVida* is also available on WhatsApp. Having open sources of contact information and services that are low-cost or free of charge creates a pathway for managing stigma, logistic and financial blocks that may accompany help-seeking. This is an example of how the anonymity and knowledge-sharing that media provides may drastically assist this process.

#### **4.8.6 Conclusion**

This research sought to gain an understanding of the general perceptions, barriers and facilitators that a young person may face while seeking mental health care in the city. From the accounts of participants, a preliminary understanding of the ways in which people perceived mental health and its care was explored. Participants also shared their perceptions of barriers and facilitators towards seeking care for one's mental health. This chapter documented these insights by presenting the findings based on the themes that emerged from the data analysis. The next chapter presents the conclusions in relation to the research objectives. It includes recommendations and concludes the dissertation.

## **Chapter 5: Conclusions and Recommendations**

### **5.1 Introduction**

The aim of this study was to explore young people's perceptions of mental health-seeking behaviour, which included barriers and facilitators that young people face in the pursuit of mental health care in the city of Maputo. This section concludes the main findings and conclusions of the study in relation to the research objectives, thus leading to recommendations for improvements for help-seekers considering the structural and non-structural factors outlined by participants.

A combination of the Behavioural Model of Health Service Utilisation and the Social Identity Perspective was used to develop a holistic description of the help-seeking processes and their origins. For example, the BHMSU was used to provide the framework for predisposing factors and facilitators. The Social Identity Perspective provides a framework through which attitudinal barriers are analysed, especially pertaining to one's identities.

### **5.2 Objective 1: To gain an understanding of young people's perceptions of mental health-seeking**

This objective explored the general perceptions young people in Maputo have towards mental health-seeking behaviour. When prompted about their perceived importance towards mental health, all participants expressed that caring for their mental health was highly important to them. Personal motivations for seeking care for their mental health included perceived consequences of poor mental health. These included reduced productivity at work or school, as well as the potential for damaging interpersonal relationships. However, some participants commented that the minimisation of poor mental health symptoms and the emphasis on self-reliance may prevent one from seeking professional care. Participants were also prompted about the role of culture and religion in one's decision to seek care. Cultural rhetoric did not particularly influence most participants directly but was noted in the extended family of a few. Participants commented on general views of this topic and explained how valued traits such as strength and resilience were loosely associated with one's African identity, making it unusual or incompatible to seek psychological or psychiatric care in the place of informal or community care.

The aspects of cultural and social context should be centred in mental health research and intervention planning, considering the multiple cultures and beliefs that exist within capital cities like Maputo. Religious interventions were cited as the first point of call for a few participants, with symptoms of mental health problems conceptualised as a lack of God, which may be remedied by prayer.

Participants were prompted to share their perceptions of the existing mental health services. They spoke about the perceived improvements needed towards tertiary and public mental health facilities in the country. Of those who received care, the reports were a mixture of positive and negative experiences. Of the positive experiences, the participants felt that the professional help they had received was beneficial to them. On the other hand, other participants reported a lack of quality or accessibility with the professionals they visited. This feature spoke to the need for more mental health professionals in the country to provide more thorough consultations. Although the Ministry of Health conducts quality control over mental health professionals in public health, the large numbers of patients and limited time may not be conducive to quality care. More research on standardising the practice is needed, to increase trust in both public and private mental health professionals.

### **5.3. Objective 2: To explore the barriers that young people face in their desire to seek mental health care**

Participants elaborated on both structural and attitudinal barriers that may prevent a young person from seeking care. They drew from their personal experiences, as well as those that may affect the broader communities of young people in Maputo. One of the most prominent barriers to seeking professional care was perceived stigma. Stigma was spoken about at three different levels: societal stigma, interpersonal stigma and self-stigma. These three categories had functioned at varying levels to cause feelings of shame for one who is suffering from mental health problems. From this theme, the need for increased mental health literacy on a public scale was raised, as this would work to increase support and understanding for those who would want to seek care. Increased mental health literacy may also increase support for young people who may need financial and emotional support to seek professional care.

