

Traditional Medicines



EXPLORING THE ROLE OF TRADITIONAL MENTAL HEALTH CENTRES AND THEIR IMPACT ON PROMOTING QUALITY MENTAL HEALTHCARE AND HUMAN RIGHTS IN GHANA

RESEARCH REPORT

HUMAN RIGHTS ADVOCACY CENTRE (HRAC)

IN PARTNERSHIP WITH MINDFREEDOM GHANA

FUNDED BY STAR GHANA FOUNDATION

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List of Abbreviations

Abbreviation	Full Abbreviation
CHAG	Christian Health Association of Ghana
CHRAJ	Commission on Human Rights and Administrative Justice
CSO	Civil Society Organisation
DA	District Assembly
FGD	Focus Group Discussion
GESI	Gender Equality and Social Inclusion
GFDO	Ghana Federation of Disability Organisations
GHAFTAM	Ghana Federation of Traditional Medicine Practitioners Associations
GHS	Ghana Health Service
HRAC	Human Rights Advocacy Centre
LGA	Local Government Authorities
MFGh	MindFreedom Ghana
MHA	Mental Health Authority
MoGCSP	Ministry of Gender, Children and Social Protection
MoH	Ministry of Health
NCPD	National Council of Persons with Disability
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
OPD	Outpatient Department
PMD	Person with Mental Disorder
PMI	Person with Mental Illness
THP	Traditional Health Practitioners
TMHC	Traditional Mental Health Centers

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EXECUTIVE SUMMARY

The Human Rights Advocacy Centre in partnership with MindFreedom Ghana launched a project titled 'Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers (TMHCs) in Ghana'. The overall aim of the project is to advocate for the improvement of mental health care services and treatment of persons with mental disorders or illness (PMD/PMI) in TMHCs and to ensure their equitable access to psycho-social support and human rights protection. Specifically, the project sought to explore and create an understanding of the functions, roles and activities of TMHCs and their contribution to the mental health sector of Ghana broadly.

This research titled '**Exploring the Role of Traditional Mental Health Centers and their Impact on Promoting Quality Mental Healthcare and Human Rights in Ghana**' was undertaken as part of the project led by Human Rights Advocacy Centre (HRAC) in partnership with MindFreedom Ghana (MFGh) under the Gender Equality and Social Inclusion (GESI) Strategic Partnership Call funded by STAR Ghana Foundation.

This exploratory study used a mixed methodological approach that combines qualitative and quantitative methods to understand the mental healthcare and services provided by TMHCs and/or Traditional Health Providers (THPs). Ten Districts were purposely selected from six zoned regions of the hitherto ten regions to participate in the study. We used in-depth interviews, Focus Group Discussions (FGD), small group discussions and observations for the data collection. Various stakeholders in the formal and informal mental health sectors were engaged to create an opportunity to gain in-depth information from various levels of service provision. All the data gathered were analyzed appropriately to reflect the methods selected; we used STATA and Atlas TI for quantitative and qualitative data respectively. We also employed the ethical procedures approved by the Ghana Health Service Ethical Review Committee.

Findings from the study revealed a general presence of misconception around mental health leading to the persistence of stigmatization of PMD/PMI. This, however, does not translate into poor attitudes towards PMD/PMI overall. Attitudes towards PMD/PMI depend largely on community awareness and

KEY FINDINGS

Stigmatisation of mental health is very persistent among the general public in Ghana shaping their attitude and treatment of PMD/PMI.

There is a general acknowledgement of both the formal and informal mental healthcare providers.

Mental health is fundamentally spiritual and TMHC/ THPs have a role in providing mental health services

TMHCs/THPs provide wholistic services targeting the physical and/or spiritual needs of the people

There is lack of collaboration among key actors within the formal and informal mental

sectors leading to a weak mental health system

There is the need to improve collaboration and resources for both the formal and informal mental health sector.

understanding of mental health, misconceptions of mental health, perceived danger from PMD/PMI and individual compassion towards PMD/PMI. Hence, we recorded both supportive and negative attitudes towards them based on these factors. The study revealed that stigmatization and attitude towards PMD/PMI as well as access to healthcare is also influenced by other factors such as gender, age, culture and who is in charge of decision making in the family. Thus, men suffering from mental disorders or illnesses are more likely to be physically abused whereas women more likely to be sexually abused. In terms of support, women are more likely to be provided with clothing and food as compared to their male counterparts.

In terms of utilisation of health facilities, we recorded a variation between the quantitative and qualitative data. From the survey, majority of respondents reported using formal mental healthcare and services at various secondary and/or primary health facilities. We also recorded a few respondents reporting that they use the traditional and alternative medicine in addition to the formal mental health services. The data from the qualitative study on the other indicated an acceptable use of traditional mental health providers based on the fundamental belief that mental health is a spiritual phenomenon. It became evident that despite the preference for formal mental healthcare and services, the perception of mental health being spiritual, the stigmatization associated to mental health and the physical inaccessibility of health facilities have constrained their use which create huge gaps in the accessibility of mental healthcare and services.

TMHCs/THPs have been critical in bridging these accessibility gaps. TMHCs/THPs reported of providing services that meet the spiritual and physical health needs of the people and address their socio-cultural needs. This informs their provision of multiple or holistic services to address the physical and/or spiritual aspects of ailments. These practices are highly acceptable to those who use their services. It is also evident that THPs understand the different types of mental illness, which informs their diagnosis and treatment regime. The study also recorded fluid utilization between the formal and informal services by respondents who are driven to seek cure for mental healthcare irrespective of who is providing the service. Therefore, clients move their wards from the formal health facilities to traditional health providers and vice versa in search of the cure they desire. These are either based on referrals from family members, the reputation of the providers and the cultural affiliations of the clients.

Findings from the national level framework for mental healthcare and services showed the lack of structures to facilitate collaboration between mental health providers and key actors within the formal and informal mental sectors leading to a weak mental health system. The reports on lack of funding, capacities and resources across both the formal and informal sector also impact the implementation of the Mental Health Act. We recommended that to strengthen the mental health sector in Ghana, the activities and functions of the informal sector must be strengthened to complement the efforts being made in the formal health sector. This will harness their contributions towards performance in health and recognize the informal mental health providers as a pathway to mental healthcare and service provision in Ghana and to improve patience/client experience.

INTRODUCTION

This report presents the research on “**Exploring the Role of Traditional Mental Health Centers and their Impact on Promoting Quality Mental Healthcare and Human Rights in Ghana**”. This research was undertaken as part of the ‘Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers (TMHCs) in Ghana’ project led by the Human Rights Advocacy Center (HRAC) in partnership with MindFreedom, Ghana (MFGh) under the Gender Equality and Social Inclusion (GESI) Strategic Partnership Call funded by STAR Ghana Foundation. The overall aim of the project is to advocate the improvement in mental health care services and treatment of persons with mental disorders or illness (PMD/PMI) in TMHCs to ensure their equitable access to psychosocial support and human rights protection. The project specifically also aims at achieving the following:

1. Improve the understanding of human rights abuses and conditions of PMD in TMHCs through evidence generation.
2. Address systemic issues and constraints that exclude PMD from having equitable access to mental health treatment in Ghana.
3. Highlight the institutional and policy lapses in the national response on mental health care
4. Use the evidence generated from the research to inform advocacy on improving institutional and policy responses on equitable access to psychosocial support and human rights protection of PMD through the regulations of TMHCs in Ghana.
5. Inform the development of specific standards/regulations and procedures (protocol) for addressing these lapses.

The 2010 Global Burden of Disease (GBD) studies showed that mental disorders account for 7.4% of the world’s burden of health conditions in terms of disability-adjusted life-years (Whiteford, et al., 2013) and nearly a quarter of all years lived with disability (Patel & Saxena, 2014). Earlier studies from GBD also documented the challenges posed by mental illness as comprising an estimated 12% of the global burden of disease as at 2000, and is predicted to rise to 15% by 2020 (Lund, et al., 2008; Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). At least 10% of the world’s population are affected by one of the wide range of mental disorders, and as many as 700 million people had mental disorders in 2010 (Patel & Saxena, 2014). It is estimated that mental disorders comprise 5 of the 10 leading causes of health disability and that figure will double by 2030 (Lund, et al., 2008). Despite these global indicators and the evidence of personal and societal impact of mental health (Patel & Saxena, 2014), there is gross inequality and resource constraint in tackling mental health.

The provision of mental health services as a fundamental human right remains one of the most neglected health services in Africa (Yankyera, 2016). The situation is no different from what pertains in Ghana (Yankyera et al, 2017). There is an estimated 2.8 million people with mental disability in Ghana, out of which 650,000 have severe mental disabilities. Systemic challenges have been reported in providing mental health services overall across the country with a

treatment gap estimated at about 98%. This indicates that among every 100 people suffering from mental illness, only 2 are likely to access formal treatment (WHO, 2017).

Majority of this gap is filled by traditional mental health centres (TMHCs), which are largely unregulated, cheaper, accessible and culturally appropriate to the needs of those who use it. It is believed that 70-80% of Ghanaians utilize traditional and alternative medicines including TMHCs. The greatest attraction for TMHCs is their proximity to the community, trust in their methods of practice, cultural and religious relevance to the beliefs and practices of communities. In Ghana, there is a widespread belief that mental disability is caused by evil spirits or demons. Therefore, TMHCs play a significant role in dealing with the spiritual and physical aspects of mental disability especially in terms of the work of prayer camps, traditional healers, herbalists and spiritual treatments.

Despite the significant role of TMHCs in the provision of mental health services, there is very little information, understanding and evidence of their practices with widespread opinions and reports of abuse of human rights of their clients. Serious mistreatments of people with mental disability have persisted with reports of chaining patients, involuntarily locked away in institutions and centers, caning, starvation, seclusion, lack of shelter, poor hygiene, prolonged detention, lack of medical treatments, among others (HRW, 2017). This has created a general mistrust of these traditional health providers by the formal sector with regards to their services and operations, methods of treatment and management of their clients

TMHCs are not regulated in terms of their operations, service provisions, facilities and their methods are not questioned until human rights groups recently started drawing the public's attention to human right abuses. There is no existing policy framework to integrate the activities of TMHCs with mainstream psychiatric facilities. The Mental Health Act, 2012 is aimed among others to regulate the practices and services of both formal and informal service providers. However, its implementation is challenged, making it difficult to regulate the provisions of TMHCs. The Gender Equality and Social Inclusion (GESI) project consists of a research, advocacy and policy engagement components of which this study constitutes the research component.

The primary aim of this study was to explore and understand the services and functions of TMHCs and their impact on promoting access to quality mental healthcare for person with mental disorders/ disability (PMD). To achieve this aim, the study explored and assessed the quality of care, variation in service provision, regulations and the adherence to human rights practices during the treatment of PMD in TMHCs across Ghana. This project created an opportunity to research, understand and unpack TMHCs and their impact on promoting mental healthcare access across the country.

It is worth noting that through this study the term TMHC was coined to describe all mental health services, practices and facilities that use traditional methods, skills, knowledge and practices to support, manage or treat patients based on their beliefs, experiences and cultural practices. Therefore, practices of TMHCs comprise of the services of faith-based healers such as

churches, fetish priests and spiritualists, hypnotists, herbalists, and other alternative practices that support, manage or treat mental health.



(SPHCM, 2019)

METHODOLOGY

The methodological approach used for this research was primarily exploratory to enable the researcher understand, describe and explain the roles, impact, gaps and challenges on promoting access to mental healthcare by TMHC. The methodology describes the study design, aims and objectives, research scope and sampling process, methods and study design. The entire research was driven by its fundamental purpose to explore and understand the services or functions of TMHCs and their impact on promoting access to quality mental healthcare for persons with mental disorders/ disability (PMD).

This study adopted a mixed method approach where quantitative data was collected to hone on the specific perspectives and numerical outcomes and the qualitative data highlights the contextual factors and generative mechanism embedded within mental health and TMHCs. This led to an effective and purposive analysis of the complexities that emerge from the practices and operations of TMHCs. In analyzing the data collected, we synthesised the key findings using emerging themes, identified and explained patterns embedded in the findings to tease out the complexities across the regions.

Purpose and Study Design

This research is an exploratory case study with the main purpose of better understanding Traditional Mental Health Centers (TMHCs) and their role in providing mental health services and how they increase access to mental health service in communities. As indicated earlier, there is very limited understanding of Traditional Mental Health Centers, their functions, services and impact on providing mental health services in Ghana. It is therefore important to explore their roles, functions, services and impact on promoting mental health services and the quality of those services which are critical for advocacy, policies and regulation of TMHCs.

accomplish this purpose, we employed a flexible approach that combined a thick description with explanation of the roles and functions of TMHCs, how they promote access to care and impact on mental health service provision in Ghana.

The philosophical purpose for conducting an exploratory study is to determine the nature of the problem, have a better understanding of the TMHCs and to remain flexible towards responding to new revelations, insights and data during the research (Dudovski, 2019).

This research creates systematic evidence and an understanding of practices of TMHCs for insight, advocacy and regulations. The flexible approach enabled us to also uncover the social determinants of health impacting on community health systems such as TMHCs, rights of patients in these settings during the provision of informal health services and the supportive structures available for TMHCs. Most importantly, it provides lessons for the government-wide integrated mental health programming.

This is what informed the adoption of an exploratory approach with key elements of descriptive, explanatory and emancipatory elements while enabling and creating evidence, understanding of their practices and contributions to mental health care and services in Ghana. It is important to note that there is very limited evidence of the work of TMHC mostly presented as reports and opinion pieces. This research provides a systematic evidence towards the understanding, policy and regulatory gaps of TMHCs in Ghana and their role as informal structures in strengthening the mental health system.

Aims of the Research:

The main aim of this research was to generate evidence for the understanding of traditional mental health centers (TMHCs) in Ghana, assess the quality of care, variation in service provision, regulations and adherence to human rights practices for the treatment of persons with mental disabilities in TMHCs across Ghana. Specific objectives include:

- ✚ Explore the general views on Mental Health and stigmatization of PMD/PMI
- ✚ Explore factors leading to stigmatization of mental health and how best to address it
- ✚ Map out and categorize the various TMHCs in the study Districts and communities
- ✚ Explore the general awareness of the different types of mental healthcare services available to the public
- ✚ Assess factors influencing accessibility to mental healthcare and services in both the formal and informal sectors of Ghana
- ✚ Explore the practices and services of TMHCs/THPs in line with human rights protection of PMD/PMI in Ghana.
- ✚ Document the role of TMHCs in Ghana to generate evidence of their services, regulations and monitoring

Research Questions

The following questions guided the study but they are not exhaustive:

- a. What is the general understanding of Mental Health and stigmatization of persons with mental disorders /illness (PMD/PMI)?
- b. What factors contribute to stigmatization of mental health and how do they impact on PMD/PMI?
- c. What factors influence accessibility of mental healthcare and services?
- d. What different types of mental health services are available in the communities?
- e. What types of TMHCs/TPHs are available in the community and what services do they provide?
- f. Are there any standards or procedures (protocol) for the treatment of persons with mental disorder/illness in TMHCs/ THPs?
- g. How does the practices and services of TMHCs/THPs protect the human rights practices of PMD/PMI?

Research Scope & Sampling

This exploratory study was conducted in ten Districts across six regions in Ghana. The study sites were purposively selected based on high prevalence of mental disorders and TMHCs in the Districts and the existence of a known TMHC. The selection process for the study sites was validated with key stakeholders at a workshop on the research and project overall. **Table 1** shows the list of regions and Districts sampled for the research.

Table 1: List of research sites

Regions of Study	Districts
Greater Accra	Dangme East (Ada) Accra (for National Actors)
Volta Region	Jasikan North Tongu
Central Region	Gomoa West Abura Asebu Kwamankese
Upper West Region	Wa West
Northern Region	Yendi West Gonja
Eastern Region	Atiwa Lower Manya Krobo

In each of these regions, a range of health services are provided. However, the presence of a known TMHC was the key indicator for selecting the communities and Districts. In each community, we engaged community leaders, PMD and their families, TMHCs/ traditional mental health service providers, community members, health facilities and any other key stakeholder as determined by the community. By default, the sampled communities constituted the target population for the survey, in-depth interviews and Focus Group Discussions (FGD).



This provided the sampling frame to enable us explore the traditional mental health services, their practices and patronage. With the sampled population, we did two things: 1) explored their understanding, experience and attitudes towards mental health and PMD, and 2) identified various TMHCs, explored their services and practices, engaged with community members, concerns and strengths of their practices, explored their roles and conduct towards mental health, their perception and awareness on stigmatisation of mental health.

The sampling frame for the study included key stakeholders engaged in mental health (see below) at the Districts, out of which participants were purposively selected to form the units of analysis. For the FGDs, the Mental Health Workers recommended family members/carers of PMD who also referred other families/carers through a snowball sampling to participate in the

study. The in-depth interviews targeted key actors and leaders. The actors targeted include but were not limited to the following:

- ✚ TMHCs Operators
- ✚ People with Mental Disorders/Disabilities (PMD) and their families
- ✚ Community leaders and elders
- ✚ Religious leaders
- ✚ Community members
- ✚ Schools and head teachers (if applicable)
- ✚ In Accra, we targeted the key State and non-State actors
- ✚ Municipal/ District Chief Executives or their representative (if applicable)
- ✚ Mental Health Workers at the local health facilities

These multiple stakeholders (listed above) were necessary to explore the TMHCs, health facility and community perspectives. Therefore, the mental health providers for both formal and informal services, PMD and their relatives/caregivers, community leaders, elders and religious leaders participated in the project.

Research Methods & Sources of Data

We adopted a mixed method approach that purposely combines primary and secondary data relevant for this study. The secondary source of data was primarily using reports from the formal institutions such as health facilities, social welfare units of the District Assemblies and community leaders. The primary sources however included data collected from sampled sites and population using surveys, key informant interviews and FGDs. The use of surveys, interviews, documentary analysis and FGDs enabled an in-depth qualitative and quantitative data, which is rich in information. Specific methods include the following four complementary data collection processes:

1. A general survey for residents in the communities and community leaders at the study sites,
2. Key informants' interview with key stakeholders at the Districts,
3. FGDs with PMD and their relatives, and
4. Documentary analysis of reports provided by the formal institutions such as the health facilities and the District Assemblies.

Researchers & Respondents Interacting



Table 2: Methodological Summary

Method	Purpose	Qualitative	Quantitative	Targeted respondents	No. of Respondents
Semi-structured interviews	Explanatory & Normative	Yes	No	TMHC Operators Health workers Community leaders DA Workers	96
Focus group discussion	Explanatory & Descriptive	Yes	No	PMD Family & Carers Mental health workers	96 (13 sets of FDGs)
Report/document analysis	Explanatory & Descriptive	Yes	No	Documents and reports from facilities	xxx

				and District Assemblies	
Survey	Descriptive	No	Yes	Community Members & Community Leaders	741

Pictures showing some Respondents and Reserchers during Data Collection



FGD Discussants



FGD Discussants



FGD Discussants



Researchers



Ongoing FGD



Researchers with Community Leader



After interviews with Key Informants

About the Research Respondents

Respondents for this research are broadly categorized into those who participated in the quantitative study (i.e. the general survey) and those that participated in the qualitative studies (i.e. interviewees and focus group discussants).

1. Description of Quantitative (Survey) Respondents

A total number of 750 respondents were estimated for the entire research with a plan for conducting a survey for 75 respondents per District. The total number of respondents that participated in the survey were 741 out of the 750 planned. Thus, a response rate of 99% was achieved during the research. In terms of the socio-demographic characteristics of the survey respondents, approximately 20% each participated in the following regions: Central, Eastern and Northern Regions. Respondents in the Volta Region constituted 22% of the total survey respondents while only 7% and 10% were sampled in Greater Accra and Upper West Regions respectively (see **Diagrams 1 & 2**). Majority of the respondents (81%) were within ages 16-45 years with the remaining 19% consisting of those aged between 46 and above (see **Diagram 3** and full breakdown of data in **Table 3**).

Diagram 1: Composition of Respondents by Region

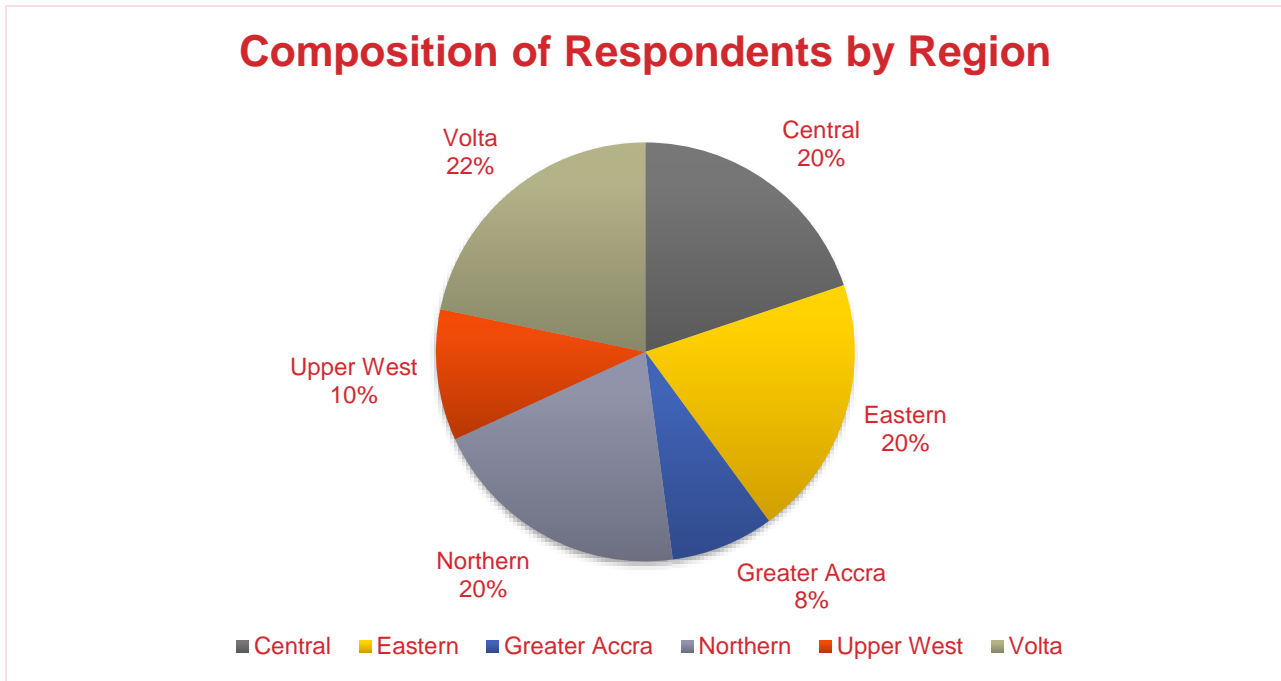


Diagram 2: Composition of Respondents by Districts

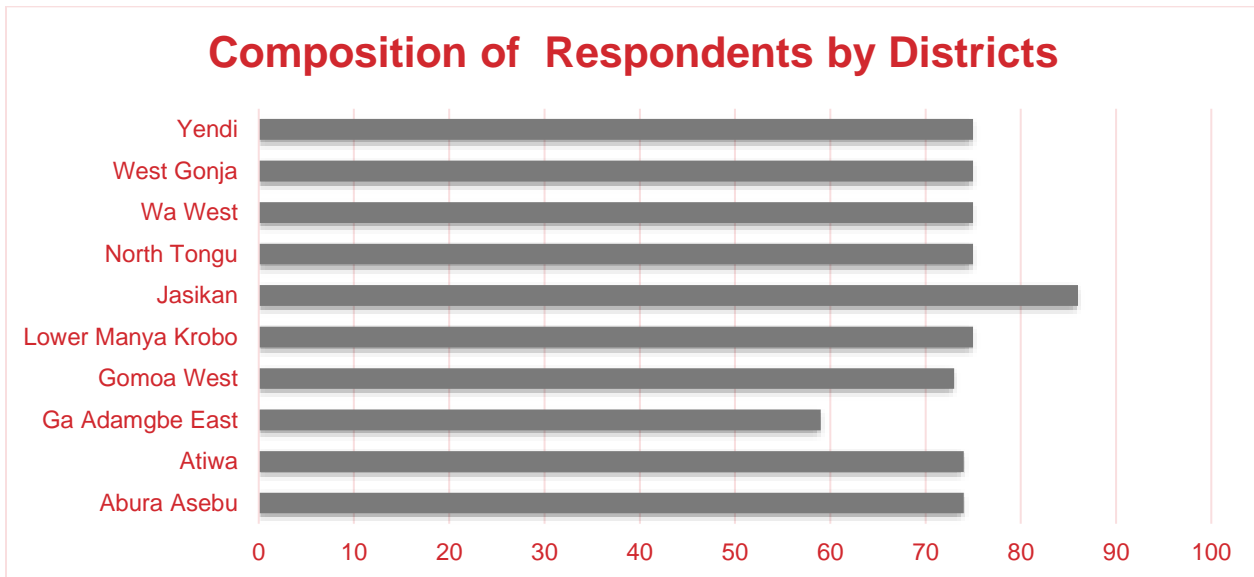
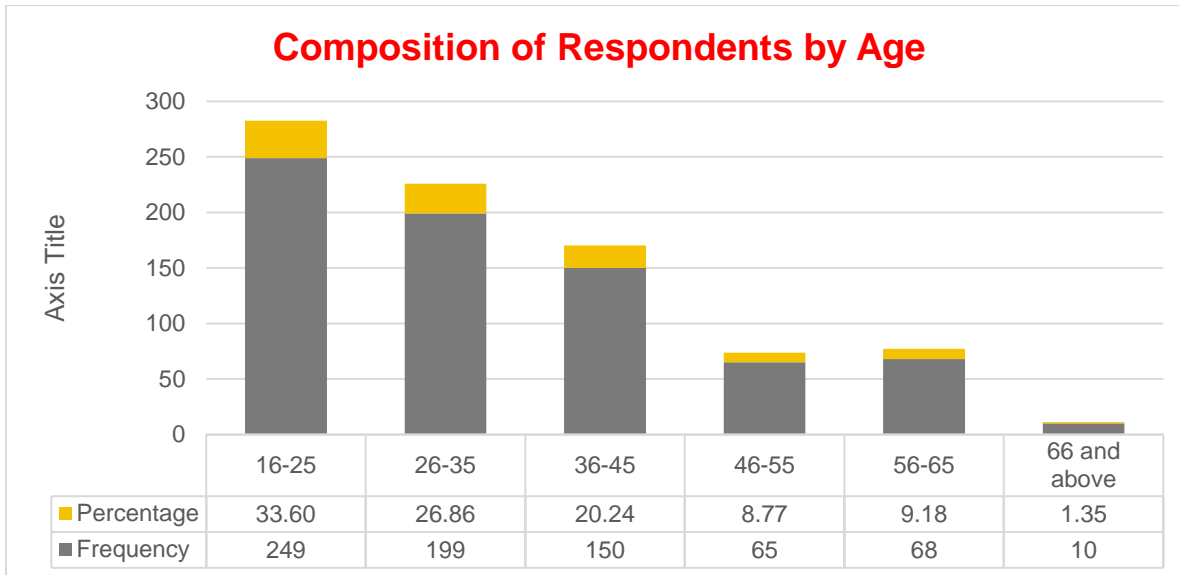


Diagram 3: Composition of Respondents by Age



About fifty three percent (53.3%) of the respondents were males while the remaining 46.7% were females (see **Diagram 4**). Rural dwellers constituted about 70% with 30% residing in urban areas. Christians formed 70% (69.64%) of the respondents with 28% and 2% comprising of Moslems and Traditional Religious Practitioners respectively (see **Diagram 5**). About half of respondents (49.65%) were married, 35% single and the remaining 15 reported to be in a relationship, co-habiting, widowed, separated or divorced. The average number of children reported by respondents was 3.1 ± 4.290 , with 15% having up to three children, 27% having between 4-6 children, 15% having between 7-9 children and 19% indicating they have 10 or more children. Twenty four percent of respondents did not have any children.

