REPORT ON

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

2020
Summarized Research Findings and Recommendations
EXPLORING THE ROLE OF
TRADITIONAL MENTAL HEALTH CENTRES
AND THEIR IMPACT ON PROMOTING QUALITY
MENTAL HEALTHCARE AND
HUMAN RIGHTS IN GHANA

2020
Summarized Research Findings
and Recommendations
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<thead>
<tr>
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<th>Full Form</th>
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<tbody>
<tr>
<td>CHAG</td>
<td>Christian Health Association of Ghana</td>
</tr>
<tr>
<td>CHRAJ</td>
<td>Commission on Human Rights and Administrative Justice</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
</tr>
<tr>
<td>DA</td>
<td>District Assembly</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GESI</td>
<td>Gender Equality and Social Inclusion</td>
</tr>
<tr>
<td>GFDO</td>
<td>Ghana Federation of Disability Organisations</td>
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<tr>
<td>GHAFTRAM</td>
<td>Ghana Federation of Traditional Medicine Practitioners Associations</td>
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<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
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<tr>
<td>HRAC</td>
<td>Human Rights Advocacy Centre</td>
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<tr>
<td>LGA</td>
<td>Local Government Authorities</td>
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<td>MFGh</td>
<td>MindFreedom Ghana</td>
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<tr>
<td>MHA</td>
<td>Mental Health Authority</td>
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<tr>
<td>MoGCSP</td>
<td>Ministry of Gender, Children and Social Protection</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NCPD</td>
<td>National Council of Persons with Disability</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NHIS</td>
<td>National Health Insurance Scheme</td>
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<tr>
<td>OPD</td>
<td>Outpatient Department</td>
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<tr>
<td>PMD</td>
<td>Person with Mental Disorder</td>
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<tr>
<td>PMI</td>
<td>Person with Mental Illness</td>
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<tr>
<td>THP</td>
<td>Traditional Health Practitioners</td>
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<tr>
<td>TMHC</td>
<td>Traditional Mental Health Centers</td>
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RESEARCH CONTEXT

Ghana has an estimated 2.8 million people having one form of mental illness or the other. Of this number 650,000 have severe mental health conditions. This population notwithstanding, health facilities, especially the secondary and specialist facilities are inequitably distributed across the country with a treatment gap of 98%.

To fill this gap, the informal sector is estimated to provide mental health care services to about 70-80% of persons with mental illness. It is however reported that treatment regimes by traditional mental health providers are characterized by human rights violations.

This research accordingly aimed to generate evidence to:

• improve the understanding of human rights abuses and conditions of PMD in TMHCs through evidence generation;
• address systemic issues and constraints that exclude PMD from having equitable access to mental health treatment in Ghana;
• highlight the institutional and policy lapses in the national response on mental health care;
• 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; and
• inform the development of specific standards/regulations and procedures (protocol) for addressing these lapses.

FINDINGS

AWARENESS, PERCEPTION AND STIGMA ABOUT MENTAL HEALTH

Awareness and perception of mental health influence the attitudes of people towards persons with mental disorder or illness (PMDs/PMIs) which may influence stigma formation towards them. Perception of mental health also influences the relationship with and treatment of persons with mental disability/ disorders.

1. Awareness and Understanding of Mental Health

Mental health is thought to be synonymous with mental illness

Survey respondents show

• 83% are aware and understand mental health as a disease as represented below:
  o 58.4% as sickness of the brain
  o 15% as a general sickness
  o 9.6% as sickness affecting mental wellness

• 17% perceive mental health to be spiritual as represented below:
  o 6% as a curse
  o 6% as spiritually caused
Interviewees and FGD participants corroborated these findings. The description of mental health as hereditary is fluid between the explanation of it resulting from a generational curse or genetic disorders.

**Perceptions**

Despite the general awareness, there are differences between community and individual perceptions.

**Individual Vs. Community Perception of Mental Health**

- MH as hereditary and family sickness
- MH is mental wellbeing
- MH results from curses
- MH has a spiritual sickness
- MH has a sickness of the brain
- MH as a general sickness

PMDs are generally perceived as social misfits who
may be seen as unkempt, incoherent and socially deviant. These perceptions are exhibited through derogatory descriptions.

These perceptions and descriptions influence the attitude towards and relationship with PMDs/PMIs.

### 2. Attitudes, Stigmatisation and Treatment of PMDs/PMIs

The survey data shows the following:

- 56% consider the attitude of members of their community towards PMDs/PMIs as generally poor
- 11% consider the attitude of members of their community towards PMDs/PMIs as average
• 31% consider the attitude of members of their community towards PMDs/PMIs as good.

The following informs the attitude above:

• 61% due to PMDs/PMIs own behaviour
• 13% due to bad attitudes of community members
• 13% dependent on family or other relationship
• 12% dependent on whether the PMD can be ignored.

Attitude towards PMDs/PMIs also depends on factors such as education, perception of danger from PMDs, experience with PMDs, and individual compassion towards PMDs. These attitudes are also influenced by
the PMDs/PMIs age and gender.

The above perception and attitudes play out in the following overall treatment of PMDs as rated by respondents:

- 74% good treatment by community members
- 69% good treatment by families of PMDs/PMIs
- 60% good treatment in schools
- 55% good treatment in religious places

In communities where support is available, PMDs are less aggressive.

3. **Gender, vulnerability & mental disorders/illness**

Predisposition to mental ailments

Gender correlates with certain mental ailments. While women are more likely to be diagnosed with conditions like depression due to their vulnerability to violence and abuse, men are more likely to be
diagnosed with substance abuse and personality related disorders.