Participants also commented on the aspect of financial exclusion from mental health spaces. Accessing professional mental health care is known to be expensive or is perceived to be

reserved for those with a higher-income background. However, major universities in the city have created initiatives for subsidised counselling, which is open to the public. These types of services not only reduce the treatment gap, but also reduce the risk of disclosure in the absence of support for a young person. For young people who were not part of a university or workplace, creating more decentralised posts of mental health care would greatly benefit those who do not reside in the city centres. This would reduce costs of transport and the risk of unavailability of health professionals in the main city centres.

#### **5.4. Objective 3: To explore facilitators that encourage a young person to seek mental health care**

The third objective of this study was to explore the factors that would encourage a young person to seek care in Maputo. Similarly, to the barriers, participants mentioned both structural and non-structural facilitators to seeking mental health care in Maputo. The main reported non-structural facilitator to seeking care was social support. The benefits of social support included emotional and financial support from families, indicated by a willingness to talk about mental health topics at home. All participants reported that their families would support them in seeking care despite differing levels of openness to talking about mental health. Peer support was also vital for those seeking care and, in some cases, encouraged the participant to seek professional care for their mental health. Social support is crucial for providing both recognition of symptoms and the emotional and financial capital to seek out care.

Participants commented on the value of campaigns in disseminating information about mental health and available care. As the Ministry of Health has used media campaigns to bring awareness to other public health concerns, material related to mental health and available care may reach a wider population, thus improving mental health literacy. With increased mental health literacy on a public scale, young people would then be more comfortable seeking care as a result of stigma reduction.

Another valuable facilitator for help-seeking is social media. Participants cited social media as a powerhouse for awareness campaigns, information-seeking and as a way to connect potential patients to professional care. Social media is the main way that Eu, Tu, e a

Depressão has functioned to carry out these functions. As many young people possess social media accounts, they can access information both actively and passively.

Participants also mentioned that they were financially able to access care through their health insurance, university services, or subsidised consultations. Universities such as Universidade de Eduardo Mondlane and the Polytechnic University have adopted these services and are open to the public. Mental health posts in educational spaces or workspaces were also mentioned as a facilitator for spatial access to care. Through de-centralising care, young people can access services without having to travel to main clinics or centres. Similarly, placing more service posts in various neighbourhoods can assist those who are not a part of education or employment.

### **5.5. Conclusions**

Based on the findings, the following conclusions are drawn from the study. Mozambique's mental health services have been evolving over the past 40 years and not much is known about the perceptions of seeking care and using these services. The participants in the study are young Mozambicans who expressed their perceptions of this topic. The participants outlined their general perceptions towards seeking mental health care, as well as the barriers and facilitators in this process.

### **5.6. Recommendations**

From the findings and conclusions, the following recommendations are proposed.

- To increase mental health help-seeking for young people in Maputo and ultimately, the rest of Mozambique, a multi-level approach is required. Given the religious and cultural fabric of Mozambique, it is important that cultural factors and alternative modes of help-seeking are integrated and respected in mental health care and service provision.
- Campaigns are needed to spread awareness of mental health and disorders. This may be done through anti-stigma campaigns.
- Given the varying levels of trust and confidence in the mental health care system, standardisation led by the Ministry of Health would guarantee a certain level of quality and confidentiality to potential users and is advised.

- Although the Ministry of Health conducts quality control for professionals in the public sector, a regulation of care that includes the private sector should also be included, as they are not regulated by the Ministry of Health.
- More mental health professionals are needed in the public care facilities to decrease workload and provide more comprehensive and timely care to patients.
- Media campaigns, including billboards, newspaper communication and television, are recommended to provide a way to introduce the topic of mental health and reduce the stigma to a larger audience.
- Social media or telehealth services may be used as a tool to disseminate information and connect potential users to services. Increasing mental health literacy through various forms of media would serve to mitigate stigma and increase mental health literacy, including symptom recognition and knowing where to seek care.
- In addition to creating more awareness and providing standardised care, the government and other funders should prioritise securing high standards of care across both public and private facilities.
- For young people, as is already in practice, using university spaces or training centres as a starting point of service can mitigate stigma and ease the help-seeking process. Participants mentioned that bringing care closer to young people may also act as a powerful facilitator for seeking care.