Diagram 4: Composition of Respondents by Sex

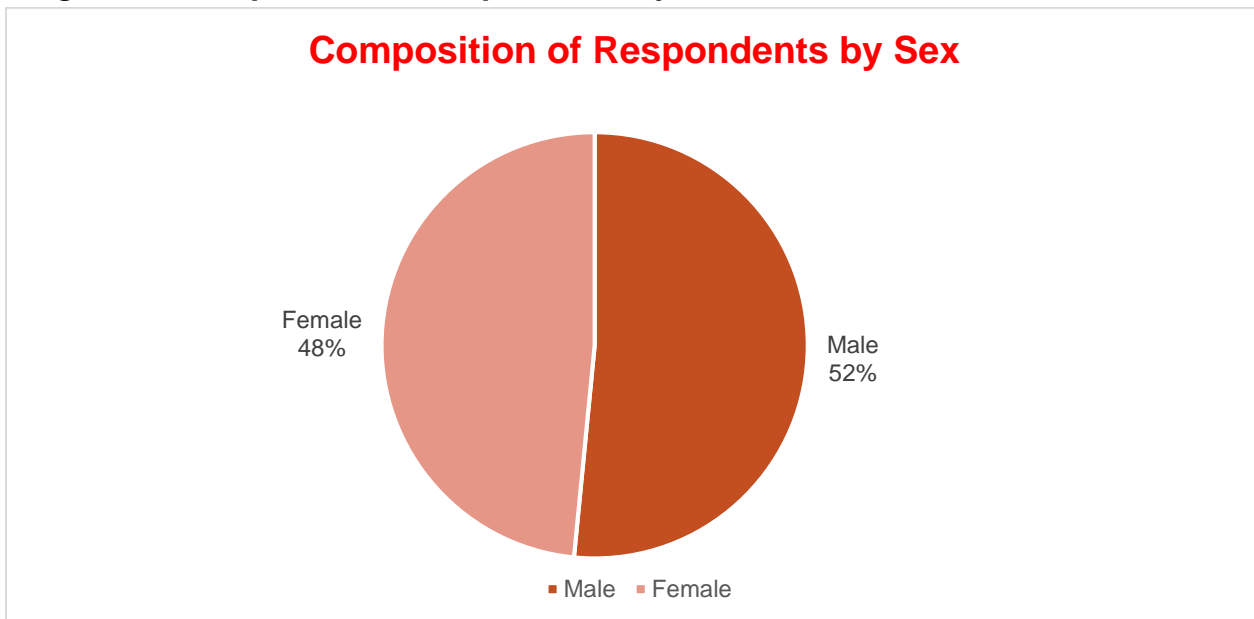
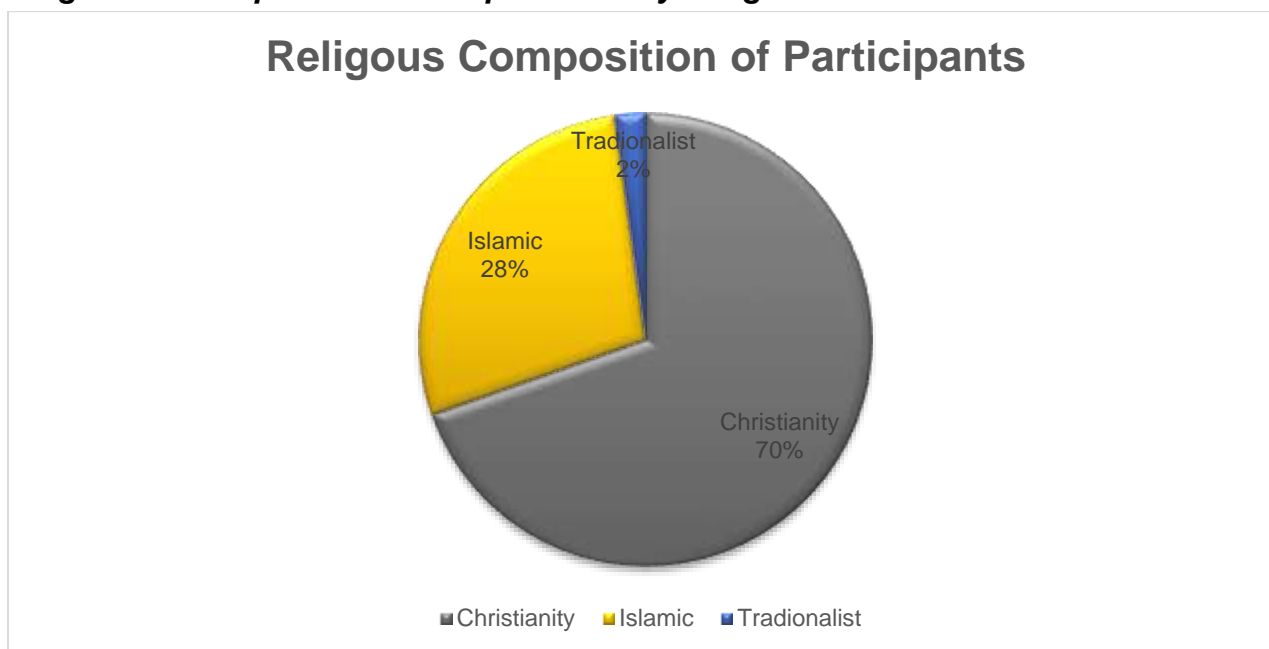


Diagram 5: Composition of Respondents by Religion



We also gathered data on household composition, which included the total number of people in a house-stead, which may comprise several family units. On average, a household had 2.7 ± 1.290 , with the majority being between 1-5 inhabitants (36.7%); 6-10 inhabitants (35%); 11-15 inhabitants (10%); and 16 or more inhabitants (18%). Majority of respondents (92%) worked in the informal sector as traders, farmers, drivers, pastors, etc. whereas only 8% indicated being employed in the formal sector e.g. doctors, nurses, teachers, District Assembly workers, etc. data on the housing units showed that 44% of respondents were in rented accommodation, 41% in family owned accommodations and the remaining 15% are in their own homes. Out of these, 79% of respondents reported living with a family member as against 21% who live alone or with non-family member (also see **Table 3** for details).

Table 3: Socio-demographic characteristics of Survey Respondents

Variable	Frequency (n)	Percentage (%)	Mean (SD)
Region of Residence			
Central	147	19.84	-
Eastern	149	20.11	-
Greater Accra	59	7.96	-
Northern	150	20.24	-
Upper West	75	10.12	-
Volta	161	21.73	-
Age of Respondents			
16-25	249	33.60	-
26-35	199	26.86	-
36-45	150	20.24	-
46-55	65	8.77	-

56-65	68	9.18	
66 and above	10	1.35	
Sex of Respondents			
Male	382	53.3	-
Female	359	46.7	
Religion of Respondents			
Christian	516	69.64	-
Moslem	209	28.21	
Traditional	16	2.16	
Marital Status			
Single	256	34.69	-
In a relationship	77	10.43	
Cohabiting	11	1.49	
Married	366	49.59	
Separated	10	1.36	
Divorce	1	0.14	
Widowed	17	2.30	
Number of Children			
0 (No children)	178	24.3	2.1 (± 3.290)
1-3	111	15.1	
4-6	201	27.4	
7-9	106	14.5	
10-15	84	11.5	
16+	53	7.2	
Number of Household			
1-5	55	36.7	2.7 (± 1.290)
6-10	53	35.3	
11-15	15	10.0	
16-20	20	13.3	
21-30	7	4.7	
Occupation of Respondents			
Farmer	131	18%	-
Trader	178	24%	
Driver	40	5%	
Doctor	18	2%	
Nurse	8	1%	
Teacher	15	2%	
Pastor	15	2%	
Others	333	45%	
Respondents type of Accommodation			
Rented compound house	231	31%	-
Rented self-contained house	93	13%	

Self-owned, self-contained house	112	15%	
Family self-contained house	27	4%	
Family compound house	253	34%	
Family rented house	24	3%	
Total:	740	100%	
Households with Immediate family			
Yes	119	79.3	
No	31	20.7	
Households with Non-immediate Family			
0-3	7	15.9	5.5 (± 5.000)
4-6	10	22.7	
7-10	13	29.6	
11-15	8	18.2	
15+	6	13.6	
Categories of persons in the Households			
Cordial	1	2.3	-
Extended family	2	4.6	
Friends	2	4.6	
Grand children	1	2.3	
Neighbors	18	60.5	
Relative	11	25.7	

2. Description of Qualitative Respondents

The main respondents of the qualitative study were TMHCs operators, community leaders, PMD and their relatives, health providers and mental health workers, workers of the District Assemblies and national level actors who participated in the interviews and FGDs. These respondents were purposively selected, hence they are not statistically representative but had a wealth of experience to share with the researchers and contribute towards the study.

At the national level, the respondents that participated in the in-depth interviews included representatives from the following institutions:

- a. Mental Health Authority
- b. Mental Health Society of Ghana
- c. Ghana Federation of And Traditional Medicine Practitioners Association: (GHAFTRAM)
- d. Ghana Health Service
- e. Ministry of Health
- f. Ministry of Gender, Children and Social Protection
- g. Commission on Human Rights and Administrative Justice

- h. National Council on Persons with Disability
- i. Ghana Federation of Disability Organisations
- j. STAR Ghana Foundation
- k. Domestic Violence and Victim Support Unit (DOVVSU)
- l. Parliament

At the Districts, we interviewed the following actors

- m. Community and religious leaders
- n. Operators of TMHCs
- o. Local Government Authorities / District Assembly representatives
- p. Health providers / Mental Health Providers
- q. Local NGOs working with PMD in the Districts and regions

For the FGDs, the following respondents participated

- r. Persons with Mental Disorders/Disabilities (PMD)
- s. Family members or Carers of PMD
- t. Mental Health workers (also sometimes participated in the FGDs)

Overall, there were a total of 13 FGDs consisting of both men and women of varying ages from various backgrounds making up a total number of 96 respondents who participated in the FGDs. Also, a total number of 96 respondents participated in the in-depth interviews.

Rigour & Ethics

To ensure this research followed the required ethical process, we sought ethical clearance from the Ghana Health Service Ethical Review Committee, and employed procedures to allow us to observe confidentiality and anonymity of our research participants. This was relevant because of the sensitive nature of the research and the participation of vulnerable groups such as PMD and their families.

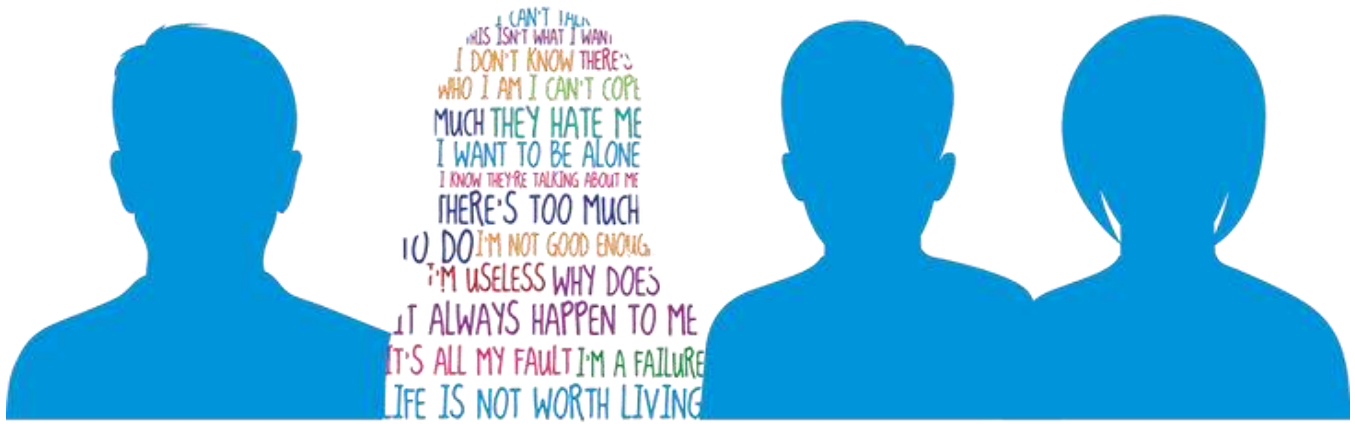
The rigour approach involved encouraged transparency, accuracy and triangulation of data (Saumure & Given, 2012). We provided a thorough description of the steps taken in conducting the research to ensure that they align to the research questions and provide transparency. To ensure credibility, we cited negative cases and member checked some of the findings to confirm the views of various participants without disclosing their identity. We also generated multiple sources of data, which enabled us carefully triangulate the data during the analysis. The rationale for selecting the following rigour and ethical strategies was to enable a systematic and credible research capable of evaluating a complex phenomenon while ensuring the research scope is successfully achieved.

Data Analysis

The data and information collected was analyzed using thematic synthesis. This formed the basis for the findings, conclusions and lessons of this report. The data analysis accommodated the mixed design (Marshall & Ross, 2006; Miles & Huberman, 1994). These analyses included both the qualitative and statistical ones appropriate for the different data collected. A statistical testing was carried out to establish significant differences between respondents' experiences and perception of mental health for the surveys that constituted the main quantitative data. We used Atlas Ti for the analysis of the in-depth interview and FGD. This enabled us to extract the thematic trends and key concepts and issues reported across the data by respondents. By employing these analysis techniques, we hope to create an in-depth understanding of the contextual and analytical factors related to mental health and the role of TMHCs. We identified and analysed common and conflicting views too. The key strategy was to triangulate the different data and outputs.

Research Problems

This evaluation employed a mixed research method, which also focused on the respondents' social world, and not their ailment. It is concerned with the perception, understanding of the meaning of mental health and the management of it by TMHCs, health professionals, patients themselves, their families and community leaders and how relationships are built around it in a particular social context (Ceña et al, 2012). One of the major challenges associated with this exploratory study is the lack of information around TMHCs. Also, the limited time allocated to collect data and engaging in purposive sampling that fundamentally lend itself to theoretical generalization were some of the constraints of the research. In doing the research, we tried to minimize our influence on participants' responses or the Hawthorn effect in gathering data from the respondents. We also recognised the need to ensure anonymity and confidentiality of FGD participants by using pseudo names during the analysis and reporting. The research also experienced a lot of difficulty around collecting data in local languages. As most respondents preferred to be engage with in their local dialects, some of the interview and surveys were done in these local languages using English questionnaires and question guides. Researchers found it difficult translating some of the English words in mental health to local languages without being derogatory. Another difficulty arose during the transcription and reporting of the interviews from local dialects into English language. It became evident that certain words such as disability, PMD, psychosis, etc. were difficult to translate and transcribe while retaining the meaning of the words. This was managed through the use of local translators during the fieldwork.



1 in 4 MENTAL HEALTH AWARENESS

Source: (SWHelper, 2019)

FINDINGS

The findings from the study are reported to demonstrate experiences from the formal and informal mental health sectors. Part one presents experiences from the formal mental health sector and part two illustrates experiences of the informal mental health sector. The synthesis of responses across the Districts in the six regions is presented in the following themes:

- Awareness, perception and stigma of mental healthcare and services
- Access to mental healthcare and services
- Other factors influencing access to mental healthcare and services
- Affordability of mental healthcare and services
- Traditional Mental Health Centers or Traditional Health Providers
- Impact of Traditional Mental Health Centers or Traditional Health Providers
- National Framework for Mental Healthcare and Services in Ghana

PART ONE: FORMAL MENTAL HEALTHCARE AND SERVICES

This part of the findings predominantly share respondents' experiences of mental healthcare and services within the formal sector. We present the general perceptions and experiences around stigma and attitudes towards persons with mental disorders or illness (PMD/PMI) and access to mental healthcare and services.

Awareness, perception and stigma of mental health care and services

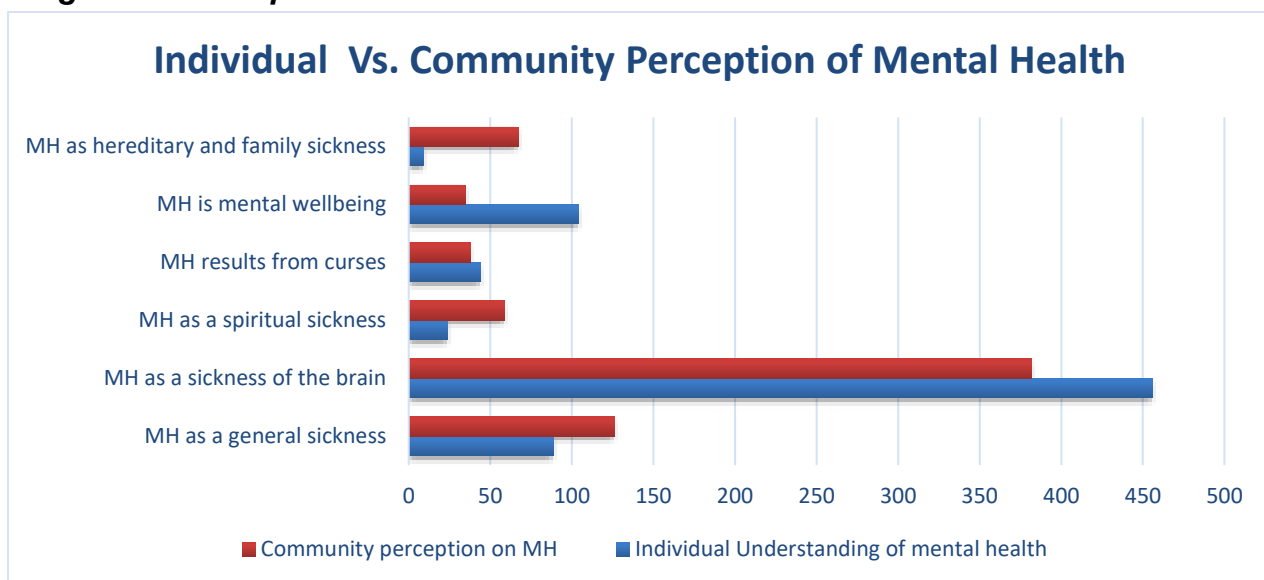
Understanding of mental health, the outlook towards mental disorders or disabilities, and the stigma surrounding mental health is highly interrelated and has been prevalently reported across various communities. Awareness and perception of mental health tend to influence the attitudes of people towards persons with mental disorder or illness (PMD/PMI) and the general outlook or stigma formation towards them. Perception of mental health also influences the relationship with and treatment of persons with mental disability/ disorders.

It is noteworthy while research sought to find peoples understanding of mental health, respondent portrayed their understanding of mental health as synonymous to mental illness.

1. Awareness and Understanding of Mental Illness

Overall, awareness of mental health and illnesses/disorders is very high across the regions. A large number of respondents (83%) expressed their awareness and understanding of mental health as a disease despite the remaining (17%) perceiving mental health to be spiritually related. A good majority of the respondents described mental illness as sickness of the brain (58.4%), general sickness (15%) or a sickness that affects one's mental wellness (9.6%). The remaining 17% described the condition as resulting from curses (6%), spiritually caused (6%) or hereditary [generational curse] (5%). Despite the general awareness, there are differences between community and individual perceptions (see *Diagram 6*).

Diagram 6: Perception of Causes of Mental Health



These views were also corroborated at the interviews and FGDs where respondents described mental health generally as a form of sickness or a spiritual problem. Some of the common descriptions given for mental health or illnesses are: abnormal behaviour, sickness of the brain, acting randomly without any sense of danger, resulting from drug abuse, madness, curses and spiritual attacks and hereditary or a combination of those factors (see **Preferences for TMHC**). The interesting description of mental health to be hereditary is fluid between the explanation of it resulting from a generational curse or genetic disorders. However, from these descriptions, respondents expressed their perception, norms, and experiences in describing PMD/PMI. They also demonstrated the various understanding, perceptions and outlook towards PMD/PMIs summarized below:

"It is someone who is not in real state of mind although they may not be mad" (Health Worker, Gomoa West)

"Someone is doing something that deviates from the normal behavior is mental health or not of sound mind" (Mental Health Worker)

"Someone who behaves in abnormal way or does not sound okay" (Health Worker, Abura East)

".. When they see someone who is mentally insane or mad if you are young active the first thing they will say is either you have done something bad and God is trying to punish you, either maybe someone has used you for something else [spiritual] that is why the person is mad..." (Traditional Leader, Gonja West)

"...my brother his own [mental illness] started when he was in school, some said smoking [marijuana] was the cause of his problem, but for a very short period now there is improvement on his health but it's seasonal, it comes and goes. He still smokes so we are still hoping for the best." (Family Member, Volta Region)

"I also heard that when someone [women] delivers, they [may] get some psychotic symptoms. I know a woman called [held] who developed a mental health issues after delivery" (Community Leader, Gomoa West).

"Another gentleman approached me to ask for medicine that because he was always complaining of ants climbing up his body so I referred him. I don't think he went to the hospital. He use to work at the [held] and came to Apam to work. Another lady also drinks a lot and this affecting her mental health" (Health Workers, Gomoa).

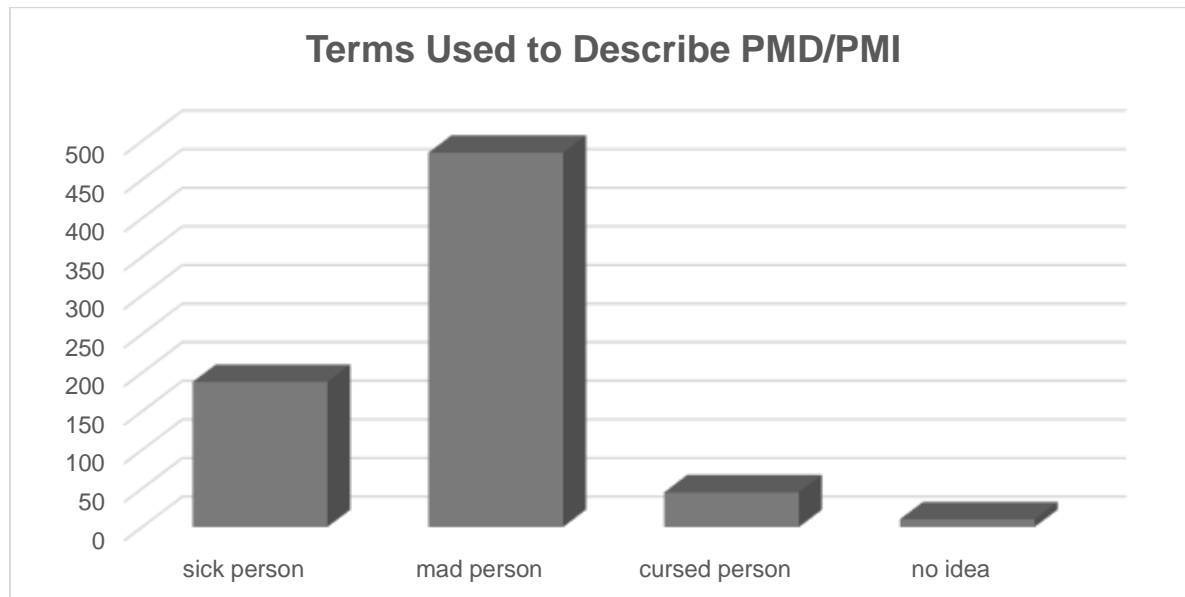
Similar descriptions were given about mental health, illnesses and disorders in the FGDs. This demonstrates broad understanding, perceptions and awareness. Despite the general consensus on the two broader explanation of mental illness to mean physical sickness or spiritual attacks, they were expressed to mean different things to different people. The following views were expressed in the FGDs:

Respondent Description¹	Description of Mental Illness
GW-O2-R1	<i>“Someone who has issues with the mind”</i>
GW-O2-R5	<i>“Someone who has a mental problem and you can clearly see a change in behavior and sometimes insults authority and does things which are not reasonable ...”</i>
GW-O2-R3	<i>“When it happens you see the person talking anyhow and misbehaving picking things from the floor”</i>
GW-O2-R8	<i>“They wear tattered clothes and do not take care of themselves so when you see something like that then it means there is a problem with the mind”</i>
GW-O2-R5	<i>“... for the guys when it happens they keep unkempt hair and behave differently from normal people but some people also dress like that mostly because of fashion”</i>
GW-O1-R8	<i>“I think sometimes they [mental illness] are caused by drug abuse and illegal drugs”</i>
GW-O1-R3	<i>“I didn’t live with the child but when I came to live with them then I realized she had such sickness... because of her behavior”</i>
GW-O1-R9	<i>“I think someone on drugs and illegal substance”</i>
GW-O1-R8	<i>“Some too is caused by over thinking [stress and depression] and it can distort the mind”</i>
GW-O1-R12	<i>“What I know is, when you have that particular sickness mental illness] and they don’t give the person medication and they leave it like that and do self-medication or don’t go to the appropriate place for help, this can cause mental health problems”</i>
GW-M1-R2	<i>“It is someone with a problem with the brains”</i>
GW-M1-R5	<i>“Those people are directed by their mind and don’t function properly, even if they have to go to the into water of fire they sometimes don’t realize”</i>
GW-M1-R3	<i>“They are not really functional but directed by their brains and he may be directed to travel or do whatever random they think of”</i>
GW-M1-R8	<i>“Normal things that people do, they cannot do that, they sometimes go into the fire or danger and don’t know it is dangerous”</i>
GW-M1-R5	<i>“Sometimes too when you get to know someone else’s secret and once you discover and panic they may curse you and punish you spiritually”</i>
GW-M1-R3	<i>“Some of the girls are betrothed to a man so when they leave them for another man, the [aggrieved] man then curse them”</i>

¹ The Respondents description is abbreviated to mean the District of resident, community and/or group and respondent’s number. For instance, GW-M1-R8 = Gomoa West of Mankoase Community FGD 1, Respondent No. 8. Also GW-O1-R12 will mean Gomoa West District in Oguva FGD 1, Respondent No. 12. (See Appendices)

These perceptions and descriptions influence the attitude and relationships towards PMD/PMI. For instance, the terms used to describe PMD/PMI connote derogatory attitudes towards them on the one hand as well as support for them by some segment of society. The most common terms used are someone who is “sick”, “mad” or “cursed”. The **Diagram 7** below shows the number of respondents in the survey that describe the condition as “madness’ and “curse” rather than “sickness”.

Diagram 7: Terms used by Individuals to Describe PMD/PMI

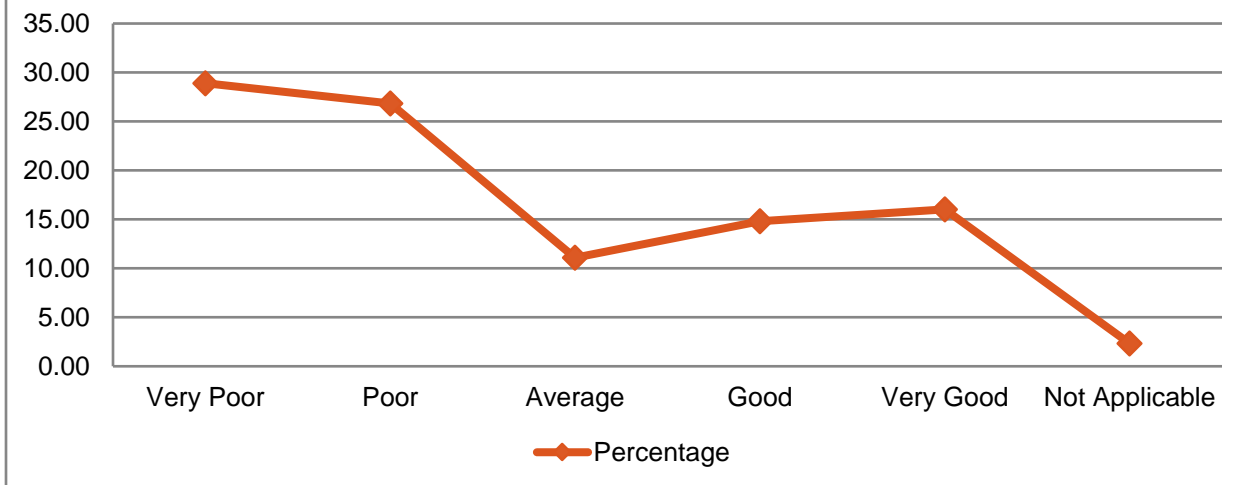


2. Attitudes, Stigmatisation and Treatment of PMD/PMI

The data showed a mixed reaction about general attitude and treatment towards PMD/PMI. Thus, in some cases, they are treated well within the communities and in other cases, individuals physically or verbally abuse them. The survey data shows that over half of respondents (56%) thought the attitude of members of their community towards PMD/PMI is generally poor as compared to an average (11%) or good (31%).

Diagram 8: Description of Community Attitude towards PMD/PMI

Community Attitude towards PMD/PMI



Explanations given for the attitude of people towards PMD/PMI were attributed to PMD/PMI own behaviour (61%), bad attitudes of people (13%), whether they are a family relation or a known person (13%), or someone you can ignore (12%). It is significant to understand how these attitudes translate into actual treatment of persons with mental disorders or illness.

"If they know you have the condition ... they don't relate to you like before, they don't relate to you like before. Usually ... they tend to see you ...like [someone] suffering from your sins, and that the gods are punishing you for something ..." **(Mental Health Worker, Damango)**

"For mine [daughter] wherever she goes people do not discriminate towards her, they always handle her well, she doesn't even go out, she only goes out when am going out then she follows me and she is in the house when am also in the house." **(Family of PMD/PMI, Gonja West)**

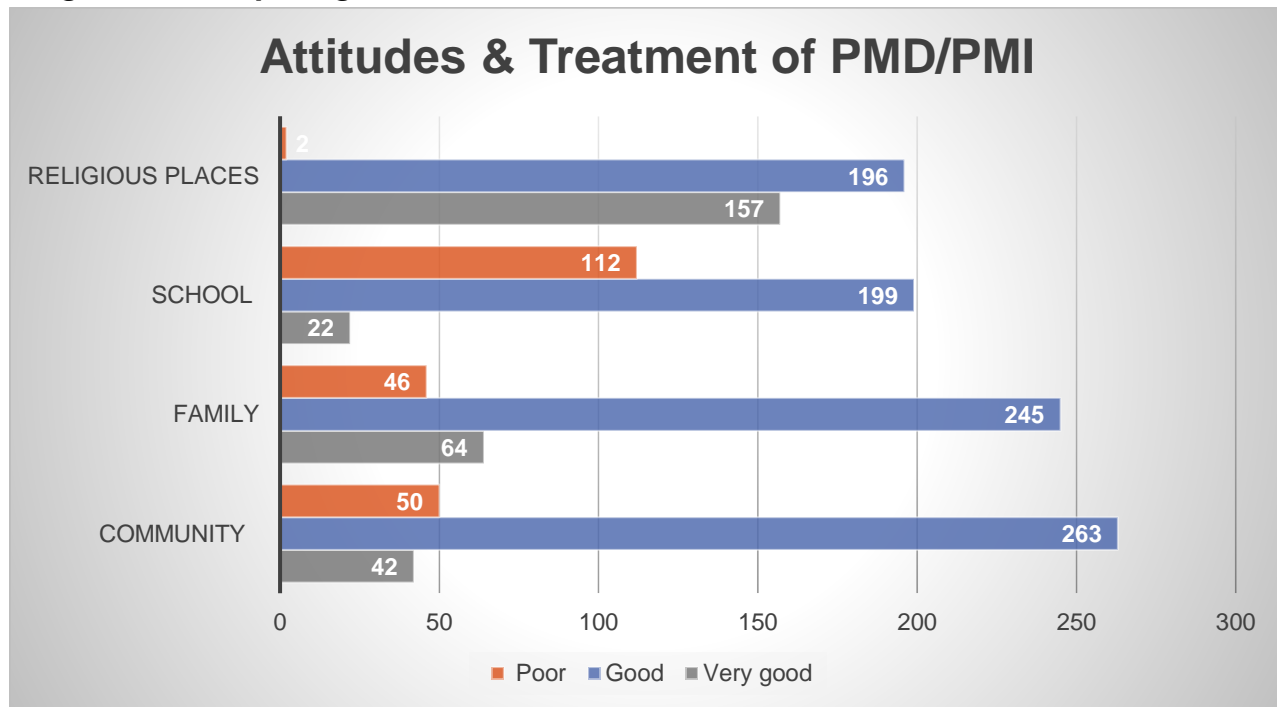
"For me, when I was with the father, [when] I cook food, no one would love to eat my food. They always criticize me and maltreat her because of the sickness, but now I have moved to my own house so whenever am not in the house my old lady takes care of her" **(Family of PMD/PMI, Wa West)**

"Discrimination, right... Sometimes when you see the person among his colleagues, they treat him some way [with contempt]. They like to exclude themselves from the person [PMD/PMI] as if he is not a human, so for the discrimination they do." **(Family Member, Abura-Asebu)**

"When some [PMD/PMI] gets the attack and the community members notice, some of them will not even stand to see the manner in which the patient struggles. Someone will not even have the patience to stand to see it. Others whom will be standing too will make mockery of the patient. There is no community support for mental epileptic patients. Only the parents or the caregivers are concerned about them. They handle everything whether it is good or bad." **[Health worker, Wa West]**

From the interviews, it was evident that the attitudes of community members reflect the way they treat PMD/PMI. Both positive and negative experiences were shared to reflect these treatments and attitude. However, the survey data showed an overall positive treatment of PMD/PMI with the highest support from community members (74%) and their families (69%) as compare to schools (60%) and religious places (55%). **Diagram 9** compares the perception on treatment received by PMD/PMI in different context.

Diagram 9: Comparing attitudes towards PMD/PMI in communities/institutions



Overall, majority of survey respondents thought that PMD/PMI are treated well in their own communities. Despite the discrepancies between the survey report and that from interviewees, it is important to note that attitude towards PMD/PMI depends largely also on factors such as education, perception of danger from PMD, experience with PMD, and individual compassion towards PMD. These attitudes are also influenced by the PMD/PMI age and gender.

3. Gender, Vulnerability & Mental Disorders/Illness

Gender correlates with certain mental ailments such as anxiety, depression and somatic disorders resulting from substance abuse. Men are more likely to be diagnosed with substance abuse and personality disorders (also reported by (WHO., 2019). Meanwhile, due to their vulnerability to sexual and other forms of violence and abuse, women are predisposed to disorders like depression and anxieties. The gender based differences therefore contribute significantly to the prevalence of mental illness and abuses.

Women reported that they are normally abandoned by their husbands and partners and young women are impregnated or raped in their communities without anyone owning up to it due to their ailment.

We have cases of girls who do get pregnant and they can't identify the persons who even impregnated them. Sexual abuse I will say yes is very high for girls with mental illness. We deal with these girls at the facility and I'm yet to see any man taking responsibility of the pregnancies or supporting the girls ..." **(Mental Health Worker, Gomoa West)**

"It affect more girls because ... people think that [other] people who use this juju medicines and especially on girls when they are after you [asking you out] and you are not interested they can do that and apply it...so this is why some of the time you see more girls being affected and some parent or children going to the traditionalist instead of the hospital" **(Headteacher, Wa West)**

"My husband left me because of this condition and it's been 10 years now and I even fell into the fire but did not receive any help" **(PMD 5, Gomoa West)**

"Yes please, he left me because of my condition and went in for another woman and also cut ties with my children" **(PMD 3, Yendi)**.

"As part of the stigma it is difficult to get a woman to marry when you are a man [with mental health disorder] and vice versa so I had the same fate until I met my wife who was also having the same condition and we got married. At the hospital, the treatment is the same" **(PMD 7, Asebu Abura)**

Support for PMD/PMI in the community is influenced by gender. Thus, women and aged with mental health problems are treated more favourably and with care and support than their male and younger counterparts. These narrations show the positive support experienced in the community by PMD/PMI.

"...women sometimes are given a special treatment but if we see mad men walked past here naked nobody will mind but as soon as a woman who is mad and she walk past here naked women around will try to get something cover her ..." **(Traditional Leader, Gonja West)**

"The women get more support than the men for instance, when a female PMD is naked the women will gather to go and clothe them as compared to the men whom people fear they will hurt them". **(Health Worker, Gomoa West)**

"I am aware of mental health and there are people in the community with such conditions and the people also treat them well, they treat them like their relatives or their own children, they do not discriminate. Anyone at all can have such problem so we should treat them well. When you even see some [PMD/PMI] hungry you give them food or when they are naked you cloth them. So they handle them very well." **(Community Leader, Apam)**

"I can [say] that in this community they are very hospitable and they don't treat people [PMD/PMI] harshly, someone can call some of them and barber them when their hair grows and feed them too" **(Family Member 9, Gomoa West)**

"They...that's why I'm saying at times when they meet them or when one is passing and you see that the person [PMD/PMI] is hungry you can give him some food, even some give them

clothing and all those things so they don't harass them..." (Community Leader, Poyeatenga)

What became evident during the research is the impact of positive attitudes and treatment of PMD/PMI in their communities. Thus, in communities where such support is available, PMD are less aggressive.

4. Impact of Stigmatisation on PMD/PMI and their Families

Unlike the survey data, interviewees reported how stigmatization impacts mental health and shapes the attitude and support given to PMD/PMI in the communities. Stigmatization perpetuates poor attitudes towards PMD/PMI and their relatives. The narrations below show how the attitude of people towards PMI/PMD in the communities affects them because of the stigmatization attached to mental health:

"People with MH issues are sometimes called names and some are also recognized as someone who has been cursed. ...When they are brought here, we don't allow people come and see them because of the behavior so that they are not tagged" (TMHC Operator, Gomoa West)

"...some [PMD/PMI] are too aggressive, so some when they even see them they try to distant themselves because you don't know the mind of the person is now different from yours the way you are thinking that is not how the person thinks..." (Mental Health Worker, Yendi).

"Once it is out in public that so so and so [person] has this mental health condition, people will pull away [avoid them], they will withdraw and you will be isolated....If you totally recover, it is still difficult for you to come into the family or to go in the company of your friends." (Health Manager, Atiwa)

"They [community] don't see these children [PMD/PMI] as useful children so they hide them and keep them away from the other people." (Teacher, Wa West).

"It [stigma] is there 100%, as soon as you visit the facility and come back they see you as still a mentally ill person even when you are cured. It affects them very much re-integrating into community. It is just like having HIV. People avoid them, no one recognizes you in family issues, isolations and putting them somewhere to be there. It also has effect on the family and so not to get stigma they isolate and hide them somewhere." (District Assembly Officer 1, Gomoa West)

"Stigma is bad although it is better now because the perception has changed but there is still a lot of stigma around. But people now come for diagnosis in confidence by following the symptoms. But it is still high, because as a politician, your opponent can use your mental health against you. Even in business and education they can use it against you". (Mental Health Senior Officer, Accra)

"Stigma is a big issue so there is the need for a lot of sensitization, even for those survivors themselves and their families and also our socialization and perception of mad people. Also when going to marry, the family wishes to investigate because of the stigma of mental health is not to the individual but entire family. Most of them are women, so maybe there is the need for a

counselling centre, homes, rehabilitation centers, etc. to support in the sensitization (**District Assembly Officer 2, Gomoa West**)

These experiences by the respondents were corroborated by their families and PMD themselves during the FGDs. Some explained that the perception and understanding of mental health create a lot of stigmatization and poor attitude towards them:

"Some marriages have been stopped or broken because of the stigma because they say ah this family they are suffering from mental illness and you want to enter that family the couples may be in love with each other than because of the stigma the other members will not agree but now they see that it can be treated and anybody can be a mental person at any time" (**Family Member 3, Wa West**)

"... When some gets the attack and the community members notice, some of them will not even stand to see the manner in which the patient struggles. Someone will not even have the patience to stand to see it. Other whom will be standing too will make mockery of the patient. There is no community support for mental epileptic patients. Only the parents or the caregivers are concerned about them. They handle everything whether it is good or bad." (**PMD 2, Yendi,**)

"When my daughter had an [epileptic] attack on the bed they took the phone and videoed what was happening to her. Fortunately, they were found ... why has this person done this to me so they quickly deleted the video. If she hasn't deleted the video people could send it to other people and it is bad" (**Family Member 6, Wa West**)

"For me what I notice is how bad people can treat you because of this condition or because a family member has it. The community and my own family members sometimes shun me ... They always criticize me and maltreat her because of the sickness but now I have moved away from my husband's house and get the support of my mother... it is only old lady takes care of her" (**Family Member 1, Tongu District**).

It is evident that the most adverse impact of stigmatization is the negative attitudes towards PMD/ PMI and their relatives. This limits access to support structures available to them because of discrimination, exclusion from social roles and sometimes abuses. Similarly, it impacts on their ability to use health facilities and resources available to them. These concerns were also expressed by health workers:

"...some will like to come to the facility but they don't want to be detain so if you have the means you will follow up to their homes and give them the care because when they come because it's like the last room is for mental health so that's the perception so anybody who comes there they say ooh this fellow is not normal and here they will just say that the fellow is mad they don't even classify the conditions and they just say the fellow is a mad person..." (**Health Workers 3, Atiwa District**)

Stigmatization affects PMD and their families and stems from cultural stereotypes, negative attitudes by the public, ignorance and misconceptions about mental illness. Some of these attitudes manifest in the form of fear, anticipation of attacks and intolerance culminating from previous experiences of extreme psychotic episodes and violence.

There is a gap between awareness, perception of mental health and the attitude of people towards it. Although the data do not portray the direct correlation between these perceptions and attitude or stigmatization, it is important noting it. Interviewees thought there is an improvement in attitudes and stigmatization towards PMI/PMD in some communities compared to others based on the exposure and level of awareness on mental health. But it is evident that a lot still needs to be done to address these gaps in information and perception towards mental health.

"The first thing we can do is to give sensitization...and then hospital training- the entire school children, society...community must be made to be aware of the what causes mental illness, the circumstances that can lead a person to become a mentally ill person...educate the communities as well the school community..." (Education Officer, Apam).

"...there are some their situation might not be all that serious because of neglect am there am going through some frustrations there is no body for me to confide in...but if education is done may be when you are going through this you come to our office there would be people who will counsel you who will let you known what you are going through is not spiritual but is just a matter of time so as soon as that enough education is done on radio or if possible they can liaise with the District assembly with assembly person move from every electoral area to talk to the people so that even some of them have the people at home but they don't see the need to come to the clinic but when they go to discus with them" (Traditional Leaders 3, Gonja West)

"It will help us a lot...people will be identified...maybe [they] will try to look for an antidote to solve their problem then...sensitization will make everybody recognize that they are part of the society and the disease is not contagious...if there are enough psychiatric nurses here I think it will be good, resourceful." (Religious Leader, Atiwa)

It is evident from this study that lack of understanding and stigmatization create stereotypes, prejudices and misconceptions about mental illness. These lead to poor treatment and discrimination of PMD/PMI. This affects the general public's perception and creates a social notion, which impacts on PMD/PMI's self-worth or creates anxieties. These anxieties make PMD/PMI lash out causing some members of the community to react to the detriment of their wellbeing. Meanwhile sensitization is very limited if not absent on how to handle or support PMD/PMI and mental health overall. Key actors throughout this research have noted the need to intensify education and sensitization to mental health.

Access to Mental Health Care and Services

There have been widespread efforts to improve availability and access to mental health services across the multiple levels of operation and service delivery in Ghana. To evaluate this, we focused on three aspects of access: availability, utilization and physical access to mental healthcare and services.

Health Facilities



Health Facilities in some of the Research Sites

5. Availability and Utilisation of Mental Health Services

In terms of availability, we assessed what mental health services were available as well as which ones were utilized. The mental health services available are specialists/psychiatric services, services provided at the regional hospitals, District hospitals and community health facilities such as health centers, Community-based Health Planning and Service (CHPS) compound and home visits.

Only fourteen percent (14%) of survey respondents reported of using psychiatric hospitals. The remaining 86% use the following: regional and District hospitals (10%) health centers (39%), CHPS services (30%) and those who have no idea what services were available (7%). Out of these respondents, 6% further reported using both the health facilities and alternative services such as churches, herbal and traditional medicines. At the communities, some families and PMD/PMI reported of receiving mental health services from community mental health nurses and workers in their homes through home visits.

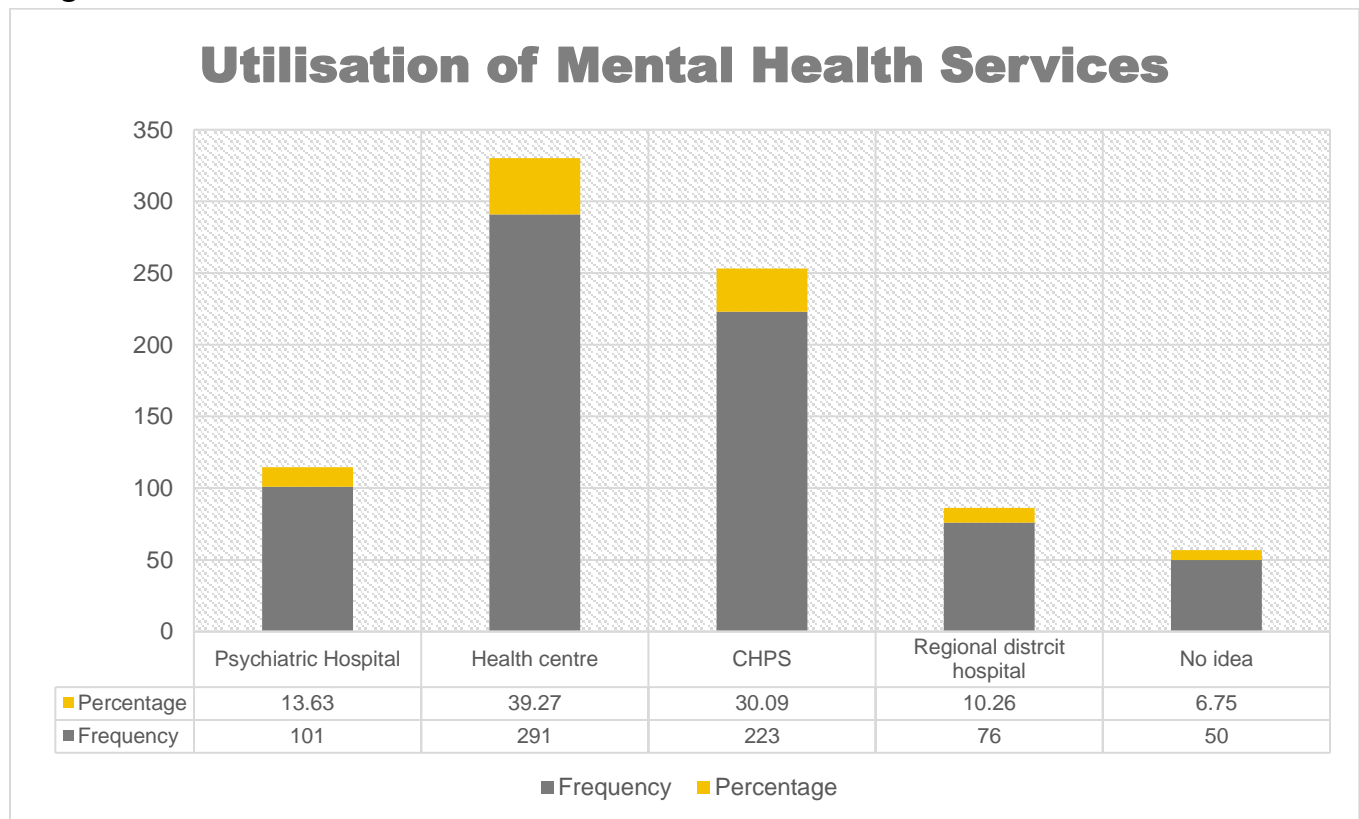
"It started like convulsion so we took her to the Gonja West Hospital. That is the hospital we used to go to for over five years....Finally they told us not to bring her to the hospital anymore but we should rather give her herbal treatment so we took her to one of our villages called Mankoma, they also tried but couldn't cure her" (Family Member 12, Gonja West).

"It started as if it was convulsion, I sent her to the hospital for medicine but they asked us to go and seek herbal treatment then we started moving from herbalist to herbalist then my uncle came from Tamale and told me there is one [herbalist] at Tamale who has the medicine and I took her

to that place but it couldn't work so I brought her back then I got the information that there is a nurse in this health facility that gives medicine so I went to the clinic and started taking medicine for her. With the help of the drugs it's better now." (Family Member, Yendi)

Utilization of mental health services is not limited to the formal mental health providers but very fluid between the formal and informal providers. Irrespective of whatever facility is being used, persons seeking for mental healthcare are driven by the desire to find solution or cure to their ailment. These decisions are sometimes based on recommendations from other extended family members, friends, neighbours and health workers at the facilities. Some also emerge from the lack of resources at the health facilities or lack of trust in the quality of care provided or given to their wards. Respondents also reported that they would not seek healthcare from a facility they believe will not get the cure they require. **Diagram 10** shows the available services used by respondents in their communities in accessing mental health care or services.

Diagram 10: Utilisation of Mental Health Services



According to families, the primary health facilities are mostly used as their first point of call for mental health services. The primary health facilities are mostly used (69%) in the communities, followed by health centers and CHPS compounds or providers (see **Diagram 10**). These health facilities or providers offer early symptoms diagnosis, basic health services, and community health, drug management and referrals. The primary health facilities then refer to the District,

regional or specialized health facilities depending on the severity of the condition, affordability and proximity to the referral facility. The secondary and tertiary mental health care facilities and services are mostly referral services. This creates the opportunity for a wider range of services to be accessed by patients and their families as noted below:

"...we also offer health education which is very important at all other level of care for example we go to the OPD, maternity, antenatal, children's ward, all services delivery point at the regional hospital we utilize this areas to carry out health education..." (Facility Manager, Northern Region)

From the study, it is evident that there are a range of mental health care and services available to the public. The primary mental health care and services such as health centers, CHPS and community services through home visits are more accessible and utilized than secondary and specialized services, which are mostly not located within the communities. This general awareness of mental healthcare services and utilisation however positive does not allude to physical accessibility.

6. Physical Access to Mental Health Facilities

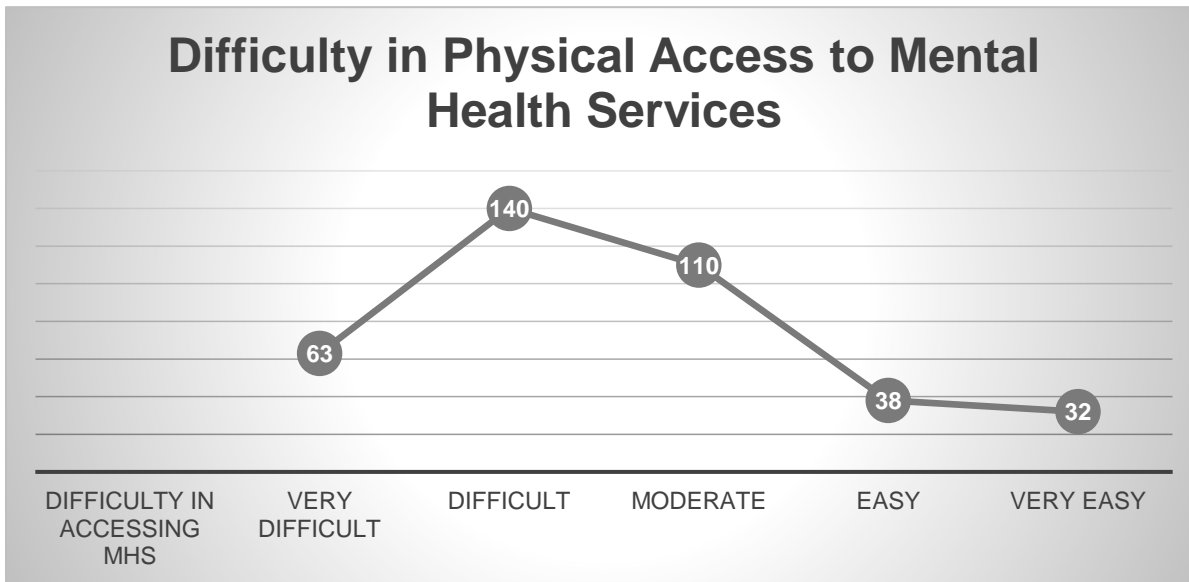
Physical or geographical accessibility to mental health include proximity to the facilities, the difficulty in getting to the facilities and means of travel to the facilities. In terms of the former, about half of the survey respondents (53%) found it to be difficult or very difficult to access secondary and specialized mental health facilities. (see **Diagram 11** below). Some of these difficulties in accessing health facilities were attributed to travel challenges, physical inaccessibility and the ability to fund the trip to the health facilities.