### **5.7. Conclusion**

The information alluding to the general perceptions towards mental health indicates that mental health is a valuable consideration to those who are aware of its impact. The general perceptions suggest that motivators such as relationships and academic and career-related aspects were present for most of the participants. Participants also talked about the ways in which cultural and religious factors affect mental health help-seeking. The Social Identity Perspective was used to understand the relationships between self-identification and mental illness in this bracket. Participants also outlined the importance of trust in the mental health care system and the benefits of quality services.

Barriers to seeking care included attitudinal factors such as stigma. Stigma was expressed in many different forms. Although some participants were not affected by stigma, they alluded to societal and interpersonal stigma, especially among extended families. Stigma and mental

health literacy are often concurrent. Therefore, creating more campaigns and awareness initiatives around common mental health disorders is needed. Structural barriers included financial burden and the lack of accessibility.

Facilitators seeking care were reported as family and peer support, both financially and emotionally. Although not all participants came from families that were open to talking about mental health, they would ultimately have support if they decided to seek care. Other facilitators, such as financial support through subsidised costs, as has been noted at some universities in the city and were noted as a benefit to those who seek care. As participants are either still in university or beginning their careers, it is a good incentive to provide subsidised costs to this group. In addition, accessible services within these locations, such as a university or close to the workplace, made it easier to avoid travelling long distances to receive care. Participants also mentioned the power of media campaigns, alluding to previous campaigns that the government had created on other public health issues. Some participants illustrated the different ways in which social media is a powerful facilitator for young people who are seeking care, as it may anonymously connect a help-seeker to resources and services.



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## **Appendix 1: Interview Guide (English Translation)**

### **Study: Exploration of the Perceptions of mental health help-seeking among young people in Maputo, Mozambique.**

Researcher: Kartheyani Nair (candidate for the Master's degree in Social Development)

Institution: University of Cape Town

Research objective: To understand general perceptions, barriers, and facilitators towards seeking mental health care in Maputo, Mozambique.

**Section 1: Predisposed characteristics:** This includes demographic data about you, the participant, e.g. age, occupation, living alone/with family, gender and location.

#### **Section 2: Attitudes around mental health-seeking behaviour**

1. Do you think taking care of one's mental health is important? To what extent do you believe it is important to take care of one's mental health?
2. If it were necessary, would you feel comfortable seeking mental health care?
3. To what extent does stigma affect the way you feel about seeking care for your mental health? How do you think stigma might affect others seeking mental health treatment?
4. What do your social circle of friends think about seeking mental health care, and what do they say about mental health in general?
  - 4.1 Based on personal observation, have you noticed any change in the attitudes towards mental health over the years? (The way friends or family talk about mental health, for example.)
5. If your family talks about mental health or mental illness, what do they usually say about this topic?
6. In your opinion, to what extent do factors such as religion or culture influence your family's perceptions of mental health?



- 6.1 Let's assume you decide to seek care from a mental health professional. Do you think you would receive support from your family and/or friends (emotionally and/or financially)?
- 6.2 In your opinion, what is the level of accessibility of mental health professionals or services in the city (cost, availability)?
7. Perception of care: (If the participant had received care.) How satisfied are you with the care you have received so far?

#### Participants' suggestions

In your opinion, how can there be improvements (visibility, financial accessibility) for those seeking mental health care?

Appendix 2: Letter from the founder of Eu, Tu, e a Depressão.

To whom it may concern:

This letter is hereby to state that I have given permission to Kartheyani Nair to recruit participants for her Master's dissertation using the social media platforms of the organization: Eu, Tu, e a Depressão.

(Signature)/Written name

Date:

A handwritten signature in black ink, appearing to read "P. Malusse". The signature is written in a cursive style with a large, looping initial "P".

# Jacqueline Kraamwinkel

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PO Box 38824 Garsfontein 0060 | +27 72 709 4463 | jackykraamwinkel@gmail.com

13/08/2022

## To whom it may concern

This is to certify that the minor dissertation **EXPLORING PERCEPTIONS OF HELP-SEEKING FOR MENTAL HEALTH CARE AMONG YOUNG ADULTS IN MAPUTO, MOZAMBIQUE** by **KARTHEYANI NAIR** has been copy-edited and proofread by a professional language editor in accordance with the requirements of the partial fulfilment of a **MASTER'S DEGREE IN SOCIAL DEVELOPMENT** at the **FACULTY OF HUMANITIES, DEPARTMENT OF SOCIAL DEVELOPMENT** at the **UNIVERSITY OF CAPE TOWN**. The onus is on the author to attend to the suggested changes. Furthermore, I do not take responsibility for any changes in the document after the fact.