For instance, respondents' inability to physically access specialized services prevents continuous use of health services. Some of these experiences are narrated below:

"My son was sick [mental illness] and the illness started from Italy and he was brought to Accra by two white ladies. Luckily my brother too was in Accra so he was sent to his place [Psychiatric hospital] and they started treating him there. After one week in Accra he was brought to Larabanga here. I was given some tablets from Accra and I was told that when they get finished I should come for more. When the tablets finished we went to Accra and they gave us some tablets. We were referred to Damongo here because the distance to Accra is far." (Family Member 13, Gonja West)

"I am a farmer. One day I was going to the farm riding on a bicycle but ...I lost control and veered into the bush. I [lost consciousness and] was there for some time and the sun burned [me]. It was later that I realize that I am in this situation [suffering from epilepsy]. ... I realized that I was sick from then on and that is how it started. I have been going to the hospital for treatment day in and day out." (PMD/PMI 3, Wa West)

Diagram 11: Level of Difficulty in Accessing Mental Health



Undoubtedly, proximity to a facility is a major determinant in the use of mental health services. It influences ability to access healthcare and use, as those within close proximity are reported to use healthcare more often than those further from the facility. In some cases, patients preferred facilities further away from them or to travel out of their communities to enable them maintain confidentiality of the use of mental health services. Others also travel out to access specialized psychiatric facilities which are not situated within their Districts. All the health facilities confirmed that they refer patients when necessary to higher facilities mostly situated outside of their communities. For health providers, distance to referral facilities mostly located in the regional capital or towns further away from their facilities is a major challenge to service users. But these District, regional or teaching hospitals are the main sources of referral. Another factor impacting on physical accessibility is the deplorable state of the roads in some communities. Health workers noted for instance that:

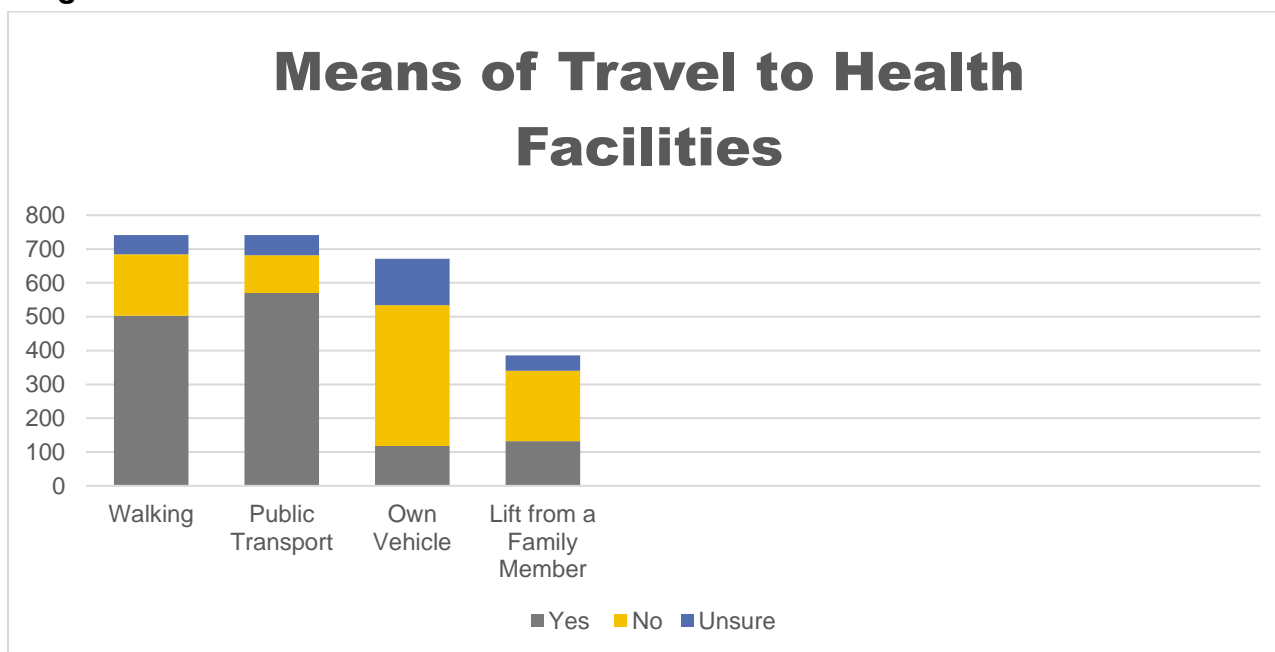
“... We have our nurses and doctors coming to treat our younger children. The hospital is in Damongo [further from the community]. If you want this man to come here you would have to fuel his motor. He will not come if you don't have money for fuel so you would not even think of bringing him. Although he comes to take care of you free of charge you would have to give him fuel money. This is our main problem.” (Family Member 9, Yendi).

It is therefore evident that proximity or distance to the facilities, the conditions of the road network and inequitable distribution of referral facilities impact on access to mental healthcare. Referral facilities are located in more urban communities with specialized ones much further in the coastal belt of Ghana. Severe mental health conditions and advance services are referred to services outside these communities. Traveling to access these facilities and inability to fund the trip are other barriers to services as discussed below. We will consider how patients travel to these facilities in the sub-section below.

7. Means of Travel to Access Mental Healthcare

With regards to how patients get to health facilities, respondents indicated that the means of travel to access mental health care and services were through walking, public transport, lifts from relatives and by own vehicle such as motorbikes, bicycles, cars and tricycles. Majority of respondents have used mental health services within their communities, which they access through walking, home visits or using local transports such as bicycles, motorbikes and taxis. Those that had to travel to neighbouring communities, other cities, towns and specialized facilities to use mental health services rely on vehicles such as public transport, taxis, lifts or their own vehicles.

Diagram 12: Means of Travel to Access Mental Healthcare & Services



PMD and their families also revealed that it is a challenge to fund the cost of travel to the health facilities, take time off work to use healthcare and get support from other family members and friends to enable them travel.

“It is difficult [to travel] when you ... don’t have money to for transport” (PMD 8, Gomoa West)

“I come to Tamale and it is difficult to come here especially for reviews and when you don’t have money you have to go round and borrow money” (PMD 3, Yendi).

“I have to travel with my son when he gets his epileptic attacks and sometimes there is no transport available to use. There were days I had to carry him on my back for several kilometers to get to the madam [health worker] to check him” (Family Member 6, Ogua).

Clearly, cost and means of travel impact on accessibility of mental healthcare and services. This leads to the deferment of service use as patients and their families do not have their own or reliable transportation or funding to enable them travel. In other instances, the decision as to where and what mental healthcare and services to access is the challenge.



Some of the health facilities in the Volta Region

Other Factors Influencing Access to Mental Healthcare and Services

We found other factors that influence access to mental health services during the study. Some of these are the impact of gender on utilization of health services, age and utilization and the role of family members who make decisions regarding access to mental health services.

8. Gender and Utilization of Mental Healthcare and Services

The occurrence of mental illness was reported to vary between men and women in the survey as compared to the interviews where most respondents reported no variation between the genders. Interviewees in some communities thought women are more likely to suffer from mental health due to high domestic violence and marital or relationship break-ups.

"...it seems the women are many... they experience mental health problems more in this community" (Community Leader, Ponyetanga)

"...Currently the situation ... is affecting the women most. Let me say that because what I have seen ... most of them are out of depression. Because of like ... let me say the poverty nature of the District." (Social Welfare Officer, Wa West)

"Ok with the women, ... it's usually relationship problem. Either divorce ... expectations in life ... for the women it's hardly you will see or get cases of substance abuse" (Community Leader, Yendi)

"...Most of the women [suffer mental problem] out of depression. You see them they are out there. And once when the person begin this then there is divorce. The man might not want to contain [accommodate] her again in the house. Then she have to move out. So that is it the only thing that is increase with the men is the epilepsy. That one the men when you go along the whole District men are the majority of those people affected by such a situation" (Social Welfare Officer, Yendi)

Health workers also noted that facility utilization was also based on gender. Women are more likely to use health facilities than men and they are timely in reporting the symptoms of mental health.

"...generally you know women easily access health care more than the male because when the woman is sick or the child is sick the woman is eager to present herself at the health facility and the men it takes time before they come to the health facility." (Health Manager, Gonja West)

"...ok in terms of gender, if I'm to use the [health] records, I'll say the females...than the male. Why because I feel maybe ... you know men naturally are risk takers ... so they will want to play down [the symptoms] and say ... it will go away. ... But women are basically concerned about their health and so they will do whatever when they notice the slightest sign, or deviation from their behaviour, they see [same] in their relative they rush them for check-up" (Health Worker, Wa West)

"More women than men in the facilities and more men in the streets. Women unit is usually full. Women in the 30s but not younger people and most of them have to do with relationship. Families are more protective of women and community are protective of women than men" (Officer, Social Welfare).

For the men, particularly young men, the episodes reported relate to substance and alcohol abuse:

"...there is substance abuse in the system and basically at the basic education level there is a lot of substance abuse amongst the men so because of that I think...and then you know this tramadol thing is also there everywhere...." (Education Officer, Wa West).

"The young guys here abuse tramadol and the smoke [marijuana] that they take but the tramadol is very severe over here." (Community Leader, Ogua)

"The young men and people are pressured from the home and take to substance abuse. Mild manic and disorder is creating some of the young men. Is there a hereditary element and old age" (Officer, Social Welfare)

"...the males are more affected than the females but of late is the abuse of drugs the males abuse drugs than the females so that is why they are more affected the females don't venture into those things and then the stress, family attitude towards males too because they feel the male can take care of himself than the female...so the child growing up is allowed to fend for himself because is a male but a female is attached to the mother so these are factors so in doing so there is pressure on the male that can lead to mental disability" (Community Leader, Wa West)

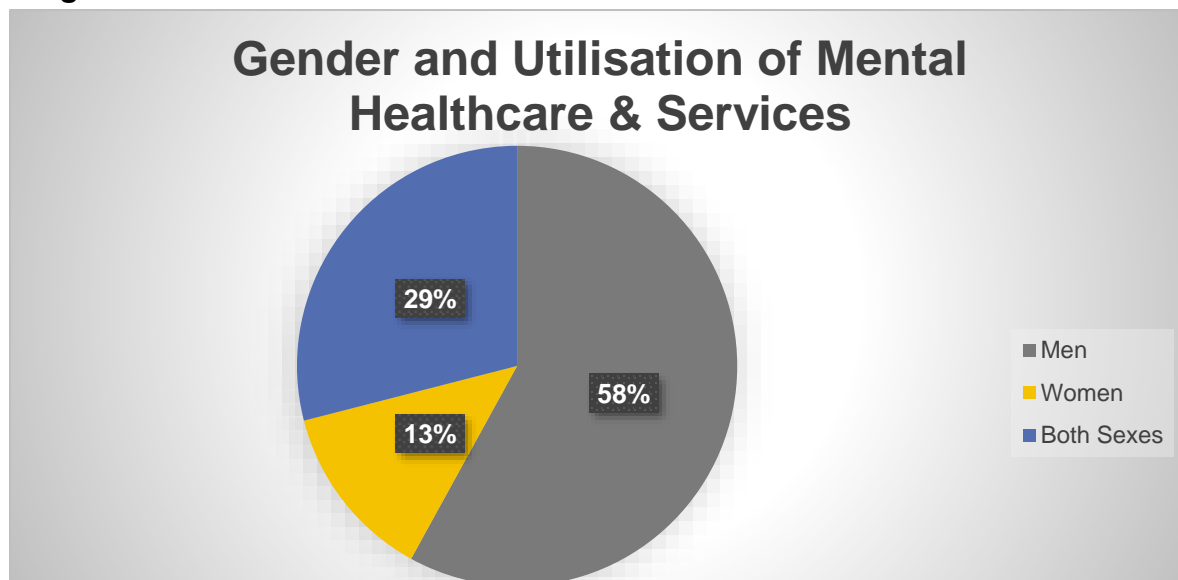
"So personally for me, what I have observed is that more males are affected than their female counterparts...I'm talking within the context of Wa West...taking of hard drugs for instance it is more prevalent among men than in women. And some of this things can predispose you to

mental health conditions....I'm not speaking as a technical person" **Senior Health Officer, Wa West)**

"...in terms of gender it depends on the [person] I think, it is ... condition by condition so for example schizophrenia we have many males than females with the epilepsy I will say it's almost equal but the females it likely to operate the epilepsy but it not a wide gap as compared to the schizophrenias I think with the substance use it start a clear cut may be new dominants that means many men abusing drugs as compared to women and then depression too we have large number of females than males but on the whole in terms of all our cases I think we have many men having mental health [conditions] than women." (**Senior Mental Health Officer, Upper West)**

The survey report below shows that men are thought to be more likely (58%) to use mental health services as compared to women (13%). The remaining 29% thought there is no differentiation in utilisation by both sexes as both men and women receive similar medical treatment irrespective of the gender differences.

Diagram 13: Gender Utilisation of Mental Healthcare and Services



9. Age and Access to Mental Healthcare and Services

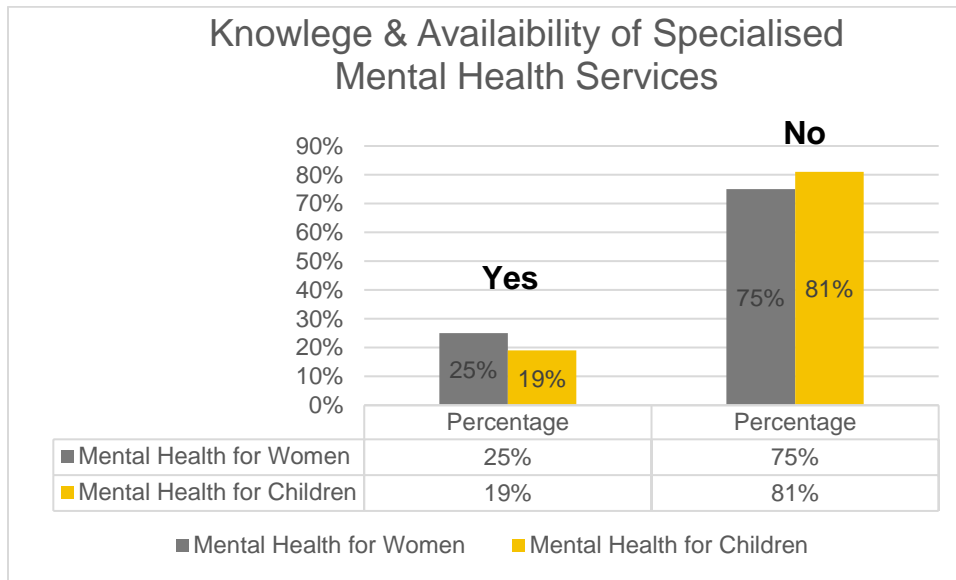
With regards to age, 46% of the survey respondents indicated that adults are more likely to use mental health services than children or the aged. Children were thought to be diagnosed later than adults except when the condition is identified at birth as a defect. Some parents were said to also confine children with mental illness or disorder to their homes, preventing them from playing with their peers. Children were also reported to lack educational support at schools and

some expelled because of their behavior. The narrations below indicate some of the perceptions that influence the difficulty associated with children’s ability to access mental health services.

“...some people, some children can be born retarded, you know you understand what I mean. I think is no fault of them. Actually some also through epilepsy they become mentally retarded...”
(Education Officer, Wa West)

“Some of the causes are that the parents are taking in hard drugs and others too are born with it, maybe family inheritance and others too are cursed, you will go and steal something and they will curse you so your child will be retarded.” (Community Leader, Mangoase)

Diagram 14: Knowledge and Availability of Specialised Mental Health Services



10. Who makes decisions for the use of mental healthcare and services

In terms of decision making about utilization, husbands were revealed to form the majority (71%) of decision takers regarding health care seeking behaviours of their spouses, children or family members as compared to 15% of wives who take decision on utilization of mental healthcare. The remaining 14% thought these decisions were reserved for the family heads. Religious affiliations also influence decisions around health seeking behavior. 79% of respondents thought decision making on mental health services are based more on religious than professional grounds (21%).

The study also found that decision takers are not necessarily the caregivers of PMD/PMI. Mothers by default are expected to take care of their wards when diagnosed, as is expected of wives. Accordingly, very few fathers and husbands were reported to be playing this role. The husbands were reported to walk away, abandon or divorce their wives when diagnosed.

“... that’s my own daughter, she started with convulsion ..., I first brought her to the hospital here so they went back home she was fine then she got another episode when she was herding sheep

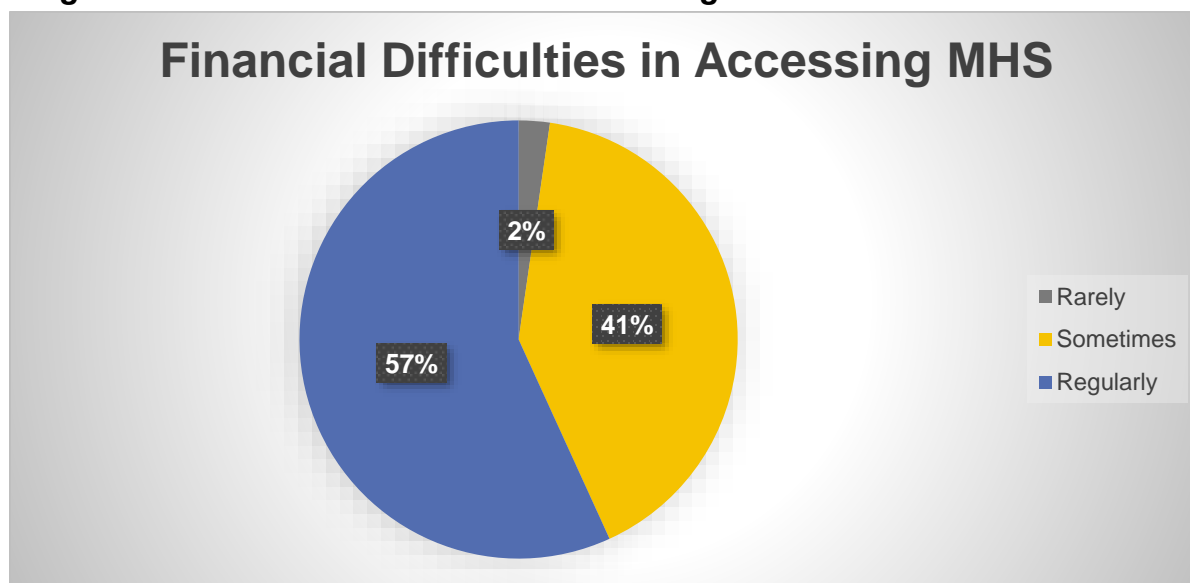
in the bush... ..they said we should send her to Daragote in Wa West, there is a village around Wechiau and I took her there... (Family Member of PMD/PMI, Wa West)

Members of the extended family were also reported to contribute towards caring for PMD/PMI especially in terms of what types of health services to seek for the PMD/PMI and using them as search parties to find PMD/PMI when they abscond from home. The role of the family heads and sometimes community leaders on treatment and management of PMD is very critical because it directly impacts on the treatment and attitude of the community members towards PMD/PMI. Some of the chiefs reported that they advocate for community members to desist from abusing or harming PMD/PMI, which has resulted in change in attitude towards them.

Affordability of Mental Health Care and Services

Affordability is one of the major barriers to mental healthcare and services. According to respondents from the survey, 57% reported that they regularly experience financial difficulties and a further (41%) sometimes experience these difficulties. Only 2% said they rarely experience financial constraint in using mental health services (see **Diagram 15**)

Diagram 15: Financial Difficulties in Accessing Mental Health Services



Interviewees and discussants corroborate the financial constraints reported above. Some of these financial hardships are said to impact on their ability to access medication, travel to the facilities and use mental healthcare services.

: "...When we returned from Accra we were still using the drugs they gave to us but when it got finished we couldn't go back again for the drugs because of financial issue but we were directed here for the drugs..." (Family Member of PMD, Gonja West)

: "...I have been spending a lot to the extent that the last time I had to go to [to the health facility] this my brother gave me assistance [financial]. I know from my experience that the medicine is

working but the sickness is still there. Today if I don't have money to go and give him treatment and it becomes worse..." (Family Member of PMD, Gomoa West)

"Finance is the major problem. If you are not supported financially you can't do anything and then like transport too is another problem...but the support to the health centre there, they don't have any fast means of transport. That man there is using his own motor bike to run all this programmes so is a very good challenge...also support with other material like stationaries and all those things are needed." (Community Leader, Wa West)

"Yes challenges I have realize we have financial challenges when we don't have anything they try to behave that way I cannot wait secondly others feel that if your child is like that and you expose him it will be a shame so because of that they try to hide that very child not until psychiatric nurse happens to find out that is like that and he goes here they don't want to open ways for the child" (Family Member 6, Wa West)

"Some of the cases that they will report to you needs a follow-up, means of transport is a factor even if you get them to agree to come, we are compelled to use our own means of transport that we have but fuel to get to the scene is another cost." (Health Worker, North Tongu)

"...At certain times, we will go to the psychiatric nurse and he will tell you this is the price of the medicine if you don't have money that is all. Certain times you will go there you will not even get the drug because the drug is no there" (Catholic Priest, Gomoa West)

"...we create the awareness we educate people, people are now interested to seek the services but at a certain point in time the medicines are not there they can't simply afford it..." (Health Worker 8, Wa West)

The cost of mental health care is a major problem for PMD/PMI and their families. Despite the general exemptions from the payment for anti-psychotic medication available to PMD/PMI, the cost of travel, private purchase of anti-psychotic medications and other charges they experience when using health facilities create a financial barrier to healthcare. The impact of this constraint on adherence to medication, check-ups, and continuity of care is negative. It was reported that most people do not return for their check-up or purchase the medications prescribed for them.

Challenges of Accessing Mental Healthcare

There are significant constraints to accessing mental health care and services. Most of these constraints have already been reported to relate to physical and financial accessibility to mental healthcare. Other challenges reported relates to health workers' inability to reach out to PMD/PMI in their communities in time of emergencies, the challenges of transferring PMD/PMI from primary health facilities to the referral facilities in times of emergencies, poor adherence to medications and check-ups and late utilization of mental health services. Some of the comments are:

"I'll will say in this District, accessibility is not an issue. It still boils down to the faith, their believe because I quite remember when I came [posted to the facility] and I was the only one, I quite remember we had people coming from very far, very far to sought treatment from even Districts

coming to [seek] treatment here in Damongo. But we don't have a lot of mental health worker and resources to do the work" (**Mental Health Worker, Damango**)

"...because it's a rural area or setting, they go to see the traditionalist or ... the fetish priest, the mallams they go to see.Although, they go to do their own thing when it doesn't work then they resort to the health center or to the professionals to attend to them. But currently I'll say that because of our [mental health workers] presence in the community for this long," (**Mental Health Worker, Gonja West**)

"...I think we have gotten to a point in time as a region that I believe the demand for mental health has being created what is left now is the service...the demand and service gap is quite wide..." (**NGO Personnel, Wa West**)

"... because we [health workers] are not staying with them [PMD/PMI] in the various communities, we will go there for home visit, outreach and come back ... maybe the time you have gone for your home visit and outreach, the fellow [PMD/PMI] has no problems but after you have left the community then the condition will now start... meanwhile you have no way of reaching them at all or on time.." (**Office, Gonja West District Health**)

"It depends on the way and manner I face problems with my patient. I go round to get something to treat him. I have been spending a lot to the extent that the last time I had to go to this my brother to for [financial] assistance. I know from my experience that the medicine is working but the sickness is still there. Today if I don't have money to go and give him treatment and it becomes worse..."

From the description above, it is evident that the challenges are related to limited resources for mental health provisions impacting on access to healthcare. There is also the attitude of service users in terms of adherence and beliefs. The lack of resources has a detrimental impact on mental health services. They impact on access to treatment, quality of care, reduction of stigmatization and community engagement. These are evidential challenges to orthodox mental health service provision with implication on access, quality of care, essential medication and preventive care. It is therefore not surprising that despite the reported high usage of primary mental health care, users opt for TMHCs in the face of the challenges in accessing these orthodox services. To summarise, the provision of mental healthcare and services within the formal sector is constrained.

PART TWO: INFORMAL MENTAL HEALTHCARE AND SERVICES

The second part of these findings discuss the roles, activities and functions of the Traditional Mental Health Centers and/or Traditional Health Providers. It identifies the different types of informal providers, services they provide and treatment procedures. The impact of THMCs/THPs on their clients, communities and the mental health sector is also discussed. The final section discusses the national framework of mental health care provision in Ghana.

Traditional Mental Health Centers (TMHC)

Considering the current gaps and challenges in providing mental healthcare and services in Ghana, there is a lot of dissatisfaction among service users in terms of the barriers and experiences associated with availability, access and use of mental healthcare services. The strong belief in mental illness or disability as predominantly spiritual has made the role of traditional and alternative service providers in mental healthcare and service provision very crucial. This section presents the findings relating to the activities and practices of traditional mental health centers (TMHCs) or traditional health providers (THPs) and their roles as alternative health care providers in mental healthcare and services. It discusses the preferences of service users, types of providers and their practices as traditional health providers, treatments and management of mental illnesses and disabilities and challenges associated with the traditional mental health service provision.

11. Use of Traditional and Alternative Mental Health Care and Services

A large number of respondents confirmed that they use both orthodox and traditional mental health services. The perception that mental health is 'not a condition for the hospital' but rather '*spiritual*' or for the fear of being recognized and stigmatized underlie some of these decisions. Some respondents recounted below:

"Just to have the child normal, they think the traditional man can help them because they think that it's something traditional...they talk of a wizard or a witch going inside that person or maybe something corrupting them so they try to go into that. If it's somebody making that person like that then that traditional man deal with that person and then the child..." (Catholic Priest, Wa West)

"...the spiritual attachment with mental health service still remains and even as much people accept that yes we are ready to seek treatment and everything that the notion that this is more spiritual than physical sets in and some just relax at a certain point in time as they concentrate more on seeking traditional or herbal treatment for their children..." (NGO Officer, Wa West)

"Some bring them to the hospital and others take them to the prayer camps while others combine the two" (TMHC Operator, Gomoa West).

"...some client will go there [TMHCs] and spent a long period of time there for the sickness gets worse before they now think of coming to us [health facilities] for treatment but if these guys can refer early and prompt enough many people who have mental illness wouldn't end up at the chronic stage..." (Health Officer 14, Yendi)

By perceiving the symptoms to be spiritual in nature, families and carers of PMD/PMI opt for alternative services from prayer centers, fetish priests, mallams, etc. to address these spiritual cases. The PMD and families that opt for alternative mental health services, or use the health facilities as their last resort delay in accessing healthcare and services.

For formal health providers, the delay in the use of mental health services means patients are brought in with complications requiring referral services usually not provided at the primary health facilities. This may be a reflection of the perception and understanding of the causation

of mental health as a spiritual problem. This is evident of the gaps in understanding of mental health and how the cultural perspective of it influences the decision and ability to access mental healthcare in most communities. But overall, it also demonstrates the significant role of traditional mental health centers as social and community structures in providing mental health care services.

12. Types of Traditional Mental Health Centers (TMHC) or Traditional Health Providers (THP)

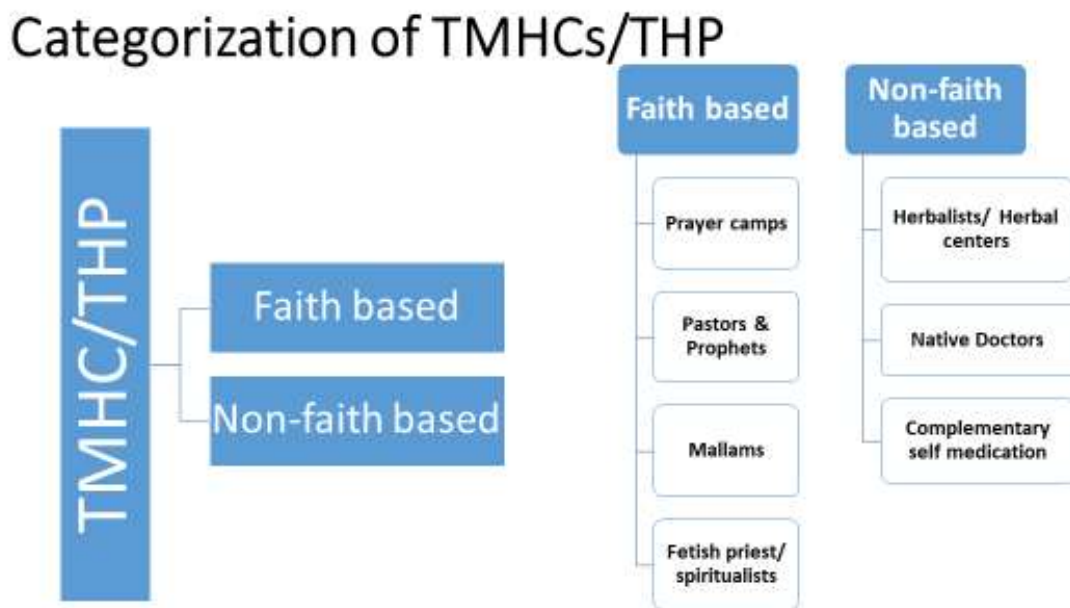
The use of traditional medicine as alternative healthcare and services is pronounced among Ghanaians and forms a major pathway for mental health services. The study revealed that the most common services sought for mental healthcare are from the prayer camps, herbalists, pastors, fetish priests, mallams and native doctors. For the purposes of this study, we classify all of these service providers as traditional mental health centers (TMHCs) or traditional health practitioners (THP). It is therefore worth noting that traditional service providers include facilities and/or individual traditional health practitioners.

The study revealed various forms of TMHCs/ THP such as the following:

- Prayer Camps
- Herbalist/ Herbal centers
- Pastors/ Prophets
- Native doctors (native healers)
- Mallams (Islamic spiritual healers)
- Fetish priest/ Spiritualists (known as jujumen)
- Complementary self- medication (which may include the use of herbs and plants as dietary supplements or homeopathy).

It is important to acknowledge that this list is by no means exhaustive of THPs but represents what was commonly reported by respondents and found during the study. The THPs are categorised into two main groups: faith based and non-faith based providers.

Diagram 16: Categorization of Traditional Mental Health Centers or Traditional Health Practitioners



The faith-based providers include prayer camps; pastors and prophets; mallams; and fetish priests/spiritualists. The faith-based providers consist of Christian, Islamic and Traditional Religious bodies that rely on their religious faith and practices to provide various forms of remedies and cure to their patients. These were described by respondents as:

“...In some of the associations [GHAFTRAM cluster of associations] you can get herbalists, traditional medicine practitioners, manufacturers [of herbal medicine], clinicians, and TBAs [traditional birth attendants] in it, and in some you can only get the Muslims index just like that,.. so we have different categories... yes, some uses Islamic faith in healings, am I right? Islamic faith is used for healing and they have patients, ...others use rituals, psychic and even hypnosis”.
(Officer 1, GHAFTRAM)

The faith-based providers use supernatural or spiritual powers to diagnose, manage and treat their cases. Some may add herbs, plants and rituals whereas other may not, depending on their particular beliefs and practices. However, prayers and rituals tend to form the basis for healing, spirits control and cure for diseases as expressed below:

“We are a prayer camp, we allow people to write their demand and make initial offering and make a promise. We use prayers a lot so we pray 4 times a day. We pray all the time and also the prophetess is directed by God on what to do and if she needs to baptized the person. Times for prayer are 9am, 12noon, 3pm, 6pm, 12midnight. Also we do fasting on behalf of the other members or the client if they are unable to do it.” **(Prophetess 1, Gomoa West)**

“...they see mental illness as highly spiritual and so they will not take the patient to the psychiatric hospital because of their beliefs. In the [named] camp, a PMD is believed to be cursed and the best cure is to let him pray, but this guy is having psychotic symptoms. This is a very strong belief systems that permeates their interpretations in life ... (Officer, Traditional Mental Health Council)

“We use prayers and purification... We use flourida water, blessed water, soap, sponge, water, etc. and wash them, we make sure the right gender appropriate prayer warrior or their family wash and dress them in white dress (robes) and then march them (PMD/PMI) with a prayer warrior in the church to pray and anoint them [PMD] from the ailment.” (Prophet and Overseer 2, Gomoa West)

From the narratives, it is evident that the decision to use faith-based health providers stems from people’s beliefs and practices. The preferences and popularity of faith-based health providers shows how much they contribute towards mental healthcare and service provision. It also aligns with their fundamental belief that mental health is a spiritual ailment. Therefore, the treatment of PMD/PMI will require addressing both the spiritual and physical aspects of the ailment.

The non-faith based providers rely predominantly on herbs and plants for their cures, treatments and therapies. They include herbalists, native doctors and those who self-medicate using herbs and plants resources or practices. The herbalists use plants, herbs, and other natural substances to improve health, promote healing, therapies and prevent illness. Some of the herbalists run herbal centers, full herbal clinics, and/ or sell them in public transports, market place, at bus stations or hawk them in residential communities. It was reported also that some herbalists only provide services based on referrals from former clients, friends and families. Herbalists may provide general services or specialize in the cure of a particular disease or physiotherapy. For instance, you may get herbalists that specialize in bone mending for fractures and dislocation, or physiotherapy for stroke survivors. Some also manufacture their herbs and drugs to be sold in pharmacies and chemical shops.

The native doctor on the other hand uses supernatural or spiritual powers to diagnose but uses herbs, plants and rituals to provide healing, control spirits and cure diseases. Most respondents also noted their expert knowledge of herbs and plants used to cure common diseases such as malaria, common cold, asthma and diabetes. The knowledge and practice of how to prepare and use herbs, plants or other natural element for healthcare are passed on from family members and friends with the gift of healing, seasoned herbalists or through common practices well known in specific communities. The most profound mode of learning to practice as a herbalist is by inheriting the gift of healing from the older generation or family member.

“... you see when you come to traditional medicines and herbal (medicine), traditional medicines embodied herbal medicine ..., but herbal is just one aspect of traditional medicine. So that is it, traditional medicine is more broader that it include the psychic, spiritualists, and all of them, but herbal medicines are those who deals with the medicines only, that is herbal medicine..., so we call ourselves for the practitioners because we deal with other substances and herbs. Sometimes,

we have other substances used by traditionalist but they are not herbalist. So we called ourselves Traditional Medicines Practitioners, you don't say I am a herbal medicine practitioner, because definitely if you are dealing with herbal medicines you will deal with things that are natural substance ...are you getting me?" (Officer 1, GHAFTRAM)

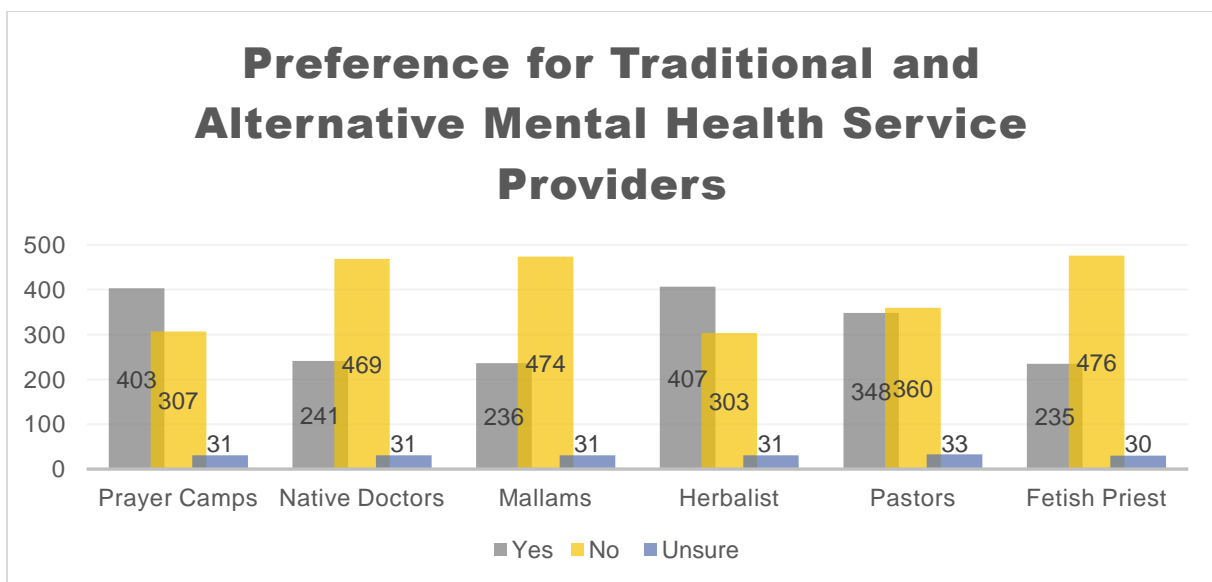
"... yes! I myself I am a clinician and at the same time a manufacturer. Some people who deals with clinics do just that but they are not manufactures, they don't have medicines but will diagnose and use only herbal medicine manufactured by others like us [to support their practice]..." (Officer 2, GHAFTRAM)

These comments show the different forms of TMHCs/THPs providing health services and by extension mental health services. There are differences in the services provided (as will be illustrated in a later section). However, these practices form the bases of the Ghanaian cultural and religious beliefs and practices. With so much to choose from, we explored which of these traditional health practices are most preferred.

13. Preferences for Traditional Mental Health Centers (TMHC)

The perspectives of users and their preferences for these services illustrate an understanding of the choices made by people for health service utilization. The survey data showed preferences to be high for herbalists, prayer camps and pastors as compared with fetish priests, mallams and native doctors.

Diagram 17: Preferences for Traditional Healthcare and Services



The preference for the use of herbalists and belief in herbal medicine aligns with common practices across the socio-economic segment of the population in Ghana. The use of herbs and herbal medicine for therapeutic and medicinal purposes is a traditional but vibrant practice among Ghanaians for the treatment of diseases, prevention of diseases, promotion of wellness such as for therapeutic purposes and the enhancement of ones quality of life. The knowledge

and use of traditional medicine is common at the individual, family and community levels and in recent times commercialized as a vibrant pharmaceutical option for people hoping to cure or manage numerous diseases and symptoms. These practices affirm the World Health Organization (WHO) report that 70-80% of the world population use herbal supplements and products for their basic healthcare services (WHO, 2019). It is therefore not surprising that the most preferred amongst the various forms of traditional health practices is the herbalist services.

Apart from the herbalists, users also patronize the services of prayer camps and pastors. Strongly held religious beliefs and routine practices influence decision-making patterns for healthcare access and usage. This is not surprising because majority of the population of Ghanaians (71%) are Christians. Most people feel comfortable using pastors and prayer camps for healing and healthcare. Majority of pastors and prayer camps profess healing and provide some form of mental health services. Some of these are confirmed below:

“... We also deal with mental illnesses too. Some people’s (PMD/PMI) sicknesses are spiritual so when we pray and when we see that it is actually spiritual, we pray and seal that [problem] spiritually and then follow with herbal medicine. It takes about 3-4 months for them to recover.”
(Pastor and Overseer 1, Gomoa West)

“... we deal with all sorts of demands and needs of our clients... so for mental health patients, actually, we use only traditional medicine to treats this mental health patient that visits our facility... I can conveniently say that we have the remedies and the solutions in handling them, but for now at my facility, we are modernizing” **(Member, 3 GHAFTRAM).**

The narratives show that the herbalists and herbal centers do provide different services including mental healthcare. Despite acknowledging providing the services, most providers don't exclusively provide mental health care but provide a wide range of services depending on the diagnosis. This influences their commitment to and investment in services and infrastructures that support the various needs of people with severe mental disorders or psychosis (see below for further discussion).

Comparatively, the use of native doctors, mallams and fetish priest is not as high as herbalists, prayer camps and pastors. Unlike the herbalists, the use of prayer camps and pastors cut across the regions. We noticed the use of mallams was more predominant among the Moslem communities in the Northern and Upper West Regions than in the remaining regions. Similarly, the use of native doctors and fetish priests is commonly found among the southern regions.

The preference for TMHC/THPs may be informed by the belief that mental health is spiritually induced. It is worth noting that although, the survey report indicated that only 17% of respondents believe mental health is spiritual, majority of the interviewees share the belief that mental health is fundamentally spiritual.

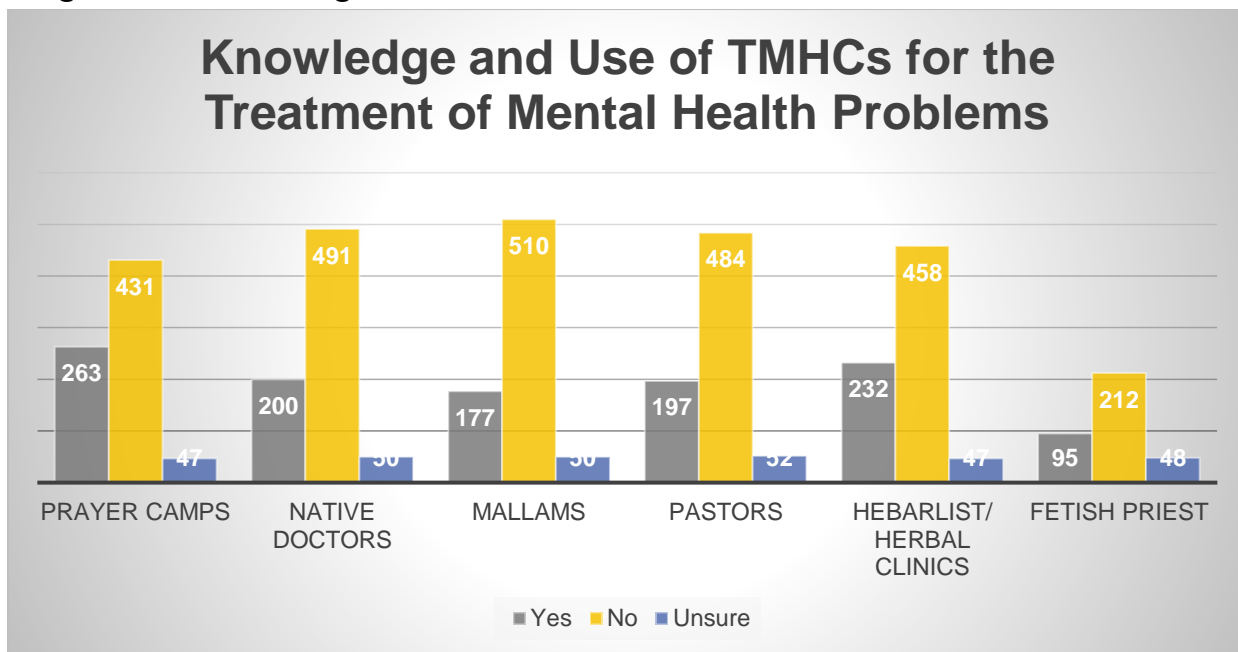
These practitioners provide services based on the beliefs of their clients and therefore their use are aligned to these individual beliefs, perceived efficacy of the provider him/herself or reputation

for curing certain ailments and diseases. To summarize, the preference for traditional health practitioners is largely dependent on the individual belief system, reputation of the practitioners, location and common practice within those location.

14. Use and knowledge of TMHCs for Mental Health Care and Services

The survey data showed a reasonable use of these traditional health practitioners (THP). On average, a third of respondents have used any one of the THPs or know someone who has used them for various needs including mental healthcare. The personal report on or knowledge of people who have used THPs for mental healthcare and services aligns with the preferences discussed earlier. The data shows utilization to be relatively higher for prayer camps, herbalist, native doctors, pastors and mallams in descending order.

Diagram 18: Knowledge and Use of TMHC/THP for Mental Health Services



The use of fetish priests is the lowest reported among the TMHCs partly because only 5% of the Ghanaian population admits to belonging to the traditional religion and partly because people who use the service do not admit it openly. Anecdotal evidence shows that the use of fetish priest is generally disapproved by the society, hence the secrecy and lack of admission to the use of their services.

Despite this, fetish priests and spiritualist provide services patronized for mental health care. About two-thirds reported that they have not used the services of THP or knew anyone who has. What is also evident is the inconsistency between reports on usage and preferences on the one hand and narratives from THPs about the influences, roles and trust in their services provided at these traditional health facilities making them preferred by the public on the other hand. All of our interviewees that provide traditional health services reported heavy use of their services for various healthcare including mental health care. Some of these were reported during the small

group discussions with the Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM).

“... we are very much aware that most of this mental health conditions do come to our facilities [TMHCs] and on several times we have gotten them cured through some of our memberships. Our members consist of faith healers, the spiritualists, herbalists, the native doctors, and the mallams...” (Member, 2 GHAFTRAM).

“I had a lot of engagements with people with mental health problems at my facility in Accra and my home town, Nkonya Akropong [in the Volta Region] which is my home town which is my headquarters. A lot of cases are brought to me there because I have a bigger facility there and can accommodate them... (Member, 3 GHAFTRAM).

“... when I was an apprentice with my grandfather, we started engaging his mental health patient and when he passed away, I continued with it until I relocated to Accra. But because of space constraints... we have a small place. So I stopped the deep [people with severe symptoms] ones and handles the minor, minor issues ... those ones are the ones that come with bad behaviors [psychotic and aggression], it is a very difficult one, actually we use only traditional medicine to treats this mental health patient that visits our facility (Member, 4 GHAFTRAM)

For these traditional health providers, their clients visit for various services some of which include mental healthcare. Thus, they contribute towards providing health care services generally and have a big role in providing a need for alternative mental health services. Although very limited usage was reported in the survey, providers stated otherwise. We explored the services provided and how ailments are managed by the TMHCs/THPs in relation to mental healthcare and services in the next section.

15. Description, Treatments and Management of Mental Disorders/ Illness or by TMHCs/THPs

The treatment and management of mental illness, disabilities and problems are defined by various factors such as the diagnosis, the beliefs and practices of the facility, services provided or available resources to support these needs. Firstly, we present the description of THMC/THPs of mental illnesses to demonstrate their understanding and insight into mental health, causes and symptoms of mental illnesses and disorders. Secondly, we considered the treatment regimes and management of diseases or PMD/PMI which also provides an insight into why and how they support their patients.

Description of the Symptoms of Mental Illnesses and Disability by TMHCs/THPs

To demonstrate practitioners understanding of mental health, we asked them to describe the mental health cases they deal with and some of the common terms used. The study shows that traditional mental health providers understand mental health conditions having regard to descriptions they ascribed to the conditions. Key amongst them are:

Description	Conditions
<ul style="list-style-type: none"> • ‘Madness’ or ‘Edam’/ ‘Abodam’ • ‘Drug addiction’ or ‘Ndroboni num’ (taking of bad drugs and things) 	Psychosis or Schizophrenia, Drug related symptoms, which may include psychosis, schizophrenia. Violent behaviours, etc.
<ul style="list-style-type: none"> • Stress, or someone over-burdened with deep worries or ‘Adwendwen’ (thinking too much/ distressed) 	Depressions
<ul style="list-style-type: none"> • Disappointment in marriage/ relationship 	Depression (or mental health related to relationship breakdown)
<ul style="list-style-type: none"> • Seizures or ‘Etwā’ / gbiligbili (falls/ siezures) 	Epilepsy
<ul style="list-style-type: none"> • Forgetfulness or ‘Awerefie’ 	Dementia
<ul style="list-style-type: none"> • Unstable person or someone suffering from mood swings i.e. ‘Onye papa biara’ or ‘Nadwen hehem’ (unstable and unreliable minds or mood swings) 	Bipolar Disorder
<ul style="list-style-type: none"> • Serious or light mental problems 	Severe or serious psychosis or other forms of mental disorders whereas someone with depression, dementia or epilepsy many be described as having light mental problems

These descriptions demonstrate an understanding of mental illnesses, the different symptoms and how best to manage them for what they may require. However, irrespective of what the diagnosis may be, for the faith-based healers, mental illnesses or disorders are predominantly perceived as spiritual, therefore the spiritual elements are tackled along-side other symptoms.

Types of Health Condition TMHCs/THPs Deal With

According to the accounts of THP and operators of TMHCs, they deal with all kinds of health problems of which mental illness is one. Thus, they address common ailments such as the malaria, diabetes, asthma, high blood pressure/hypertension, cancers, mental illnesses, skin diseases, and others. Some of these are reported below:

*“By the grace of God, I care for all sorts [of ailments] from headache, stomach aches, to bareness. I also care for **persons with mental illness**. The last one I care for left about 1 ½ years ago. I have not been working so hard now because of my age I was working here in Apam then travelled Accra and Liberia before coming back this way.... I have looked after about 13 people with mental health problems but most of the people I care for were in Liberia. Here I also care for Epilepsy, I have cared for only 4 people so far. I had two epileptic patients one of which is still here and the other had left. The patients here are allowed to come or go to the hospital and also receive home visitation”. (Prophetess and Overseer 4, Apam, Central Region)*

“We deal with mental health problems here a lot- all of them have left so we only have one in residence now. This [prayer camp] was started in 1957 ... so I can’t give you exact number of PMD that have gone through here. In the past, we use to get about 30-40 people but with

community mental health, it has reduced to about 10-15 a year.” (Prophetess and Overseer 5, Ogua West, Central Region).

Most of the TMHCs/THPs provide general services with very few specializing in services and conditions such as physiotherapy, basic chronic diseases and mental illnesses. It was reported that the practitioners do not set out to specialize in mental health services, but get most of their cases through testimonies from former clients when they get cured. What is evident as well, is that, these centers and practitioners have engaged and/or supported PMD/PMI with various needs they classify to be spiritual and physical.

Causes of Mental Illnesses and Disorders according to TMHCs/THPs

The diagnosis ascribed to these mental illnesses were noted to include the following: drug abuse and alcoholism; wrongful use of black magic for easy money or wealth (called ‘sakawa’ or ‘juju’); meddling with spirits and rituals; depressions; and epilepsy. The faith-based healers attribute the causes listed below to their diagnoses:

- Ancestral curses, witchcraft, sorcery, etc.
- The displeasure of the spirits and gods
- Spiritual possession of the person (PMD/PMI)
- Curses and hexes from people in the community which they have offended
- Substance abuse such as marijuana, alcohol, cocaine, methamphetamine, etc.
- Violation of juju /sakawa (spiritual money) conditions
- Depressions resulting from relationship breakdowns, societal pressure, disappointments, not meeting life’s expectations and poverty
- Genetic condition or family history of mental illness and episodes
- Pregnancy related depressions
- Long-term chronic ailments e.g. HIV, TB. etc.

These descriptions demonstrate knowledge and understanding of mental illnesses and disorders although the explanations for the causes may vary from biomedical ones. These explanations are however in line with the belief systems of the people and their community values. Examples of some of these explanations are given below:

"A lot of them [mental illness] is through spiritual issues, some are developed through the taking of drugs and some too, through family illness, so is just it varies." **(Community Leader, Wa West)**

"Some take drugs, some call for saints, some are referred to the hospital so we work with Ankaful. Some are aggressive so we pray and ask for direction and sometimes refer them" **(Prophet and Overseer 8, Eastern Region)**

"... so you see, a lot of young people are now chasing wealth, they are not working, so they are deluded and they are going to unknown areas [spirits & rituals known as sakawa] to fetch money and that also is affecting their minds. So a lot of them you will see that they have a depressing syndrome. Their parents are not satisfying their needs so they will be finding a way for quick money so that they will make their living and on that ground. It is really harming them because most develop mental problems and get haunted along the way of doing these things". **(Member 5, GHAFTRAM, Accra)**

"... you see we were very strong and healthier people [as Ghanaians] ... but because there is a lot of pressures on the children [young people] and adults. A lot of the pressures are also on the women, especially the women they have a depression syndrome so it is affecting them and also the young, young people some take drugs ... and others too suffer it because of genetics in their family history..." **(Member 3, GHAFTRAM, Accra)**

"There are more men than women suffering from mental illness in this community. The men are on illegal drugs like marijuana and other narcotics. I even suspected my nephew but I realized he has never taken any of such things not even cigarette. He was healed at some point after a year when he lived with me in 2015 but since then has become calmer than he arrived... He now is on anti-psychotic medication and we also pray for him a lot". **(Pastor & Family of PMD, Oguwa West, Central Region)**

"... yeah and those who are with all kinds of sickness [chronic diseases], even the women when they are having a pregnant problem [infertility] they are held there [facilities] because of their behaviour, some also we treat them, they have a depression syndrome" **(Member 4, GHAFTRAM, Accra)**

"... we are seeing for the first time a lot of depression cases where some even want to kill themselves.... The women especially, because some ladies get disappointed by men, or when they get pregnant and they have pressure they also get it ... so you will see that depression on the woman.... When you consult some of the women, you will see sometimes that the man have gone for another women or begin to turn to 'side-chicks' [mistresses] and that causes the problems..." **(Member 1, GHAFTRAM, Accra)**

The causes of mental illness according to the THPs have both spiritual and physical elements to them. They are associated with deviations from socio-cultural norms, may be attributed to biological explanations, induced by the persons suffering from it or spiritually induced. These causes may be attributed to any of the mental health condition described above and their severity or otherwise. The causes are determined based on the history provided by the patients themselves, their families or the revelations gained by the THPs. Once a determination of the root cause of the illness or disability is made, the appropriate treatment or managements is given.

Treatment and Management of Mental Illnesses and Disorders by TMHCs/ THPs

With the variations in conditions and causes of mental illness, their treatment and management differ accordingly. Therefore to address these conditions, they require either or both the spiritual and physical means to resolve them. According to respondents' accounts and specifically those from THPs and operators of TMHCs, they use indigenous and traditional practices, plants and herbs; hypnosis and homeopathy; faith and religious healing i.e. cleansing, prayers, fasting and rituals, and in some cases anti-depressants or anti-psychotic medications are used in combination with their practices to enable them address both the spiritual and/or physical causes of the ailment.