Sincerely,



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**Jacky Kraamwinkel**

BA (English and Psychology) – UJ

BA (Hons) English Literature –

UJ PEG membership no: KRA002



**DEPARTMENT OF SOCIAL DEVELOPMENT  
UNIVERSITY OF CAPE TOWN  
AMENDED ETHCS REVIEW FORM**

**AMENDED ETHICS REVIEW FORM: JOINT STATEMENT BY STUDENT & SUPERVISOR**

**This form is filled in jointly by the student and the supervisor**

**NOTE: THIS IS ETHICS FORM IS AN AMENDMENT**

**PROCESS:**

- Student and Supervisor need to read the UCT/FACULTY ETHICS GUIDELINES on the WEBSITE.
- The ethics pertaining to the profession of Social Work also needs to be taken cognisance of in relation to social work students/candidates carrying out research with human participants.
- Once this ethics review form has been completed it is submitted to the Departments' Post Graduate Committee which according to the Guidelines laid down should consist of all academics who will do the reviewing.
- Once the Department approves the proposal/ethics then only is it sent through to faculty.
- **This form should be completed by the research student and then co-signed by student and supervisor: Tick the YES or NO box, and write in details where appropriate. Please read the UCT Ethics Guidelines involving Human Subjects before completing the form. Ask your supervisor for clarification and help if needed.**

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-  
**Student researcher name:**

**Kartheyani Nair**

**Student number:**

**NRXKAR001**

**Title of research project:**

**Exploring Perceptions of Mental Health-Seeking Behaviour among Young Adults in Maputo, Mozambique**

**Degree:**

**Masters of Social Science**

**Supervisor:**

Dr. Somaya Abdullah

1.

The sample for the study consists of young adults from the ages of 18-35 who reside in the city of Maputo. The participants will be recruited through an organization called 'Eu, Tu, e a Depressao', ( You, Me, and Depression). Participants may or may not be diagnosed with a mental illness but must 'follow' the organization on social media, where the information of the study will be posted. They must have WhatsApp installed on their cell phones and working internet connection or data. Exclusion criteria involves those with a diagnosed severe mental illness, as this might impair the participants' ability to consent to the interview and thus place them at risk.

**1.2.2. Sampling Procedure [process involved in obtaining the sample]**

Purposive sampling will be used based on the sample characteristics. After permission is granted from the founder of the organization, invitation to volunteer in the research will be uploaded on platforms such as Twitter and Instagram. Participants may contact me via email expressing their interest in participating in the research. When it has been established that they meet the criteria for participating in the research, a date and time will be scheduled. Before the interview, I will conduct a short questionnaire. Using the template for a Screening interview and Distress Protocol from Draucker, Mardsoff, and Poole,( 2009), I will screen potential participants to make sure that they are not under distress, nor are in an incapacitated mental state before the interview.

**2). INFORMATION PROVIDED ABOUT RESEARCHER AND RESEARCH TO BE UNDERTAKEN**

<b>2.1. Will participants (research subjects) in the research have reasonable and sufficient knowledge about you, your background and location, and your research intentions?</b>	<b>YES</b>	<b>Yes</b>	<b>NO</b>	
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**2.2. Describe briefly how such information will be given to them. If there is any reason for withholding any information from participants about your identity and your research purpose, explain this in detail below.**

Upon expressing interest, an email or whatsapp message will be sent to the participant with a complete description of and purpose of this study. This includes the purpose of the study, nature of the study and questions to be asked in the interview, the right to leave or terminate the interview without consequence, and possible risks. The researcher will