"...Okay talking about the traditional way of healing... you know, the 'mental people', we will give them herbs and plants to heal them and helps them... you know, in curing PMD, we try them on different things to see the results that we get ... (Member, 5 GHAFTRAM)

"Sometimes someone have been to the clinic for several times but it is not going [not cured] and then, if it is spiritual we help. Some come from Accra, Tema, Kumasi, Apam and all over the place. Mostly they are directed through word of mouth or testimonies" (Prophetess and Overseer 5, Ogua West, Central Region)

"[we] deal with the spiritual aspect, so the prophetess pray for direction so that we follow procedures on what to do and through the prayers we bathe them, pray over it [sickness] and care for them until they get their healing. We keep them here and wash them, we have rooms at the back of the property, ... women and men are taken care of [by carers] of the same sex" (Prophetess and Overseer 7, Apam, Central Region)

"... So when the person comes like that you see that this is her problem, then you help her, but especially the young people you know that they have something [drugs/alcohol] that they are taking and that have affected their mind, so you need to cleanse their system so that he comes back to his normal senses, that is what we do. Sometimes I will give them herbs and then he/she will sleep for about five to seven days, they cannot wake up and be active and by the time they are back they have whatever substance they are taking gone off their system..." (Member, 2 GHAFTRAM)

"She does not come out by calling people to bewitched but she prays for direction and the only person to guide her is from God. But some patients confess of their own acts and activities as witches, or used magic, etc." (Prophetess and Overseer 3, Gomoa, Central Region)

Another evidence from the study is the types of services provided by TMHCs/THPs. They have both 'in-patient' care (i.e. patience requiring boarding facilities) and 'out-patient' care or those that are treated on the day and discharged. Most of the prayer camps tend to have boarding facilities for PMD/PMI unlike the herbalists, fetish priests and native doctors. The severity of the condition will determine whether one requires an 'in-patient' or 'out-patient' services. Herbalists, fetish priests and mallams provide the most 'out-patient's care irrespective of the condition.

Impact of Traditional Mental Health Centers/ Traditional Health Practitioners on Mental Health

The impact of TMHCs and THPs is reported in terms of the roles and contributions of TMHCs/THPs to mental health services overall.

16. Role and Contribution of TMHC/THPs to Mental healthcare and Service Provision

Traditional mental health centers and traditional health practitioners play significant role in providing health services including mental healthcare and services. The roles and contributions impact on the clients and their families and communities. Some of the contributions reported by respondents include:

- They address spiritual and physical health as well as socio-cultural needs. This addresses clients' faith in healing and personal beliefs in the efficacy of traditional medicine. It is also a holistic way of addressing ailments or diseases, which is culturally appropriate.
- THPs provide healthcare and services of all kinds and needs. They offer this as a one-stop shop for every need.
- Their modalities for healing and dealing with difficult sicknesses or diseases are more preferred than the bio-medical health facilities. For instance, with the relatively reasonable numbers of patients in their care at a time, they are said to be committed to their client's needs.
- They are highly accessible to all, as they are usually located in rural areas. They are reported to be obscured enough to provide confidentiality and anonymity for those who use these services.
- They provide therapeutic and rehabilitation services i.e. for stroke, accident and injured persons as well as for PMD/PMI.
- They provide advice and counselling to their clients and their relatives to prevent further occurrences.
- They provide promotive and preventive services in line with beliefs and practices of the people. For example, using messages around the impact of 'juju' and curses to prevent risky behaviours.
- They work closely in the communities and meet their needs. As a result they have built goodwill and trust in their communities to support their work and influence.

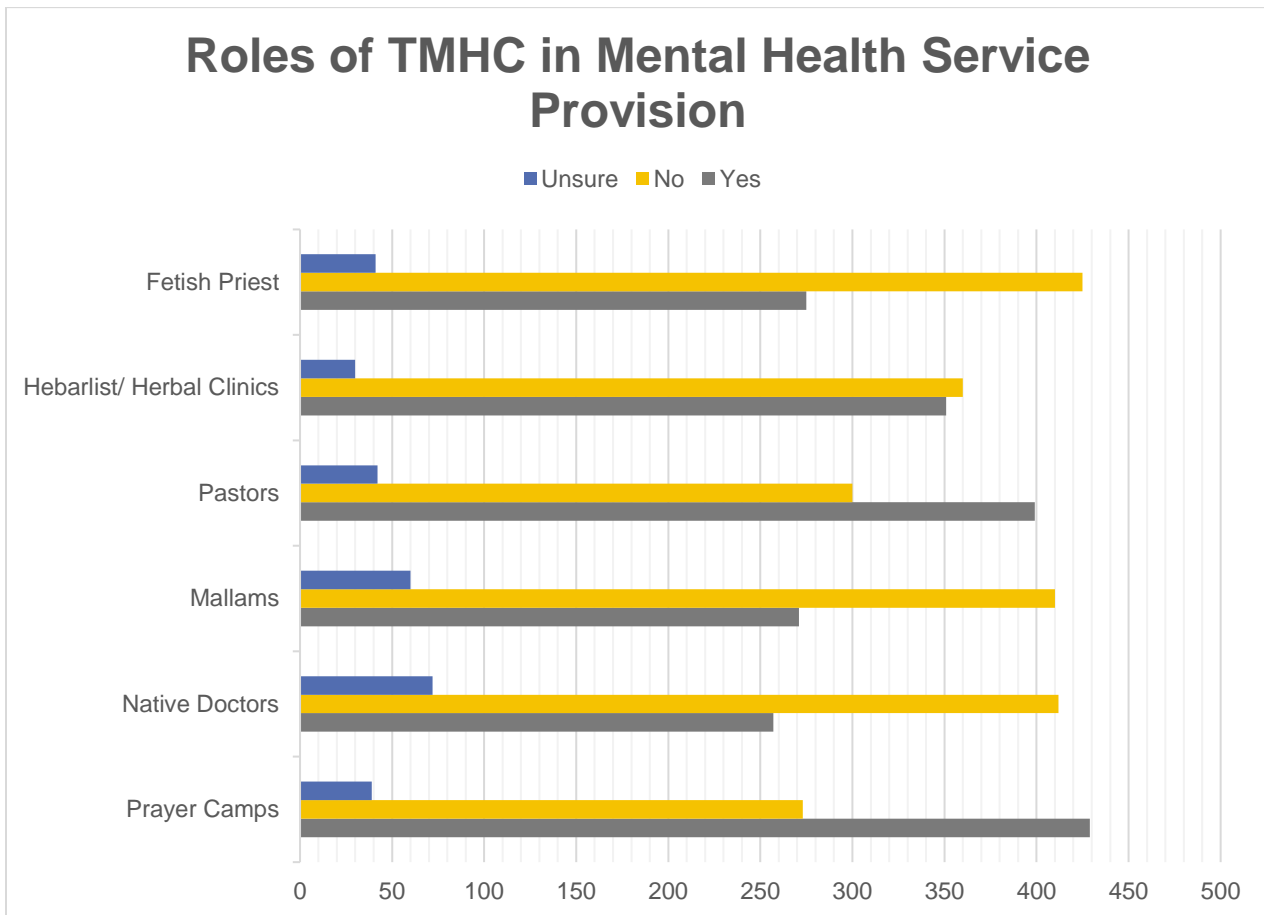
- They address the gaps between traditional and allopathic medicine where people are dissatisfied with the latter services, the cost involved, impersonal relationship, and perceived efficacy.
- They also provide deeper meaning beyond bio-medical explanation for their illnesses and causes of diseases. For instance, alcohol abuse per biomedical explanations is because of addiction whereas traditional explanation such as hexes by a relative be given.

The survey data also showed respondents believe TMHC/ THP have an important role to play and impact the health systems and community wellbeing overall. Respondents rated the roles of prayer camps, pastors and herbalists to be most prominent compared to mallams, fetish priests and native doctors. This survey data corroborates the views expressed by THPs themselves. Their roles are seen to be aligned with the beliefs and practices of the people. It is believed that the people can determine or anticipate the source of power of the THP. Mostly, families, friends and communities have faith and belief in the THPs, hence influence decisions for their sick relatives to use these services.

Another important factor and contribution of THPs/TMHCs is the cost of care. The general view of respondents is that it is cheaper to use TMHCs/THPs than it is to use the hospitals. Although there are some who reported the cost to be equally expensive as the health facilities, they felt less pressurized to raise the funds immediately for the TMHCs/THPs.

"The distance determines the amount you would need to send your ward to the place [TMHC/THP]. When you get there [THMC/THP], there is a fixed instant charge that you have to pay before he look into your case....Sometimes it maybe GHC 60 that you would have to pay before the man will look into your matter whether you can be treated or not. After he had looked into your case he will then tell you to bring either a fowl, a sheep or a goat which is another cost. We have been through some of this challenges and now some of us are fed up but the sickness is still there." (Family Member of PMD, North Tongu)

Diagram 19: Role of TMHC in the Provision of Mental Healthcare & Services



17. Challenges associated with the traditional mental health service provision.

Respondents noted that despite their resilience over the years they are faced with real challenges. Most of these challenges were reported to include:

Resource Constraints

- Their inability to support the residential needs of mental health clients who tend to require long term care and ‘inpatient’ services especially by those suffering from psychosis (‘madness’) or tend to be aggressive.

“We have about 16 chamber and hall, 8 singles rooms and 10 visitors accommodation. We get a lot of support from members have been healed but we need more so the people who come can also be really helped ... most people pledge but they don’t fulfill them.” (Prophetess and Overseer 2, Gomoa, Central Region)

- THMCs/THPs lack funding opportunities either through government programs or private credits programs because the nature of the work is not profit making. Meanwhile, THMCs/THPs are perceived to be making profit when in actual sense they are incurring cost for supporting their communities with a lot of their needs.

“If someone arrives, we bring the person to the prayer ground, you are made to pledge willingly any gifts and then we purify them after the healing. They may offer 1/10th of it [pledge] to sow a seed. We have mostly people paying the pledge and purify them. Some abscond and sometimes they have problems and they are referred to come fulfill that pledge... - some of the people are poor and some people come without resources so we look after them.” (Prophetess and Overseer 2, Gomoa, Central Region)

“I don’t take any money from them but I ask them to buy candles, soap, sponge, towel and anointing oil to be blessed and wash them after which they pledge and most people don’t finish paying for the pledge. Most pledge for about 50-100GHS” (Prophetess and Overseer 1, Apam, Central Region)

Abandonment by Family

- They also experience a lot of abandonment from family members of their clients because they either cannot stay much longer caring for their wards or do not want them any longer. Some of these abandonments stem from avoiding stigmatization and lack of resources on the part of the family members.

Limited Capacity

- THPs report having limited capacity to handle aggressive clients without chaining them. For instance, in cases regarding clients on anti-psychotic medications, THPs report that where they do not have immediate access to their medication to calm them down, restraining them without chaining is difficult. Meanwhile, THPs are responsible for their clients and their actions. Therefore, these restraining practices of chaining their clients is undertaken to mostly guarantee their safety without worrying about them absconding or causing harm to people and property. But with the new regulations, that has become a major challenge for them.

“... honestly it’s [ban on chaining] affecting us seriously, because even if you look at the environment [community] you will find out that PMD/PMI are increasing, the number of PMD/PMI in the street are now more than before. This is as a result of this law. , members of the association are discouraged from admitting people when it comes to an extreme violent or when they notice something like that, because if you get a problem we won’t be there for you... (Officer 1 GHAFTRAM, Accra)

- The capacity to use government guidelines on mental health patients’ management and protocols: there is very limited understanding and training on how and when to refer PMD/PMI to health facilities. THP feel they are being chastised when their patients are referred to the facilities.

“... From my personal experience when you just [refer] ...to the government facility and you don’t specify to our people [GHAFTRAM members] how and who should refer patients... they [GHAFTRAM members] will continue praying at prayer camps and when the condition is worse and they take [the PMD/PMI] to the hospital, the health providers there will ask you why you are now bringing him” you see so if they give us guideline for

people to be making referrals, it should be specified in the guideline....” (Member, 2 GHAFTRAM, Accra)

- THPs report that they lack opportunities for training and capacity building to enhance their work and contribute more to their societies. THPs consider this very critical because despite their knowledge in their practice most of them are uneducated or barely literates.
- Handling suicide prone clients is a major issue to some practitioners due to their lack of resources and ability to monitor suicide-prone PMD/PMI.

Collaboration in Mental Health

- Lack of support from the government and recognition for THMCs/THPs work: There were reports by the THMCs/THPs that the Mental Health Authority as a body does not adequately engage them or their facilities to support the services they are providing.

“The TMHCs are jack of all spiritual problems so they address all sorts of problems and not specialize [only] in mental health. So [we] expecting the MHA to report and get the TMPC involved keenly when they find a facility to be closed down for violating these rules. TMPC will not be happy that they [MHA] closed down some facilities licensed by TMPC without their involvement. (Officer, Traditional Medicines Practitioners Council)

“... So we are looking forward to a way out and so it’s our prayers that Mental Health Authority will look at this and for effective collaborations so that the institution will agree on something reasonably in order to help improves mental health treatment” (Officer 1 GHAFTRAM, Accra)

Prejudice against traditional mental healthcare

- Misconceptions about THMCs/THPs work and their contribution to society: It is reported that despite all the contributions being made in the health sector, they are treated with a lot of contempt by the government agencies. Generally, they are misconceived to be providing dissatisfactory services despite the trust of their clients in them and the impact of their work. Some other misconception is about THMCs/THPs exploiting their clients, when in fact they rather get exploited.
- It is reported that some of the herbal providers focus too much on virility and sexual cures and appetites. This over simplifies and stereotypes their roles in the health sector.

Regulatory Gap

- Dealing with fake practitioners and pastors who exploit people is a major challenge reported by some of the practitioners and GHAFTRAM. They noted the wide variety of services provided meant that it is difficult to monitor and easily detect fake providers or those providing fake services especially among the faith-based providers which affects the reputation and credibility of their work.

Accessibility

- The rural location of most TMHCs inhibits easy access by their clients due to inaccessible roads. Additionally, accessing health facilities from their rural location in cases of emergencies is a challenge.

To summarise, TMHCs/THPs are significant providers of mental healthcare and other health services. They contribute to fulfill the cultural and social health needs of the people. Their understanding of mental illnesses informs their services and practices. They form the fabric of the social health systems. Yet, they are faced with problems which prevent them from being integrated into the health sector to provide continuum of care.

National Framework for Mental Healthcare and Services in Ghana

Understanding the framework supporting mental health care, service provision, policies and operations at the national level is very crucial in understanding some of the challenges and opportunities enumerated in the early the discussions. This section will outline key provisions in the law guiding mental health in Ghana and discuss findings from the study in relation to achieving the core mandates of the Mental Health Authority (MHA), service provision, funding, and protecting the rights of PMD.

18. Core Mandates of the MHA

The Mental Health Act 2012 (Act 846) was enacted to replace the Mental Health Decree, 1972 (NRCD 30) The Act 846 is the current framework guiding mental health in Ghana. It sets out the values, principles and priorities for the government, key stakeholders and operational standards required of them. The sections that legislates the setting up of the Mental Health Authority, its mandates and operations are listed below.

Section 2 of Act 846 stipulates the object of the MHA to include “(a) propose mental health policies and ensure their implementation; (b) implement mental health policies; c) promote mental health and provide humane care including treatment and rehabilitation in a least restrictive environment; and (d) promote a culturally appropriate, affordable, accessible and equitably distributed, integrated and specialised mental health care that will involve both the public and the private sectors.” This provision sets out the governance structure and policy framework for mental health to be led by the MHA. It also highlights the range of mental health services and the need for an enabling environment to promote culturally appropriate care and services.

The core function of the MHA per **Section 3 of Act 846**, includes: (a) consult persons with experience as service users as well as family members for the formulation, development and implementation of mental health policies; (b) provide a mental health service that shall collaborate with the general health care system at the primary, District, regional and national levels and specialised services as necessary; (c) collaborate with the relevant regulatory bodies

to ensure compliance with accreditation and other standards of mental health care; (d) provide service for substance use disorders at the primary care, District, regional and national levels; (e) collaborate with other healthcare service providers to ensure the best care of persons with mental disorder; (f) protect the rights and responsibilities of persons with mental disorder; (g) ensure and guarantee the fundamental human rights of persons with mental disorder against discrimination and stigmatization; (h) provide mental health care service to voluntary and involuntary patients with mental disorder; (i) provide for safety concerning persons suffering from mental disorder; (j) provide psychiatric in-patient care which is of an equitable standard to physical in-patient care; (k) provide for educational, vocational and leisure opportunities within mental health facilities; (l) provide for the safety of staff of the Authority;

In respect of the core mandates of the MHA, the object and functions have been interpreted as the mandate of the Authority:

“The Act is meant to ensure the establishment of MHA, ensure quality, affordable, culturally sensitive mental health service to all residents who require mental health. ... The mandate of MHA is 2: the regulatory and service delivery aspect. There is the service delivery mandate and regulatory mandate. The service delivery mandate is directly responsible for the 3 psychiatric hospitals in Ghana. The MHA regulates other service providers like the GHS, CHAG, etc. providing MH services and care (Officer, Mental Health Authority).”

The MHA is described to have a regulatory and service provision mandate guiding its actions and programs. For the service delivery mandate, the MHA is directly responsible for the three psychiatric hospitals in Ghana but has to collaborate with other agencies and departments for the provision of mental healthcare and services.

...By virtue of the mandate they [MHA] have, we are developing regional and District offices. We are recruiting and allocating these regional and District mental health coordinators to coordinate mental health care and services delivered by GHS, CHAG, and other agencies providing mental health care, etc. Anyone who have anything to do with the mental health care comes under the MHA so we provide these regulatory mandate to them as well.” (Officer, Mental Health Authority)

The descriptions above by the officers of the MHA focuses on the regulatory mandate of the MHA. Despite this, other key stakeholders at the national level believe their role in practice should be collaborative in nature for service provision, policy implementation and regulation as stipulated in sections 3 (b) provide a mental health service that shall collaborate with the general health care system at the primary, District, regional and national levels and specialised services as necessary; 3 (c) collaborate with the relevant regulatory bodies to ensure compliance with accreditation and other standards of mental health care.

However, for some national level stakeholders,

“The structure of the agency versus the MOH is challenging in terms of reporting lines and addressing some of the functions of the actors and the power play. There is the need to accommodate CHAG, GHS, 3 Psychiatric facilities, private providers and collaborate their efforts effectively” (Officer, Ghana Health Service)

For these key stakeholders, the relationship is more collaborative than regulatory because their roles are complementary to that of the MHA. The regulatory mandate of the MHA appears problematic to some actors because when it comes to service delivery, reporting and budgeting, there are clear bureaucratic hierarchies to be followed which excludes MHA. Therefore, their regulatory functions to some of these actors must be purely done in relations to adherence to the Act 846 and not decision on services and postings of mental health workers. An officer at the GHS reported for instance that;

The collaboration is not clear and this is reflective of the Act, which is causing the problems. The 3 psychiatric hospitals are directly under the MHA. The Psychiatric units in the Teaching Hospitals, Regional and District Hospitals are not under the MHA. CHAG is an agency providing their own services and do not necessarily report to MHA and [they] have their own regional reps. GHS also have their facilities in which some regional hospitals have dedicated mental health wards that is independent of the MHA, so it is [the extent of the regulation] that is not clear for GHS.” (Officer, Ghana Health Service)

Another officer from the National Council on Persons with Disabilities (NCPD) also explained that all matters relating to mental health are led by the MHA because they have both the mandate and funding to deal with those issues. Therefore, despite coordinating issues of disability, the NCPD do not include those of mental health as they feel that they do not have the mandate and funding to support issues of mental health.

*“The National Council on Persons with Disabilities (NDPC) is limited to physical disabilities and not mental disabilities, all issues of mental health or [classified] as mentally challenged or ill people are addressed by the MHA. We engage in referral to appropriate agencies to deal with persons with mental disability. ...We are the council for disability but when there is a disability with mental health this is referred to MHA. **Their [MHA] work involve[s] a lot of collaboration too. Most of the work [on mental health] are done by other institutions such as District assembly using some of their common fund for financial support” (Officer, National Council on Persons with Disabilities)***

The Traditional Medicine Practitioners Council also reported of collaborating with the MHA for training for some of their traditional health practitioners although that collaboration was limited to promoting allopathic mental health practices rather than the traditional health practices. This to them limits the role of the MHA which has led them to ignore the significant role of traditional providers of mental health care and services.

*“...We [TMPC] have a relationship with MHA and they work with the trainer at the TMPC to train the people, they engage them and regulate jointly, **there is no conflict because the MHA concentrate on allopathic practices and not traditional medicine.** They frown on the*

traditional medicine but it is very important The MHA see mental health to be orthodox focus, and it can't be so because it [mental health] is rooted in beliefs. So they have to collaborate with our members” (Officer, Traditional Medicine Practitioners Council (TMPC))

This view of promoting allopathic medicine for mental health was also expressed by the representative of GHAFTRAM and the Ghana Federation of Disability Organisations to selectively exclude their contribution towards service provision in mental health. Therefore, the MHA is failing in creating an enabling environment for the promotion of culturally appropriate mental health care.

“In terms of policies, there is failure on the part of the government [MHA] to implement some of these provision[s], the NFDG level, there were inputs to the Mental Health Act. It is has been enacted but not implemented properly. Ghana has ratified the UN [Convention on the] Rights of Persons with Disabilities, we also have sign[ed] on to the SDG to not leave no one behind. But the law enforcement agencies are not aware of such laws and this means the agencies and the government have failed. But the CSOs and NGOs must keep pressing for the policies to be included. (Officer, Ghana Federation of Disability Organisations)

From the perspective of GHAFTRAM, the Act has not categorically included the informal providers adequately to streamline their practices. The MHA has also not included them in strategic decision making fora, committees and meetings to enable them collaborate adequately or understand their operations. Here are some views expressed by senior officers of GHAFTRAM:

“... we are very much aware that most of the mental health conditions do come to our facilities and on several occasions we have got them cured through some of our membership’s effort. Little did we know that, they [MHA] will limit themselves to allopathic practitioners only, especially during the establishment of their members and their governing board and other committees of the Mental Health Authority” (Officer 1, GHAFTRAM)

“They [MHA] have only invited us to very few meetings [before the law was made] and now that the law is here they don’t include us in most of their policies, meetings and training. They [MHA] are waking around claiming they are ‘Mental Health Authority’ they are not doing anything collaborative with our providers and we have a lot of people providing mental health care” (Officer 3, GHAFTRAM)

“So in fact, the absence of GHAFTRAM in decision making in mental health and the authority [MHA] is not in good faith with us. So I can purposely say the Acts should be re-looked at and if possible since the Law has already been passed, other sub-committee should include the real people who are dealing with the communities and majority of mental health people and that is GHAFTRAM. We [GHAFTRAM] must be involved so that we can all work to promote mental health in the country. Look at this [Act 845], the first one [provisions] in the law and all about the mental health authority what else do we have and how do we officially contribute...’ (Officer 2, GHAFTRAM)

From the above discussions and comments from key national level stakeholders, despite the extensive role of the MHA to provide governance and leadership in the mental health arena, they have not adequately engaged key actors and providers of services to enable the

collaboratively achieve their mandates. The lack of effective coordination by the Mental Health Authority has raised concerns around issues of trust, transparency, efficiency, participation and accountability for some of these stakeholders. The opportunities for participation of the various actors operating in the mental health arena have not been adequately harnessed to create the culturally appropriate environment stipulated in **S.2(d) of Act 846** (to “promote a culturally appropriate, affordable, accessible and equitably distributed, integrated and specialised mental health care that will involve both the public and the private sectors”).

19. Framework for Mental Healthcare and Service Provision & Funding

From earlier discussions, it is evident that services are provided across the formal and informal sector. Therefore, the pathways for mental healthcare in Ghana is not only through the formal structures but also the informal ones. The functions of the MHA per section 3 of Act 846, paragraphs (b) [is to] provide a mental health service that shall collaborate with the general health care system at the primary, District, regional and national levels and specialised services as necessary; (e) collaborate with other healthcare service providers to ensure the best care of persons with mental disorder.

The delivery of care and services were entrusted to providers in both the public and private sector which include: the Ghana Health Service (GHS), Teaching Hospitals (TH), Christian Health Association Ghana (CHAG) and other providers within the private or informal sector. The MHA is in charge of the 3 specialist providers in Ghana: i.e. the Accra Psychiatric Hospital, Pantang Hospital and Ankaful Psychiatric Hospital. However, at the Districts and regional levels there is an overlap of function between the Ghana Health Service and the MHA.

At the National level, we are running the parallel service at the national level, down to the regions the GHS structures are working and when you get to the communities there ... There are two agencies, but MHA appoints GHS staff but GHS pays them. There is a challenge for this because they are not seconded but rather appointed and allocated by the GHS but not by different institutions...” (Officer, Ghana Health Service)

The challenge confronting the implementation across the Districts and regions is the overlap of functions not accompanied by funding and accountability. All the agencies and public institutions have government funding allocated to them for specific services. It is reported that since the Act was enacted, all funding relating to mental health is specifically allocated to the MHA despite some of these overlapping functions. It is for this reason that the complementary roles of some agencies providing services or regulations are shirking such duties. For instance,

The MHA people always quote that they will use existing structures to implement mental health services but GHS is not only the existing structures, but it seem they are using GHS structure as an extension even though they have their own funding as is GHAG or the 3 [psychiatric] hospitals and the teaching hospital. They have their regulatory functions, they are supposed to have their regulatory functions. (Officer, Ghana Health Service)

Funding is a major challenge confronting the national level institutions implementing mental health care and services. For instance, the MHA has always complained about funding challenges impacting on its operations. The Authority reports having lesser resources to meet the mental health needs at the national level. Another challenge is the delay in release of these funds despite being inadequate. This in effect, creates an over-reliance on donor funding for the MHA to undertake its functions and mandates.