Is this form being submitted for ethical approval as an amendment to the one previously approved by this committee?	YES		NO	No
Is your research making use of human subjects as sources of data?	YES	Yes	NO	
<p><b>Title of the Research Project:</b></p> <p>Exploring Perceptions of Mental Health-Seeking Behaviour among Young Adults in Maputo, Mozambique</p>				
<p><b>Specify the Main Objectives of the Study?</b></p> <p>The main objectives are as follows:</p> <ul style="list-style-type: none"> <li>• To gain a general understanding of young people’s perceptions of mental health seeking behaviour in Maputo.</li> <li>• To explore the barriers that young people face in their desire to seek mental health care in Maputo, Mozambique.</li> <li>• To explore factors that encourage a young person to seek mental health care in Maputo, Mozambique.</li> </ul>				
<b>1). METHODOLOGY</b>				
<p><b>Has the research design changed from the previous submission? No</b></p>				
<p><b>1.2. Population and Sampling</b></p>				
<p><b>1.2.1. Sampling Technique</b></p> <p>The sampling method that will be used for this study consists of purposive sampling, where participants will be selected based on the below criteria. I will employ the use of purposive sampling as it centres the participant as a contributor to a deeper understanding of the phenomenon being studied, adding a ‘unique, different, or important perspective’ to the subject matter under investigation. (Robinson, 2013). Based on a similar investigation, the ideal number of participants for the nature of this research is twelve, as it is likely to reach data saturation beyond this figure. (Scull et al, 2013). Due to the detailed nature of the interview and shared aspects of identity of the participants, an adequate idea of the perceptions of mental health care in Maputo may be deduced from this sample size.</p>				

### 1.2.2 Sample Characteristics

disclose their identity. If the participant is still interested, a consent form will be sent to which the participant can provide a typed response and send it back through either platforms.

### 3). HOW PERMISSION WILL BE SOUGHT

<b>3.1. Will Participants will be fully informed when permission is sought from them to participate in the study?</b>	<b>YES</b>	<b>Yes</b>	<b>NO</b>	
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### 3.2. Describe the process of how this will be done [letter seeking permission & details of study purpose/objectives, will initial contacting take place?]

The participants will be recruited through an organization called 'Eu, Tu, e a Depressao', ( You, Me, and Depression). Eu, Tu, e a Depressao is a new organization based in Maputo, Mozambique, run by a collective of mental health activists and psychologists. This research will be conducted in collaboration with this organization for recruitment and support. Permission was given to conduct the research, and a formal letter of permission will be requested before the research is conducted. As the researcher is a member of the organization, a letter from the founder of the organization will be provided. After the poster with the details of the research is posted, potential participants will contact the researcher either through email or Whatsapp message. From there, the researcher will provide complete details of the study, including study objective, the nature of the questions of the interview, and will answer any questions that the participant may have. Only after they have been thoroughly informed of the study will the participant then be able to give consent.

### 4). SOCIAL DISTANCING DURING COVID-19 PANDEMIC

**PLEASE NOTE: According to the Lockdown Alert Levels Guidelines published by the South African Government, NO research that requires physical human participant interaction in close proximity e.g. face-to-face interviews, focus groups, human sample collection is permitted.**

**4.1. If the nature of your study is such that you can ONLY collect data using face to face methods, what measures will you take to ensure social distancing and safety measures for researchers and participants? Provide details below**

**4.2. If you plan to use REMOTE Methods of Data Collection, please indicate which of the following modes is to be used**

Telephone		
Zoom		
Microsoft Teams		
WhatsApp	Yes	
Skype		
Online Survey		
Other, Specify:		

**4.3. Based on your selection above, please explain how you will ensure the following**

**4.3.1 Confidentiality**

Confidentiality requires that the researcher honours the privacy of the participant by making sure that any identifying information of the participants will not be shared under any circumstances unless the participant gives explicit permission to do so. (Smythe and

Murray, 2000). To ensure this, I will be the sole researcher collecting and handling the data, to mitigate any information being shared outside of the research. As participants will engage using their cell phone numbers to volunteer in the research and to carry out the research, each cell phone number will be saved under an alias. During the transcription stage, numbers will be assigned to each transcript to further separate the data from the participants' identity. No information from the interviews, including demographic identifiers as well as subject matter discussed, will be shared with anyone.

**4.3.2. Privacy**

Privacy of participants is of utmost importance and will be upheld throughout the entire research process. No form of identifiable information of participants will be shared outside of the research, and this will be stated in the consent form. By using Whatsapp as the data collection tool, messages from the participant are encrypted. After the conclusion of data collection, the cell phone numbers, voice recordings, as well as transcripts will be destroyed. Measures towards confidentiality and anonymity will reinforce the participants' privacy (Creswell, 2003). During the data collection process, the researcher will not be surrounded by any other people and will conduct the interviews from the privacy of their room. I will also request that the participant respond to the interview from a private location, where they will be able to speak without interruption.



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**4.3.3. Anonymity**

Anonymity can be conflated with confidentiality but refers more specifically to an ideal separation between the participant and the data shared about them. (Saunders, Kitzinger and Kitzinger, (2015). However, because of the direct interaction between participant and researcher, true anonymity cannot be achieved. Volunteers will come into contact either through email or phone number. As a measure towards overall confidentiality and anonymity, upon first contact from the participants' cell phone numbers will be saved as an alias. The only information that will be used directly from the interview is the participants' age and location, and whether they have or have not been diagnosed with a mental illness. When transferring the voice note data into transcript form, each transcript will be numbered to identify each interview.

**4.4. Please indicate how the data costs incurred by the participants will be covered when using the abovementioned remote tools**

Before the interview, the researcher will ask if the participant is using either pre-paid Wi-Fi or data to connect to the WhatsApp application. If it is the latter, a total

of 20mtn, or R5 will be sent to the participants' cellphone account to ensure that they do not incur any costs from the receiving and sending of voice note messages.

**5). CONSENT**

<b>5.1. Will you secure the informed written consent of all participants in the research?</b>	<b>YES</b>	Yes	<b>NO</b>	
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**5.2. If your answer is yes, Describe how you will do this below**

Participants will be sent the detailed brief of the research either through email or through the WhatsApp application, which will be followed up by an attached document with a letter of consent. The letter of consent will reinstate the details of the research, including confidentiality, privacy, and the right of the participant to leave the interview at any time, without consequence. The participant is to either sign electronically or provide their written statement of consent within the letter. The signed letters of consent through email will be stored safely.

**5.3. If your answer is NO, give reasons below.**

**5.4. Do the respondents have the right to withdraw?**

Yes

**5.5. If yes, explain how this would be obtained?**

Before the signing of the consent forms, participants will be made aware that they have the right to withdraw from the study without consequence, and any data collected up to the point of withdrawal will be destroyed.

**5.6. Will respondents be informed of the use of data post-data collection?**

Yes

**5.7. If yes, how**

They will be informed of the use of the data in the briefing, the primary use of this data is to understand the reality of theoretical barriers and facilitators of mental health among young people in Maputo. The completed thesis will be made available to members of the organization or participants, or anyone else who would be interested in accessing this data. There is also the possibility of the dissertation's use to inform or provide increased incentives towards accessible mental healthcare in the city, and the country as a whole.

## 6). CONFIDENTIALITY, PRIVACY AND ANONYMITY

**10. 1. Are you able to offer Confidentiality, Privacy & Anonymity to participants?**

YES

Yes

NO

**10.2. If you answer YES then give details below as to what steps you will take to ensure participants' confidentiality. If there are any aspects of your research where there might be difficulties or problems with regard to protecting the confidentiality and rights of participants and honouring their trust, explain this in detail below**

**10.2.1. How will Confidentiality be ensured?**

The names/identities of the subjects will not be saved on any device or system. As soon as the participant gets into contact, their name attached to their number will be saved as an alias. In the transcription phase, each transcript will be coded. None of the information discussed in the interview will be shared outside of the research parameters. I will be the sole researcher collecting and handling the data, to mitigate any information being shared outside of the research. During the transcription stage, numbers will be assigned to each transcript to further separate the data from the participants' identity. No information from the interviews, including demographic identifiers as well as subject matter discussed, will be shared with anyone.

### **10.2.2. How will Privacy be ensured?**

The researcher will engage with each participant directly, using their phone numbers. I will not disclose any information about the participants in the study, neither to each other, nor outside of the study. By using Whatsapp as the data collection tool, messages from the participant are encrypted. After the conclusion of data collection, the cell phone numbers, voice recordings, as well as transcripts will be destroyed. During the data collection process, the researcher will not be surrounded by any other people and will conduct the interviews from the privacy of their room. I will also request that the participant respond to the interview from a private location, where they will be able to speak without interruption.