“MHA is funded by DFID and it is coming to an end, but the NCPD have its resources and have its own challenges that prevent them from working effectively. The disability definition is so vague and not mentioned in any law or Act and have issues of who is involved. ...MHA relates with them but the council is not virtually functioning ...1.4% or less than 1% of the health budget comes to mental health - 219,000 was budgeted for the MHA in 2017 but it was given at the end of that year. The funding situation is very bad and we are still waiting for this year’s allocation” (Officer, Mental Health Authority)

“GHS also admits [PMD/PMI] but we don’t receive operational funding for them. They are doing the home visit but they are not supported. They come to the wards, they lie on the beds and treated and charged. Otherwise some abscond and if they don’t they just incur bad debt. Government owe them because they have not been reimbursed [for services provided]... MoH does not give funding, all the funding are from DFID to BasicNeeds Ghana [an NGO], CHAG, GHS, MHA. We got for 3month for community level and home visit but how do you support when the funding finishes? (Officer, Ghana Health Service)

“Funding is important when it comes to policy implementation. We (CSO and Human Rights Groups) must do advocacy to promote mental health. Government is not thinking about it as a societal issue but an individual issue rather than social, economic and political issues. We need a strong advocacy just like the gender issues. We need to prioritise mental health in an advocacy and provide further platform on SDG ...for advocacy. At the organizational level we need to promote more advocacy in this regards. Capacity building of persons PMD, officers, workers, etc. needs to be prioritised...” (Officer, Ghana Federation of Disability Organisations)

Despite the effort to promote mental health care in Ghana, it is evident that, it is generally underfunded creating a lot of challenges for institutions working in the field to support the needs of their clients. Funding from government health budget is very limited and poorly procured whereas, the donor support is also facing funding cuts as most development partners are exiting the country. This is a practical problem for service provision, operations, advocacy, resources and capacity building. Per the MHA officer, the lack of funding has led to:

“..Lack of medication and psychotropic [drugs] is a major issue. When the law was passed the anticipation of the psychotic medication was that we will have enough resources to procure them. Every two years the government procure medication but since 2011 there has not been any procurement of the mental health [drug?] and there is a funding and procurement challenge” (Officer, Mental Health Authority).

From the GHS perspective, there is...

“No funding for mental health, that is why they need to plan the work, implement and monitor together with us [GHS] and others [national level actors], but they [MHA] don’t release any funding. Coordination and collaboration is bad, the ownership is poor, supervisions and monitoring is poor and this is affected by funding and its reporting mechanisms” (Officer, Ghana Health Service).

“There is the need for a lot of engagement with government to promote more support for the budget, donors are pulling out of the country and this is making it challenging to get external funding for advocacy. So we need to task government [to provide more funding] and also promote mental health to deal with mental disability to enable promote more inclusiveness. Government have little know-how [on disability issues] and need education with the prerequisite institutions to support implementation of government policies in mental health and disabilities” (Officer, National Federation of Person with Disability)

“Funding is an issue for the people mandated to work with the mental health patients. They [MHA and other actors in the field] are also challenged in resource. Some families, friends and relations reject them [PMD/PMI] and we [social welfare] don’t have the resources to support them too” (Officer, Gender Department, Ministry of Gender & Children’s Welfare)

Funding has impacted on service provision across the national level stakeholders performing complementary roles to support the MHA. The extent of the funding impact transcends from the national to the Districts through the regions. This affects services provided to PMD and their families. It is very crucial that a sustainable funding for mental health is agreed by the key actors to promote the functions and mandates of improving mental health care and services per the provisions in the Act 846. This is summarized by an officer who observed that:

“The Mental Health Act was crafted to take into consideration the structures [required] to enforce it but this is affected by the lack of resources. The patient’s charter is used and it includes the mental health services. I think in future we might consider extracting some of it for our facilities but as it stands now it is being used broadly as patient charter for all... and I wonder if we can meet it” (Officer, Mental Health Authority).

20. Treatments and Patients’ Rights

The Mental Health Act, 2012 (Act 846) is tailored to improve service provision, patients’ rights, access and quality of care for PMD/PMI. The Act 846 makes provisions for the protection of vulnerable groups, rights of persons with mental disorders, procedures for voluntary and involuntary admission and treatments, and the regulation and sanctioning of offences relating to discrimination against persons with mental disorders.

Following the enactment of Act 846, the MHA, Non-Governmental Organisations (NGO), Civil Society Organisations (CSO) such as the Human Rights Advocacy Centre, MindFreedom Ghana, BasicNeeds Ghana have trained traditional health providers on the rights of PMDs/PMIs. The training encompasses protection for PMD/PMI and how MHA can collaborate with them to

protect these vulnerable groups. These provisions particularly protect all PMD/PMI seeking mental health care and services whether in the formal or informal setting against human rights violations and other forms of abuses like abandonment and chaining which is commonly reported in the field. The views of some PMD and their families show why these provisions are important.

"...I cannot be sick and you [THP] add to my sickness. So if I'm sick and you chain me, you are adding more sickness. They chained me, and for me, chaining me ... it makes me less human ... it makes me less human. You don't treat human beings like that. So if we are sick they should understand that we are sick so they shouldn't chain us. And if they are to chain us ... they should quickly remove those chains when the person calms down. We are not criminals to be handcuffed like that" **(PMD_1_Wa West)**:

"The child or maybe especially the mental challenged ones - when they put chains on them its dehumanising." **(District Education Officer, Upper, West)**

"Instead of reporting it [aggressive behavior] to the right authorities for them to take the necessary steps, maybe he just need some mild treatment but they won't. But when they chain the person down like that food might not be given to the person. There may be something [medication] that the person is supposed to be on which they have been deprived and continue to be deprived because of the chaining. With the chaining of that person, the situation [condition of the PMD/PMI] before you realise becomes worse..." **(Social Welfare Officer, Central Region)**

Despite these views, some communities and THPs attest to these outlawed practices. For THPs, some family members and communities that support the practice of chaining, their main aim is to restrain PMD/PMI from aggressive behaviours and/or absconding from their facilities/communities or homes. Despite the physical and psychological impact of chaining on PMD/PMI, those who practice it think it is the best option to support or restrain their clients/wards.

"I chain the ones who are aggressive and some of them also ... I give them medication to make them sleep for about 6-8 hrs. then they will be calm and it [herbs] weakens them. There is only one person who absconded and was caught by the police and they brought him back to the camp. We make them sit under the trees and chain them but we make sure they don't get hurt. If they walk around with it then they develop some sores. ...But otherwise, restraining them when they get violent and abusive can be difficult..." **(Prophetess and Overseer 1, Apam, Central Region)**

"We handle them very well and then we give them support, you know some of them they are very aggressive, so if one of them is aggressive the youth will come together hold him then we will chain that person or if that person is running into the bush we will go and catch that person and come and chain him till I come. So, here they [community members] don't have any problem with me chaining, they only help me" **(Chief & Community Leader, Wa West)**

"And here [District], the way we treat them at the traditional camps and places, ... the aggressive ones of course, if you are dealing with them, most of them are aggressive, you would have to ... you may need to tie their hands, tie the legs together and then restrict them. His [PMD/PMI] movement is restricted because they [community] have the fear that he can hurt somebody..." **(District Health Officer, Upper West)**

"...some are extreme, some too... they want to, how do we call it, be violent against someone, so restrict their movement if you are the violent type they will actually chain you down which is not also good because they don't want them to be violent they want to restrict their movement in doing so they use some other means to restrict their movement..." **(District Health Officer, Central Region)**

During the study, THPs reported that with the introduction of the Mental Health Act that contain provision that ban chaining of PMD/PMI, most THPs have had to reassess their ability to provide services based on the severity of the illness and type of facilities available in their centers. Although, no one reported being sanctioned in court or by the MHA, the trainings being provided by the MHA, CSOs and NGOs have highlighted and educated on the provisions of the Act that criminalise such practices.

Some of the respondents noted that they find it difficult managing those with severe symptoms, hence their tendency to chain them as a restraining mechanism. However, as the new law has criminalised these practices, they find it difficult to handle PMD/PMI that are aggressive or keep absconding. Some providers have resorted to either referring them, or admitting them only if their relatives are willing to manage them or outrightly rejecting to provide them any services. However, others have simply resorted to offering only 'outpatients' services, which they say is easier to manage although adherence to treatment can be a challenge.

"The aggressive ones are managed calmly with medication, herbs or prayers, we also use strong people to restrain them. But if there is no strong relative to manage them we don't admit them. We ask the family to take him but come for consultation and treatment. So that is how we have reduced the numbers drastically for those who stay ..." **(Prophetess and Overseer 2, Gomoa, Central Region)**

"... honestly it's [the banning on chaining] affecting us seriously, because even if you look into the environment [community] you will find out that patients [wondering about] are increasing. The number of patients in the street are now more than before. This is as a result of this law, members of the association are discouraged from admitting people when it comes to an extreme violent PMD or when they notice something like that," **(Member 1, GHAFTRAM, Accra)**

Thus, THPs recognize their own limitations and sometimes refer what they cannot handle to other THPs, medical or psychiatric hospitals for better support. Increasingly, TMHC/THP are collaborating with community mental health nurses to support their clients with medication and visits at the TMHCs. What became evident is the general perception that there is no alternative to the chaining to restrain PMD/PMI who may require it. Very few THPs reported using anti-psychotic or depressant medication to achieve the same purpose.

To conclude, the national framework demonstrates the significance of collaboration, capacity building and resource availability to support the mental health sector. It is evident that the MHA will require further engagement with key actors to enable them educate and strengthen the mental health systems for its implementation.

DISCUSSION

Stigmatisation of mental illness is very high and persistent across all segments of persons. It is perpetuated through the descriptions and derogatory words used to describe PMD/PMI as well as misconceptions about mental illness. In some cases, this leads to the development of

negative attitude towards PMD/PMI. This leads to discrimination, prejudices, and social exclusion of PMD/ PMI. Common experiences reported include being blamed for their ailment, labelling, being unfairly judged, shunned or socially excluded, harassed, abused, mocked, treated with contempt and their inability to access social services. Both of the sexes experience the impact of stigma although differently due to their socially ascribed roles. For example, men are likely to be excluded from decision-making processes, social and political roles while women are mostly prone to neglect from their spouses, sexual abuses and harassment. Women are however more likely to be supported, sympathized with and included despite their ailment. In most cases, the negative impact of this stigmatization extends from the PMD/PMI to their families members and communities.

An interesting outcome from the study is that the words used to describe mental ailments in the local dialects are very derogatory when translated into the English language. The literal translation of mental illness simply means 'madness' or 'mad person' irrespective of the local dialect used. For instance, 'Abodam' or 'Bodamni' in Akan; 'Sekehelo' in Ga, 'Hawuk' in Hausa, 'Tagbor gbegble' or 'adabator' in Ewe all mean 'madness or a mad person'. In cases where people want to acknowledge this derogation, they preface their word with 'sebi' (that may translate from Akan to English as 'excuse my language' or 'with all due respect') to use the same words to describe the condition. It is evident that so long as alternative local words are not introduced for mental ailment, the derogation and discrimination associated with stigmatization will persist despite all the effort to educate and create awareness on the condition. The other element of stigmatization that became evident from the study is people's difficulty to accept behaviours that deviate from the norms, customs, practices or acceptable standards in society. PMD/PMI exhibit behaviours that do not conform to these norms, customs and practices and these behaviours are difficult to accept, misunderstood, threatening and to some evasive (Fink & Tasman, 1991).

The Mental Health Act 2012 focuses on improving access to care for PMD/PMI by safeguarding their rights, proscribing abuses and increasing regulations of the sector overall. The law also provides for the integration and regulation of spiritual and traditional mental health practices in Ghana (Roberts, Asare, Morgan, & Osei, 2013). PMD/PMI struggle with their conditions as well as practices that demean them as members of their families or communities. They are subjected to chaining, discrimination, prejudices, social exclusion from social and economic opportunities because of their ailment or experiences. Many have been robbed of a quality of life including access to good jobs, housing (Corrigan & Watson, 2002) healthcare, education, professions and careers.

In this study, some traditional health providers, communities and families have limited knowledge, understanding and structures on supportive ways to handle or manage PMD/PMI. This is evident of the collective notion that perpetuates some of these abuses. For instance, the reasons provided for chaining in this study is based on the convictions that they are critical strategies to manage or treat PMD/PMI and the lack of alternative practices if not checked, will reinforce the practice despite the law preventing it.

TMHCs/THPs are established pathways to mental health care and services in Ghana, despite the limited acknowledgement of their roles and impact in the mental health setting. The overwhelming acknowledgement and utilization of THMC/THPs is evident of how they bridge the treatment gap for mental healthcare and services. Also, their ability to satisfy the social and spiritual needs of PMD/PMI and their family will continue to make them relevant. Furthermore, the depth of knowledge and understanding of traditional health practitioners of mental health as described by their symptoms demonstrate an opportunity for training to enable THPs to build their capacity on the various ailments and the expectation to improve the quality of treatment and management regimes.

However, these informal mental health services and providers are still underdeveloped and poorly regulated. The challenge of regulating practices that differ widely across providers, practices and beliefs is also evident in this study. The process of diagnosing, providing treatment and supporting PMD/PMI is dependent on the providers' beliefs and practices. Thus, while the herbalists will use herbs to support the treatment of their patients, fetish priests will resort to spiritual ostracism, purification and ritual, and the pastors or prayer camps will use prayers, counseling, blessed water, anointing oil and/or herbs. Creating standards to measure the efficacy of these practices is a challenge. Despite this obvious challenge, it is not difficult to monitor and regulate the TMHCs/THPs and the conditions within which services are provided to PMD/PMI.

Also, Act 846 has influence on the practices of most TMHCs/THPs. However, the lack of understanding of THPs of the Act as well as its implications on PMD/PMI means that some THPs are still using illegal methods and practices, which violate the rights of their clients. The enforcement of Act 846 and other guidelines is reported to be weak, which further impacts on effective regulation. It is evident that efforts are being made between the MHA on the one hand and the GHS, CSOs and NGOs on the other hand to protect the rights of PMD/PMI.

However, an effective regulation especially of the informal mental health service providers, collaboration with them and the structures to develop their resources and services is still lacking. This has created a dichotomy of 'us' and 'them' between the formal and informal sector with adverse effect on regulations, collaboration and support for traditional health systems. Yet, both services are complementary for the continuum of care in the mental health sector in Ghana. This may partially stem from the different approaches to disease causation, treatments and the approaches towards measuring effectiveness (Kpobi & Swartz, 2018). Also, the disparities between cultural expectation and mental health services has created gaps that require collaboration with traditional and religious healers to enable them adapt services, establish a stronger working relationship for referral and de-stigmatization of persons with mental health (Alem, Jacobbson, & Hanlon, 2008).

CONCLUSION

Barriers to mental healthcare access within the formal sector have made the role and contribution of TMHCs/THPS very crucial in Ghana. The THMCs/THPs consists of the informal mental health care providers who address the socio-cultural and alternative health needs of the people. The role and contribution of the TMHCs/THPs is not usually perceived as complementary but rather put in a dichotomy of parallel health systems. The formal and informal mental healthcare divide has masked the co-existence of the two mental healthcare system constraining access, coverage and responsiveness of the mental healthcare system.

The lack of collaboration between the formal and informal mental health sector has inhibited the ability to harness the limited resources for the management of mental health care and services in Ghana. The propensity to recognize TMHCs/THP as relevant community health structures has potential enabling impact on improving quality of care, regulation and enforcing the provisions in Act 846.

Lessons from this research demonstrate the need to incorporate the practices of THMCs/THPs into a broader mental health care system to improve accessibility, reduce stigmatization and focus on responsive mental healthcare and services relevant to clients' needs and beliefs.

RECOMMENDATIONS

We have made some recommendations based on the evidence presented above. These findings were validated with key actors in the field of mental health. These can be summarized in the following themes: improving stigmatization and education; regulations and protection of rights; capacity building and training in recognition of the role of TMHCs/THPs; collaboration between the formal and informal sector, and prevention.

1. Stigma and education

The MHA and stakeholders within the mental health space need to intensify national level education and sensitization to mental health using various strategies like mental health champions and community leaders for maximized impact. As part of this, efforts must be made to revise derogatory local language ascribed to mental illness.

2. Regulation

There is the need to regulate the conditions of services provided by the TMHCs/THPs to ensure compliance with minimum standards of care and treatment for PMD who resort to these services. This must be supported with effective monitoring to ensure compliance. The MHA must ensure that TMHCs/THPs who violate prescribed standards are adequately sanctioned in accordance with the regulatory and legal framework.

3. Capacity building

THPs need to invest in building their capacity to provide the right standard of care and support for their users.

The MHA and other stakeholders need to train THPs on new and/or relevant policies and guidelines in mental health whilst building their capacities on standards of care and practices.

Additionally, the GES needs to ensure that schools are mental health friendly by building the capacity of teachers and sensitizing them to mental health to identify children with mental health conditions for support and early treatment.

4. Collaboration

The MHA should identify clear areas of collaboration including linkages between the orthodox and unorthodox sectors; provide collaborative mechanisms among key community stakeholders especially between mental health workers and traditional and faith-based healers; and, build confidence between the formal and informal mental health service providers.

5. Prevention

Mental health service providers (both orthodox and unorthodox) should drive specialized preventive and treatment services having regard to the factors that heighten a person's vulnerability to mental illness. For example, considering that women are vulnerable to mental health conditions because of domestic abuse, efforts must be made to reduce or eliminate domestic violence and its effects.

It is recommended that mental health service providers including THPs must work collaboratively with clinical psychologists to support the needs of their patients or clients.

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LIST OF APPENDICES

Appendix 1: Assessment Terms of Reference



TERMS OF REFERENCE

RESEARCH ON PROMOTING QUALITY ACCESS TO MENTAL HEALTH CARE AND RIGHTS OF PERSONS WITH MENTAL DISABILITIES IN TRADITIONAL MENTAL HEALTH CENTRES IN GHANA

HUMAN RIGHTS ADVOCACY CENTRE

This document is to guide the operations of the consultant in providing research assistance to the Human Rights Advocacy Centre. Terms are subject to change in consultation and by the final approval of HRAC.

1. Project Title: Promoting quality access to mental health care and rights of persons with mental disabilities in traditional mental health centres in Ghana

2. Background

Human Rights Advocacy Centre is undertaking an eighteen (18) months project aimed at promoting quality access to mental health care and human rights of persons with mental disabilities in traditional mental health centres in Ghana.

The study will assess the extent of quality of practices and human rights conditions surrounding treatment of persons with mental disabilities in the traditional mental health facilities. The study will be conducted on average of, but not limited to two districts in each region of Ghana.

The consultant's responsibility will cover proposing appropriate research methodology, designing research instruments, analysing research data and producing a research report. The Researcher will also be responsible for seeking ethical approval for research from an appropriate authority, facilitating training of research assistance (if required), facilitating validation and dissemination meetings with key stakeholders.

3. Overall Objectives

The objective of this consultancy is to support HRAC to produce a study report on the conditions/practices surrounding mental health treatment in traditional mental health centres.

4. Scope and Methods of the Work

The Consultant will work in close contact with HRAC represented by Ms. Wendy Abbey, the Technical Advisor/Project Lead of HRAC. She, in consultation with the Executive Director of HRAC will work with the Consultant in the production of the study report.

The research is expected to take place in an average of 20 districts nationwide.

The target sample size will include but not limited to;

1. Mental health patients in traditional mental health centres.
2. Family members/caretakers of mental health patients in traditional mental health centres
3. Operators of traditional mental health centres
4. Providers of unorthodox mental health care (including traditional medicines)
5. Members of the Mental Health Authorities (MHA)
6. Visiting Committee Members of (MHA)
7. Representatives of Traditional and Alternate Medicine Council
8. Members of the Mental Health Review Tribunal
9. Civil Society Organisations working on Mental Health Issues
10. Any other sample that the Consultant finds relevant to the research



Our Ref: DC.3.71.01.01

19th March, 2018

Dr. Gina Teddy
Centre for Health Systems and Policy Research
GIMPA
Accra

Dear Madam,

INVITATION TO KEY ACTORS MEETING ON PROMOTING QUALITY ACCESS TO MENTAL HEALTHCARE AND RIGHTS OF PERSONS WITH MENTAL DISABILITIES IN TRADITIONAL MENTAL HEALTH CENTRES IN GHANA

The Human Rights Advocacy Centre (HRAC) and Mind Freedom, Ghana (MFG) under a Gender Equality and Social Inclusion (GESI) support program by STAR-Ghana, is implementing a project to promote quality access to mental healthcare and rights of Persons with Mental Disabilities (PMDs) in Traditional Mental Health Centers (TMHCs) in Ghana.

The project aims at improving understanding of human rights abuses and conditions of PMDs at TMHCs through information and data collection. It will also advocate for improved institutional and policy responses on equitable access to psycho-social support and human rights protection of PMDs through the regulation of traditional mental health centers in Ghana.

As part of this project, the HRAC and MFG will hold a Key Actors' meeting with stakeholders and partners of the project. The meeting is expected to provide a platform for dialogue and knowledge sharing as part of mapping out strategy for the takeoff of research activities.

The meeting will be held on **Tuesday 20th March, 2018 at 9:00am at the HRAC Office at Osu Ako-Adjei, Accra.**

As the research consultant of the project, you are kindly invited as a facilitator at the meeting. Your presence will be greatly appreciated. We would be grateful if you acknowledge receipt of this invitation and confirm your participation not later than Monday 19th March, 2018.

Please contact George Owoo on 0302768733 / 0266302582 or george@hracghana.org or info@hracghana.org for any clarifications you may require.

Thank you for your cooperation.

Sincerely,

George Owoo
(Programmes Manager)

BRINGING RIGHTS TO LIFE

Tel: +233 (0) 302 768733 / +233 (0) 264 214018 Fax: +233 (0) 302 787093 Address: P. O. Box 05 134, Osu, Accra, Ghana (W/Africa)
Loc: House No. F1002/2 Kol Street, Osu Ako-Adjei, Accra. Email: info@hracghana.org Website: www.hracghana.org

**Appendix 2: Ethical Clearance from the Ghana Health Service Review
Ethical Committee**

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.



Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
17th March, 2018

MyRef. GHS/RDD/ERC/Admin/App 118/036
Your Ref. No.

Gina Teddy
Centre for Health Systems and Policy Research (CHESPOR)
GIMPA, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC: 015/01/18
Project Title	Research on Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana
Approval Date	17 th March, 2018
Expiry Date	16 th March, 2019
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months.
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

APPENDIX 3: PARTICIPANTS INFORMATION SHEET

INFORMATION SHEET FOR OPERATORS OF TRADITIONAL MENTAL HEALTH CENTRES

Field study on Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana

Principal Investigators:	Dr. Gina Teddy, (Centre for Health Systems and Policy Research, GIMPA)
Co-Investigator:	Ms Wendy Abbey, Human Rights Advocacy Centre (HRAC) Mr. George Owoo, Human Rights Advocacy Centre (HRAC)
Committee Administrator:	Hannah Frimpong (Ethical Review Committee, Ghana Health Service)

The name of this study is “Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana”. In addition to this information sheet, which explains the study to you in writing, an interviewer will also talk about the study with you today. We invite you to ask any questions about any part of the study that you do not understand. After you know what is involved we will ask you to decide if you wish to participate or not.

A. Purpose of the Study

In September 2017 the Human Rights Advocacy Centre (HRAC) and MindFreedom Ghana (MFGh.) launched a project entitled Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana. This field study is being conducted to find out how people overall understanding or feel about Mental Health and treatments provided by Traditional Mental Health Centre (TMHC). The study will be undertaken throughout the nation for a period of nine months.

Through the findings of this field study, HRAC intends to generate evidence for understanding treatment services provided by (TMHCs), assess the quality of care, variation in service provision, regulations and adherence to human rights practices for the treatment of persons with mental disabilities in TMHCs across Ghana.

A. Procedures

- 1) If you agree to be in this study you will meet with a trained interviewer who will hold discussions with you. This will take about 60-90 minutes.
- 2) You don't need to answer all the questions in the interview if you don't want to. If a question makes you feel uncomfortable or you do not know the answer, it is ok to ask the interviewer to move on to the next question. You can also stop the interview at any time without penalty.
- 3) The interview is anonymous. We will at no point in the project disclose the identities of individual interviewees.
- 4) We will take notes on paper during the course of the interview.

B. Potential risks and discomfort

Due to the fact that some parts of the interview are about mental health, certain questions may make you feel uncomfortable. Furthermore, you may be concerned that others in your community view your participation in the study negatively. To protect you, all information we gather during the interview will be anonymous. The place where the interview takes place will be private and unmarked, and there will at no time be a written list of people who were interviewed.

C. Benefits

This interview will assist HRAC in identifying mental health services available in your community and the protection of human rights for Person with Mental Disabilities. This information will inform policy reforms and advocacy for improved mental health services by TMHC.

D. Compensation

Respondents will not receive any monetary compensation. Participation is voluntary and aimed at a social good. However, any transportation cost incurred by participants will be reimbursed accordingly. Participant will be informed of the benefit of the research and

encouraged to participate. Participants will be provided with refreshment (meat/fish pie, water and soft drink).

E. Confidentiality Statement

Whatever information you will give us will be kept confidential and private. Except for the HRAC/MFGh staff, who will have secure access to the information you would give us, no one will be privy to the information and knowledge you will give to us. Therefore, only HRAC/MFGh staff will have access to the interview notes and/or recordings (audio). **All audio recordings will be destroyed by file shredding upon the completion of the research study** in 2021.

F. Right to refuse or withdraw

Taking part in this interview is voluntary. You have the right to refuse to discuss any questions or those questions that you feel invade your privacy. In light of this you can withdraw from the interview at any time.

G. Agreement

Do you have any questions? (***Moderator: Answer any questions posed by the participant before proceeding to the next question.***)

H. Persons to Contact

The people in charge of this research are Mr. George Owoo (0266302582) and Ms. Wendy Abbey (0243749899) both of the Human Rights Advocacy Centre, Dr. Gina Teddy (Centre for Health Systems and Policy Research, GIMPA - 0240948104) and **Hannah Frimpong of Ethical Review Committee, Ghana Health Service (0507041223)**

I. Declaration

You have read and/or had the explanation of this study read to you. You have also been given a copy of this form, told you can refuse to participate and give the chance to ask questions. I am going to ask for your consent to take part in this interview. By saying yes, you agree to do the interview. By saying no, you decline to do the interview.

Do you agree to take part in the interview?

Signature/Initials of Interviewee: _____ Date: _____

OR

Thumbprint of Interviewee: _____ **Date:** _____

Initials of Moderator: _____ **Date:** _____ to
confirm affirmative verbal consent.

I have explained to the participant the study purpose and procedures and have discussed all the risks that are involved. I have answered questions to the best of my ability that the participant asked.

Date: _____ **Signature of moderator:** _____

APPENDIX 4: OPERATORS OF TRADITIONAL MENTAL HEALTH CENTRES

Field study on Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana

CONSENT FORM

Name of Interviewer:

Region:

District:

Name of Community:Urban [] Rural []

Target Group:

Date of Interview / / /
DD, MM, YYYY

Principal Investigators: Dr. Gina Teddy, (Centre for Health Systems and Policy Research, GIMPA)

Co-Investigator: Ms Wendy Abbey, Human Rights Advocacy Centre (HRAC)
Mr. George Owoo, Human Rights Advocacy Centre (HRAC)

Committee Administrator: **Hannah Frimpong (Ethical Review Committee, Ghana Health Service)**

A. Agreement

Based on what had been explained to you regarding the information sheet, do you have any questions?

Investigator: Answer any questions posed by the participant before proceeding to the next question.