### **10.2.3 How will Anonymity be ensured?**

Both modes of communication, cellphone and email accounts, are password protected, enabling access solely to the researcher. As a measure towards overall confidentiality and anonymity, upon first contact from the participants' cell phone numbers will be saved as an alias. The only information that will be used directly from the interview is the participants' age and location, and whether they have or have not been diagnosed with a mental illness. When transferring the voice note data into transcript form, each transcript will be numbered to identify each interview.

6. RESEARCH INVOLVING CHILDREN				
6.2. In the case of research involving children, will you have the consent of their guardians, parents /caretakers?	YES		NO	
6.3. If your answer is YES, briefly describe how this consent will be secured? [Type here]				
6.4. If your answer is NO, give reasons below [Type here]				
6.5. In the case of research involving children, will you have the consent of the children as much as that is possible?	YES		NO	
6.6. If your answer is YES, describe briefly how this consent will be got from the children [Type here]				
6.7. If your answer is NO, give reasons below. [Type here]				
6.8. Will you use face to face data collection methods with children	YES		NO	
6.9. If yes, what measures will you take to ensure social distancing and safety measures for researchers and participants? Provide details below [Type here]				
7). POTENTIAL HARM TO RESPONDENTS				
7.1. Are there any foreseeable risks of physical, psychological or social harm to participants that might result from or occur in the course of the research?	YES	yes	NO	
7.2. If your answer is YES, outline below what these risks might be and what preventative steps you plan to take to prevent such harm from being suffered.				

There is a risk that talking about perceptions towards mental health may cause feelings of upset or retrieval of unpleasant memories. In order to mitigate this, I have created questions in a way that does not ask the participant to elaborate on upsetting or personal experiences, but have kept the questions in a generalized tone. A psychologist will review my interview guide to ensure none of the questions could cause harm or be a trigger to the participant.

Upon showing interest, an email will be sent summarizing the risks and benefits to participating in the research stated. The nature of the interview will be stated. When the participant shows interest, I will contact them and assess their eligibility using a short questionnaire. Using the template for a Screening interview and Distress Protocol from

Draucker, Mardsoff, and Poole,( 2009), I will screen potential participants to make sure that they are not under distress, nor are in an incapacitated mental state before the interview. I will also make sure to note cues of distress or emotional stress as the participants are sending me their voice notes. I will also provide contacts to mental health professionals that the participant may contact in case of any distress experienced as a result of the interview.

**8). POTENTIAL FOR HARM TO UCT OR OTHER INSTITUTIONS**

<b>8.1. Are there any foreseeable risks of harm to UCT or to other institutions that might result from or occur in the course of the research? e.g., legal action resulting from the research, the image of the university being affected by association with the research project, or a school being compromised in the eyes of the Education Ministry.</b>	<b>YES</b>		<b>NO</b>	<b>No</b>
<b>8.2. If your answer is YES, give details and state below why you think the research is nonetheless worthwhile.</b>				
<i>[Type here]</i>				
<b>8.3. Are there any other ethical issues that you think might arise during the course of the research? (e.g., with regard to conflicts of interests amongst participants and/or institutions)</b>	<b>YES</b>		<b>NO</b>	<b>None</b>
<b>8.4. If your answer is YES, give details and say what you plan to do about it.</b>				
<i>[Type here]</i>				

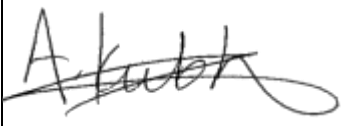
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SUPERVISOR: I have carefully considered all the ethical issues pertaining to this study as reflected in the proposal and at this stage cannot see any ethical obstacles

Supervisor Signature: \_\_\_\_\_  \_\_\_\_\_

**STUDENT: I have discussed the ethical issues with my supervisor and am forwarding this review form to the department's ethics committee for further consideration**

\_\_\_\_\_  
Student Signature: Kartheyani Nair 11/10/2020

DSD ETHICS REVIEW COMMITTEE CHAIR (to sign)	Review meeting: Time spent	Date of completion of review
Chair : Dr Khosi Kubeka 	30 minutes	2/11/2020

Departmentally approved (YES/NO) YES \_\_\_\_\_