B. Participant statement and signature

You have read and/or had the explanation of this study read to you. You have also been given a copy of this form, told you can refuse to participate and give the chance to ask questions

Before proceeding to read the consent form out to you, I should have you know that you are under no obligation to continue in the interview, especially if you feel it invades your privacy. You've volunteered to be interviewed and so you have the option to withdraw from the interview should you choose to do so. Whatever information you will give shall be kept confidential and private in a secured HRAC database. Upon completion of the field study all data shall be destroyed by file shredding, except for when you or the Ethical Review Committee request to have access to your information. Now, I am going to ask for your consent to take part in this interview. Do you agree to take part in the interview? (If answer is affirmative as participant to sign/thumbprint)

Signature/Thumbprint of interviewee: _____ **Date:** _____

HRAC/MFGh Officer Signature: _____ Date: _____

Checked by supervisor (signature): _____ Date: _____

C. Investigator statement and signature

I have explained to the participant the study purpose and procedures and we have discussed all the risks that are involved. I have answered questions to the best of my ability that the interviewee asked.

Signature of investigator: _____ Date: _____

D. Statement of Witness and Signature

I have witnessed that the investigator has explained to the participant the study purpose and procedures and all the risks that are involved. And that the investigator has answered questions interviewee asked to the best of ability of the interviewee.

Signature/thumbprint of witness (who may provide assistance to interviewee): _____ Date: _____

E. Statement of Translator and Signature

I have translated and explained the purpose of the study and procedures and all the risks that are involved, and the investigator's answered to questions interviewee asked to the best of ability to the interviewee.

Signature/thumbprint of interpreter (who may provide assistance to interviewee):

_____ Date: _____

For further clarification on any other issues please contact:

1. **Mr. George Owoo** of the Human Rights Advocacy Centre (0266302582)
2. **Ms. Wendy Abbey** of the Human Rights Advocacy Centre (0243749899)
3. **Dr. Gina Teddy** of Centre for Health Systems and Policy Research, GIMPA - (0240948104)
4. **Hannah Frimpong of Ethical Review Committee, Ghana Health Service (0507041223)**

**APPENDIX 5: INFORMATION SHEET FOR ACTORS AND
STAKEHOLDERS ON MENTAL HEALTH
(COMMUNITY LEADERS. HEALTH PROVIDERS, TEACHERS, DISTRICT ASSEMBLY
OFFICERS, FAMILY MEMBERS. ETC.)**

Field study on Promoting Quality Access to Mental Health Care and Rights of Persons with
Mental Disabilities in Traditional Mental Health Centers in Ghana

Principal Investigator: Dr. Gina Teddy, (Centre for Health Systems
and Policy Research, GIMPA)

Co-Investigator: Ms Wendy Abbey, Human Rights Advocacy
Centre (HRAC)
Mr. George Owoo, Human Rights Advocacy
Centre (HRAC)

Committee Administrator: **Hannah Frimpong (Ethical Review
Committee, Ghana Health Service)**

The name of this study is “Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana”. In addition to this information sheet, which explains the study to you in writing, an interviewer will also talk about the study with you today. We invite you to ask any questions about any part of the study that you do not understand. After you know what is involved we will ask you to decide if you wish to participate or not.

B. Purpose of the Study

In September 2017 the Human Rights Advocacy Centre (HRAC) and MindFreedom Ghana (MFGh.) launched a project entitled Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana. This field study is being conducted to find out how people overall understanding or feel about Mental Health and treatments provided by Traditional Mental Health Centre (TMHC). The study will be undertaken throughout the nation for a period of nine months.

Through the findings of this field study, HRAC intends to generate evidence for understanding treatment services provided by (TMHCs), assess the quality of care, variation in service provision, regulations and adherence to human rights practices for the treatment of persons with mental disabilities in TMHCs across Ghana.

J. Procedures

- 1) If you agree to be in this study you will meet with a trained interviewer who will hold discussions with you. This will take about 60-90 minutes.
- 2) You don't need to answer all the questions in the interview if you don't want to. If a question makes you feel uncomfortable or you do not know the answer, it is ok to ask the interviewer to move on to the next question. You can also stop the interview at any time without penalty.
- 3) The interview is anonymous. We will at no point in the project disclose the identities of individual interviewees.
- 4) We will take notes on paper during the course of the interview.

K. Potential risks and discomfort

Due to the fact that some parts of the interview are about mental health, certain questions may make you feel uncomfortable. Furthermore, you may be concerned that others in your community view your participation in the study negatively. To protect you, all information we gather during the interview will be anonymous. The place where the interview takes place will be private and unmarked, and there will at no time be a written list of people who were interviewed.

L. Benefits

This interview will assist HRAC in identifying mental health services available in your community and the protection of human rights for Person with Mental Disabilities. This information will inform policy reforms and advocacy for improved mental health services by TMHC.

M. Compensation

The respondents will not receive any monetary compensation. Participation is voluntary and aimed at social good. However, any transportation cost incurred by participants will be reimbursed accordingly. Participant will be informed of the benefit of the research and

encouraged to participate. Participants will be provided with refreshment (water, meat/fish pie and soft drink).

N. Confidentiality Statement

Whatever information you will give us will be kept confidential and private. Except for the HRAC/MFGh staff, who will have secure access to the information you would give us, no one will be privy to the information and knowledge you will give to us. Therefore, only HRAC/MFGh staff will have access to the interview notes and/or recordings (audio). **All audio recordings will be destroyed by a file shredder upon the completion of the research study** in 2021.

O. Right to refuse or withdraw

Taking part in this interview is voluntary. You have the right to refuse to discuss any questions or those questions that you feel invade your privacy. In light of this you can withdraw from the interview at any time.

P. Agreement

Do you have any questions? (***Moderator: Answer any questions posed by the participant before proceeding to the next question.***)

Q. Persons to Contact

5. The people in charge of this research are Mr. George Owoo (0266302582) and Ms. Wendy Abbey (0243749899) both of the Human Rights Advocacy Centre, Dr. Gina Teddy (Centre for Health Systems and Policy Research, GIMPA - 0240948104) and **Hannah Frimpong of Ethical Review Committee, Ghana Health Service (0507041223)**

R. Declaration

You have read and/or had the explanation of this study read to you. You have also been given a copy of this form, told you can refuse to participate and give the chance to ask questions. I am going to ask for your consent to take part in this interview. By saying yes, you agree to do the interview. By saying no, you decline to do the interview.

Do you agree to take part in the interview?

Thumbprint/Signature/Initials of Interviewee: _____ **Date:** _____

Initials of Moderator: _____ Date: _____ to confirm affirmative verbal consent.

I have explained to the participant the study purpose and procedures and have discussed all the risks that are involved. I have answered questions to the best of my ability that the participant asked.

Date: _____ Signature of moderator: _____

**APPENDIX 6: CONSENT FORMS FOR ACTORS AND STAKEHOLDERS
ON MENTAL HEALTH**

**(COMMUNITY LEADERS. HEALTH PROVIDERS, TEACHERS, DISTRICT ASSEMBLY
OFFICERS, FAMILY MEMBERS. ETC.)**

Field study on Promoting Quality Access to Mental Health Care and Rights of Persons with
Mental Disabilities in Traditional Mental Health Centers in Ghana

CONSENT FORM

Name of Interviewer:

Region:

District:

Name of Community:Urban [] Rural []

Target Group:

Date of Interview/...../...../

DD, MM, YYYY

Principal Investigator: Dr. Gina Teddy, (Centre for Health Systems
and Policy Research, GIMPA)

Co-Investigator: Ms Wendy Abbey, Human Rights Advocacy
Centre (HRAC)

Mr. George Owoo, Human Rights Advocacy
Centre (HRAC)

Committee Administrator: **Hannah Frimpong (Ethical Review
Committee, Ghana Health Service)**

F. Agreement

Based on what had been explained to you regarding the information sheet, do you have any
questions?

***Investigator: Answer any questions posed by the participant before proceeding to the
next question.***

G. Participant statement and signature

You have read and/or had the explanation of this study read to you. You have also been given a copy of this form, told you can refuse to participate and give the chance to ask questions. **Before proceeding to read the consent form out to you, I should have you know that you are under no obligation to continue in the interview, especially if you feel it invades your privacy. You've volunteered to be interviewed and so you have the option to withdraw from the interview should you choose to do so. Whatever information you will give shall be kept confidential and private in a secured HRAC database. Upon completion of the field study all data shall be destroyed by file shredding, except for when you or the Ethical Review Committee request to have access to your information.** Now, I am going to ask for your consent to take part in this interview. Do you agree to take part in the interview? (If answer is affirmative as participant to sign/thumbprint)

Signature/thumbprint of interviewee: _____ Date: _____

HRAC/MFGH Officer Signature: _____ Date: _____

Checked by supervisor (signature): _____ Date: _____

H. Investigator statement and signature

I have explained to the participant the study purpose and procedures and we have discussed all the risks that are involved. I have answered questions to the best of my ability that the interviewee asked.

Signature of investigator: _____ Date: _____

I. Statement of Witness and Signature

I have witnessed that the investigator has explained to the participant the study purpose and procedures and all the risks that are involved. And that the investigator has answered questions interviewee asked to the best of ability of the interviewee.

Signature/thumbprint of witness (who may provide assistance to interviewee): _____ Date: _____

J. Statement of Translator and Signature

I have translated and explained the purpose of the study and procedures and all the risks that are involved, and the investigator's answered to questions interviewee asked to the best of ability to the interviewee.

Signature/thumbprint of interpreter (who may provide assistance to interviewee):

_____ Date: _____

For further clarification on any other issues please contact:

Mr. George Owoo of the Human Rights Advocacy Centre (0266302582)

Ms. Wendy Abbey of the Human Rights Advocacy Centre (0243749899)

Dr. Gina Teddy of Centre for Health Systems and Policy Research, GIMPA - 0240948104)

Hannah Frimpong of Ethical Review Committee, Ghana Health Service (0507041223)

APPENDIX 7: INFORMATION SHEET FOR COMMUNITY LEADERS

Field study on Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana

Aims of the Study

The main aim of this study is to assess the quality of care, variation in service provision, regulations and adherence to human rights practices for the treatment of persons with mental disabilities in traditional mental health facilities (TMHCs) across Ghana. This will enable us to understand and explore the TMHCs in Ghana. Its specific objectives are:

- Map out the range of TMHCs operational in Ghana
- Assess TMHCs awareness of the Mental Health
- Assess the quality of practices, regulations and monitoring of TMHCs
- Explore gaps in practices for treatment protocol development
- Assess practitioners understanding of human rights practices of PMD
- Explore the management of stigmatization
- Generate evidence on TMHC in Ghana
- Assess the proportion of traditional mental health Centres in which orthodox mental health treatment is provided

Research Methods

This is a mixed study combining key informant interviews with surveys, focus group discussions, observation, conversation and workshops with members of the local communities, community leaders, health provides, TMHC providers, family members of people living with mental disability (PMD), other stakeholders and health professionals. A total number of 30 or more people and stakeholders will be interviewed to explore their perspectives and experiences with the mental health and the running of TMHCs in Ghana. A further focus group discussions and workshop will be held in each District for community residents will also be held. All interviews or focus group discussions will cover similar themes and will be subject to thematic analysis.

Outcomes

Undertaking this exploratory study, we hope will generate adequate evidence to create an understanding of the practices, processes and services provide by Traditional Mental Health Centres (TMHCs) in Ghana. Also, we hope this research will inform and contribute to the knowledge on mental health practices and the informal structures support structure and service provision for mental disability in Ghana. This research will also inform policies, advocacy and reveal the need to strengthen the practices of TMHCs in Ghana. The main findings will

disseminated with key stakeholders of mental health in Ghana and published online and at conferences. Some of these findings will also be published in peer reviewed journals highlighting the lessons learnt.

Research Team

This research is led by three principal investigators and 12 research assistants. The PI are Dr. Gina Teddy (PhD), Miss Wendy Abbey (MA) and Mr. George Owoo (MA) whom together will be supervising and directing the research activities. Please note that this activity is purely research devoid of any political or regulatory affiliation, therefore, it is being carried out to create evidence and inform policies and advocacy on TMHCs in Ghana in the future.

If you would like to know more about the research you may contact the following persons:

- **Dr. Gina Teddy, (PI of the Research Project)**
Centre for Health Systems and Policy Research, GIMPA, Achimota – Accra.
Tel: (+233) 0240 948 104; Email: gteddy@gimpa.edu.gh
- **Miss Wendy Abbey, (Co-PI of the Research Project)**
Human Rights Advocacy Centre, Osu – Accra
Tel: (+233) 0544 094 807; Email: wendy@hracghana.org
- **Mr. George Owoo, (Co-PI of the Research Project)**
Human Rights Advocacy Centre, Osu – Accra
Tel: (+233) 0540 168 340 Email: george@hracghana.org
- **Hannah Frimpong (ERC Administrator)**
Ethical Review Committee, Ghana Health Service
Tel: (+233) 0507041223

APPENDIX 8: CONSENT FORMS FOR FOCUS GROUP DISCUSSANTS

COMMUNITY LEADERS ON TRADITIONAL MENTAL HEALTH CENTRES IN GHANA

Field study on Promoting Quality Access to Mental Health Care and Rights of Persons with Mental Disabilities in Traditional Mental Health Centers in Ghana

CONSENT FORM

General Information:

This interview is meant to assess the quality of care, variation in service provision, regulations and adherence to human rights practices for the treatment of persons with mental disabilities in traditional mental health facilities (TMHCs) across Ghana. This will enable us to understand and explore the TMHCs in Ghana. As an operator of TMHCs, your perspectives of the services provided, regulations and clients will be explored in this interview. This will take about one hour and your time is much appreciated.

Confidential Notice

Please be assured that your answers, views and perceptions will remain confidential. To ensure anonymity, there will be no reference to the identity of any participant in this exercise. Views, experiences and perceptions expressed will be represented strictly by dummy names or figures during the analysis. However, references to person's views or experiences will be made with the full consent of the participant and he/she will be duly acknowledged.

Information and Informed Consent

Please ensure you have read and understood the information forms in a language that you understand, ask question about research and signed the informed consent forms before participating in this focus group discussion. We appreciate your time and participation in this interview.

Name of Interviewer:

Region:

District:

Name of Community:Urban [] Rural []

Target Group:

Date of FGD///
DD, MM, YYYY

Principal Investigator: Dr. Gina Teddy, (Centre for Health Systems and Policy Research, GIMPA)

Co-Investigator: Ms Wendy Abbey, Human Rights Advocacy Centre (HRAC)
Mr. George Owoo, Human Rights Advocacy Centre (HRAC)

Committee Administrator: Hannah Frimpong (Ethical Review Committee, Ghana Health Service)

A. Agreement

Based on what had been explained to you regarding the information sheet, do you have any questions?

Investigator: Answer any questions posed by the participant before proceeding to the next question.

B. Participant statement and signature

You have read and/or had the explanation of this study read to you. You have also been given a copy of this form, told you can refuse to participate and give the chance to ask questions. Before proceeding to read the consent form out to you, I should have you know that you are under no obligation to continue in the focus group discussions, especially if you feel it invades your privacy. You've volunteered to participate in the said focus group discussions and so you have the option to withdraw from should you choose to do so. Whatever information you will give shall be kept confidential and private in a secured HRAC database. Upon completion of the field study all data shall be destroyed

by file shredding, except for when you or the Ethical Review Committee request to have access to your information. Now, I am going to ask for your consent to take part in this focus group discussions. Do you agree to take part in the interview? (If answer is affirmative as participant to sign/thumbprint)

Signature/thumbprint of interviewee: _____ Date: _____

HRAC/MFGh Officer Signature: _____ Date: _____

Checked by supervisor (signature): _____ Date: _____

C. Investigator statement and signature

I have explained to the participant the study purpose and procedures and we have discussed all the risks that are involved. I have answered questions to the best of my ability that the interviewee asked.

Signature of investigator: _____ Date: _____

D. Statement of Witness and Signature

I have witnessed that the investigator has explained to the participant the study purpose and procedures and all the risks that are involved. And that the investigator has answered questions interviewee asked to the best of ability of the interviewee.

Signature/thumbprint of witness (who may provide assistance to interviewee): _____ Date: _____

E. Statement of Translator and Signature

I have translated and explained the purpose of the study and procedures and all the risks that are involved, and the investigator's answered to questions interviewee asked to the best of ability to the interviewee.

Signature/thumbprint of interpreter (who may provide assistance to interviewee):

_____ Date: _____

For further clarification on any other issues please contact:

Mr. George Owoo of the Human Rights Advocacy Centre (0266302582)

Ms. Wendy Abbey of the Human Rights Advocacy Centre (0243749899)

Dr. Gina Teddy of Centre for Health Systems and Policy Research, GIMPA - 0240948104)

Hannah Frimpong of Ethical Review Committee, Ghana Health Service (0507041223)

APPENDIX 9: INTERVIEW GUIDE FOR COMMUNITY LEADERS

A. GENERAL INFORMATION

1. Tell us about yourself
2. Tell us about your community
3. Tell us about the health services available do you provide?

B. AWARENESS OF MENTAL HEALTH

4. What does the term “mental health” mean to you?
5. What is your experience of mental health?
 1. What is the situation on mental health in this community?
 2. What is the general understanding on mental health in this community?

C. STIGMATISING MENTAL HEALTH

3. How do people handle mental disability and people living with mental disability?
4. How are people living with mental disability treated in this community?
5. How will you describe someone with mental health for instance?
6. What words would people use describe mental health generally?
7. Do you know about the Mental Health Act (Act 846), 2012?
8. What is your understanding of the current Mental Health Act in Ghana?
9. How would a child having mental health difficulties be treated by others?
10. How are children with mental disability treated by other family members?
11. How are children with mental disability treated in school?
12. How are children with mental disability treated at religious places like churches, mosques or other religious grounds?
13. How are people with mental health disability treated by others in the community?

D. ACCESS AND GENDER ROLES

14. Are there any specific mental health care services for children and women?
15. Do you think there is a difference between how men and women with mental health issues are viewed or treated?
16. Who is more likely to seek mental health treatment, women or men?

17. Who decides when to access mental health services or care?
18. Who decides what services should be accessed for mental health and why?

E. TREATMENT FOR MENTAL HEALTH (ORTHODOX)

19. What mental health services are available in this community?
20. How accessible are mental health services for people in this community?
21. How often do the community use these mental health services if any?
22. Have any of you used any of these services?
23. Or do you know anyone who use these services?
24. What do you think of the services?
25. Will you consider the services appropriate?
26. If not why and what can be improved?
27. If yes, what treatments are available for mental health services?
28. What happens if someone cannot afford to pay for the services?
29. What do you think is needed to have more mental health providers?
30. What other resource do you think is needed to increase access to treatment?
31. In your opinion are the current mental health services meeting the needs of people?

F. TRADITIONAL MENTAL HEALTH SERVICES

32. What is the role of traditional healers (including religious leaders) in caring for mental health services?
33. Are there any TMHC in this community?
34. How often do people use the TMHCs?
35. Have you OR any one you know used the services of TMHC?
36. What do you think of the mental health treatment provided by TMHCs?
37. What do you think of the services provided by TMHCs?
38. Will you recommend TMHC to anyone with mental illness and WHY?

G. GENERAL ISSUES

39. In your opinion are the current mental health services meeting the needs of people?
40. Are there NGOs or CSO that support with mental health services in this community?
41. Is there anything needed to improve mental health care and services in this community?
42. What in your view should be done and by whom?

APPENDIX 10: INTERVIEW GUIDE FOR OPERATORS OF TRADITIONAL MENTAL HEALTH FACILITIES

A. GENERAL INFORMATION

1. Tell us about yourself
2. Tell us about this community

B. AWARENESS OF MENTAL HEALTH

3. *What does the term “mental health” mean to you?*
4. What is your experience of mental health?
5. What is the situation on mental health in this community?
6. What is the general understanding on mental health in this community?
7. Do you know about the Mental Health Act (Act 846), 2012?
8. What is your understanding of the current Mental Health Act in Ghana?
9. Have you interacted with the MHA or used it?
10. Do you know about the Mental Health Authority?
11. How does the MHA affect their practices?
12. Explore gaps in practices for treatment protocol development
13. Do you have any guidelines for your practices and services?

C. STIGMATISING MENTAL HEALTH

13. How do people handle mental disability and people living with mental disability?
14. How are people living with mental disability treated in this community?
15. How will you describe someone with mental health for instance?
16. What words would people use describe mental health generally?
17. How would a child having mental health difficulties be treated by others?
18. What are the practitioners and operators of mental health view of mental health?
19. Is stigma a problem for their practices and how best can it be address?
20. How do they address stigma in the community?

D. TRADITIONAL MENTAL HEALTH SERVICES

21. What you do as a TMHC provider?

22. What services do you provide?
23. What are the main practices of TMHCs?
24. Can you explain what your daily routine is in terms of services?
25. Can you explain how treatment protocols are (if okay)
26. Who do you work with in running the TMHCs?
27. How many people do you need to run your facility?
28. How do you fund your services?
29. Do you generate enough funds providing services at the TMHCs?
30. Do you combine your services with that of orthodox mental health services?
31. Do you allow your patients to access orthodox medical care?
32. How are your services and practices regulated?
33. How do you diagnose your patients?
34. How are patients managed at your facilities?

E. CLIENTS AND SERVICES

35. Who are your clients?
36. Which group of people usually constitute your clients?
37. What proportion of men, women and children do you get using your facility?
38. How often do you get clients?
39. How far or near do your clients travel to use your facilities?
40. Are you providing any orthodox mental health formal services for persons with mental health?
41. How often do the community use these mental health services if any?
42. What do your clients think of the services you provide?
43. Do they consider the services appropriate?
44. If not why and what can be improved?
45. What services are available for patients' families?
46. What happens if someone cannot afford to pay for the services?
47. What do you think is needed to have more mental health providers?
48. What other resource do you think is needed to increase access to treatment?
49. In your opinion are your services meeting the needs of people?

F. GENERAL ROLE OF TMHCs

50. What is the role of traditional healers (including religious leaders) in caring for mental health services?
51. How many are there in this community?
52. How often do people use the TMHCs?
53. What do you think of the mental health treatment provided by TMHCs?
54. What do you think of the services provided by TMHCs?
55. Who usually recommend people to use TMHC and WHY?
56. How can the TMHC be supported?
57. Do you work with any NGOs or CSOs?
58. Do you work with any community organisations or leaders?

G. MAP OUT THE RANGE OF TMHCs OPERATIONAL IN GHANA

59. What types of TMH centres and services are available in this and neighbouring community?
60. What different kinds of Traditional Mental Health Centers (TMHCs) facilities are available in the community and District?
61. Which other person(s) provide some of these services in the community
62. Where are they located and who are the practitioners of it?
63. What kinds of services are provided by TMHCs?

H. MENTAL HEALTH AND HUMAN RIGHTS (Assess practitioners understanding of human rights practices of PMD)

64. What is your perception of human rights and protection of the dignity of PMD?
65. Are your practices concerned with human rights adherence?
66. How do practitioners manage and protect their clients under your care?
67. Are there practices that may affect your clients or the treatment of persons with mental disability?
68. If so what, practices could this be?

APPENDIX 8: INTERVIEW GUIDE FOR STAKEHOLDERS

ACTORS AND STAKEHOLDERS ON MENTAL HEALTH (COMMUNITY LEADERS, HEALTH PROVIDERS, TEACHERS, DISTRICT ASSEMBLY OFFICERS, FAMILY MEMBERS ETC.)

This interview is meant to assess the quality of care, variation in service provision, regulations and adherence to human rights practices for the treatment of persons with mental disabilities in traditional mental health facilities (TMHCs) across Ghana. This will enable us to understand and explore the TMHCs in Ghana. As an operator of TMHCs, your perspectives of the services provided, regulations and clients will be explored in this interview. This will take about one hour and your time is much appreciated.

Confidential Notice

Please be assured that your answers, views and perceptions will remain confidential. To ensure anonymity, there will be no reference to the identity of any participant in this exercise. Views, experiences and perceptions expressed will be represented strictly by dummy names or figures during the analysis. However, references to person's views or experiences will be made with the full consent of the participant and he/she will be duly acknowledged.

Information and Informed Consent

Please ensure you have read and understood the information forms in a language that you understand, ask question about research and signed the informed consent forms before participating in this focus group discussion. We appreciate your time and participation in this interview.

GENERAL INFORMATION

1. Tell us about yourself
2. Tell us about your community
3. Tell us about the health services available do you provide?

AWARENESS OF MENTAL HEALTH

4. What does the term “mental health” mean to you?
1. What is your experience of mental health?
2. What is the situation on mental health in this community?
3. What is the general understanding on mental health in this community?

STIGMATISING MENTAL HEALTH

1. How do people handle mental disability and people living with mental disability?
2. How are people living with mental disability treated in this community?
3. How will you describe someone with mental health for instance?
4. What words would people use describe mental health generally?
5. Do you know about the Mental Health Act (Act 846), 2012?
6. What is your understanding of the current Mental Health Act in Ghana?
7. How would a child having mental health difficulties be treated by others?
8. How are children with mental disability treated by other family members?
9. How are children with mental disability treated in school?
10. How are children with mental disability treated at religious places like churches, mosques or other religious grounds?
11. How are people with mental health disability treated by others in the community?

ACCESS AND GENDER ROLES

1. Are there any specific mental health care services for children and women?
2. Do you think there is a difference between how men and women with mental health issues are viewed or treated?
3. Who is more likely to seek mental health treatment, women or men?
4. Who decides when to access mental health services or care?
5. Who decides what services should be accessed for mental health and why?

TREATMENT FOR MENTAL HEALTH (ORTHODOX)

1. What mental health services are available in this community?
2. How accessible are mental health services for people in this community?

3. How often do the community use these mental health services if any?
4. Have any of you used any of these services?
5. Or do you know anyone who use these services?
6. What do you think of the services?
7. Will you consider the services appropriate?
8. If not why and what can be improved?
9. If yes, what treatments are available for mental health services
10. What happens if someone cannot afford to pay for the services?
11. What do you think is needed to have more mental health providers?
12. What other resource do you think is needed to increase access to treatment?
13. In your opinion are the current mental health services meeting the needs of people?

TRADITIONAL MENTAL HEALTH SERVICES

1. What is the role of traditional healers (including religious leaders) in caring for mental health services?
2. Are there any TMHC in this community?
3. How often do people use the TMHCs?
4. Have you OR any one you know used the services of TMHC?
5. What do you think of the mental health treatment provided by TMHCs?
6. What do you think of the services provided by TMHCs?
7. Will you recommend TMHC to anyone with mental illness and WHY?

GENERAL ISSUES

1. In your opinion are the current mental health services meeting the needs of people?
2. Are there NGOs or CSO that support with mental health services in this community?
3. Is there anything needed to improve mental health care and services in this community?
4. What in your view should be done and by whom?

APPENDIX 10: GENERAL SURVEY QUESTIONNAIRE