**Experiences**

**The experiences after mental health diagnoses also vary for the sexes.** Women with mental health disorders often experience abandonment by their husbands and partners, become more vulnerable to sexual abuse and unwanted pregnancy by unidentified men while men are often socially excluded particularly from assuming their leadership roles.

**Support**

**Gender also influences the extent of support.** Women and the aged with mental health problems are treated more favourably and with care and support than their male and younger counterparts. Children are reportedly expelled from school because of their behavior.

4. **Impact of Stigmatisation on PMDs/PMIs and their Families**

Interviewees report that stigmatization perpetuates poor attitudes towards PMDs/PMIs and their relatives.

PMDs themselves and their families report that the cultural stereotypes, perception and understanding of mental illness create stigmatization and poor attitude towards them. Some of these attitudes manifest in the form of fear, anticipation of attacks and intolerance.
This limits access to health facilities, resources and support structures available to them because of discrimination.

The existence of a gap between awareness and perception of mental illness and the attitude of people towards mental illness influences attitudes towards and stigmatization of PMIs/PMDs. Communities with more exposure to mental health awareness have lower stigma compared to others.

FORMAL MENTAL HEALTHCARE AND SERVICES

1. Access to Mental Health Care and Services

To evaluate availability and access to mental health services across the multiple levels of operation and service delivery in Ghana, the research focused on three aspects of access: availability, utilization and physical access to mental healthcare and services.

2. Availability and Utilization of Mental Health Services

The following mental health services are available: specialists/psychiatric services, services provided at the regional hospitals and district hospitals (secondary) and community health facilities such as health centers, CHPS compound and home visits (primary).

Respondents reported the following usage:

- 14% psychiatric (specialist) hospitals
- 86% use the following:
  - 10% regional and district hospitals
- 39% health centers
- 30% CHPS services
- 7% no knowledge on available services

6% of respondent also report using in addition to the formal health care services alternative services such as churches, herbal and traditional medicines.

69% of respondent resort to primary health care which serves as the first point of call for mental health services. Primary health care offers early symptoms diagnosis, basic health services, and community health, drug management and referrals. These facilities refer to the secondary and specialist facilities depending on the severity of the condition, affordability and proximity to

![Utilisation of Mental Health Services](image)

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Hospital</td>
<td>13.63%</td>
<td>101</td>
</tr>
<tr>
<td>Health Centre</td>
<td>39.27%</td>
<td>291</td>
</tr>
<tr>
<td>CHPS</td>
<td>30.09%</td>
<td>223</td>
</tr>
<tr>
<td>Regional District Hospital</td>
<td>10.26%</td>
<td>76</td>
</tr>
<tr>
<td>No Idea</td>
<td>6.75%</td>
<td>50</td>
</tr>
</tbody>
</table>

![Graph showing frequency and percentage](image)
the referral facility.

Primary health care facilities are more accessible and utilized compared to secondary and specialized services which are mostly located outside the communities of service users.

3. Physical Access to Mental Health Facilities

Physical or geographical accessibility to secondary and specialized mental health services assesses proximity to the facilities, the difficulty in getting to the facilities and means of travel to the facilities.

53% of the survey respondents find it difficult or very difficult to access secondary and specialized mental health facilities. Some of these difficulties are attributed to travel challenges like the deplorable state of the roads.

Points to note on proximity:

- Those within close proximity report more frequent use of mental healthcare facilities than
those further from the facilities.

- Referral facilities are located in more urban communities with specialized ones much further in the coastal belt of Ghana.
- Difficulty in taking time off work to use healthcare facilities.

In some cases however, patients in close proximity may prefer facilities further away from them in order to

- maintain confidentiality, and
- avoid stigmatization of the use of mental health services.

4. **Means of Travel to Access Mental Healthcare**
Majority of users access mental health services within their communities through walking, home visits or using local transports such as bicycles, motorbikes and taxis.

Those who 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.

The ability to use these means of transport is influenced by the availability or otherwise of funds which may results in deferment of service use.

OTHER FACTORS INFLUENCING ACCESS TO MENTAL HEALTHCARE AND SERVICES

1. Gender and Utilization of Mental Healthcare and Services

According to health workers, facility utilization is influenced by gender. Women are more likely to use health facility than men and are timely in reporting the symptoms of mental health.
Survey respondents (58%) however perceive that men are more likely than women (13% of respondents) to use mental health services. 29% of respondents perceive there is no differentiation in utilisation by both sexes.

2. Age and Access to Mental Healthcare and Services

46% of the survey respondents indicate that adults are more likely to use mental health services than children and the aged. According to respondents, children are less likely to use mental health services because:

- They are often diagnosed later than adults
- Parents often confine children with mental illness or disorders.

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

Healthcare and services utilization decision is reportedly made as follows:

![Gender and Utilisation of Mental Healthcare & Services](image)
- 71% husbands in respect of their spouses, children or family members
- 15% wives
- 14% family heads

Such decisions are made based more on religious (79%) than professional (21%) grounds.

4. Roles played by decision makers in the treatment and management of PMDs/PMI

- Mothers mostly assume responsibility as caregivers of their wards with mental disorders unlike few fathers and husbands who play this role.
- Members of the extended family contribute towards caring for PMD/PMI including acting as search parties for PMDS/PMI who abscond from home.
- Family heads and sometimes community leaders influence treatment and attitude of the community members towards PMDs/PMIs.

AFFORDABILITY OF MENTAL HEALTH CARE AND SERVICES

Survey respondents experience various levels of financial difficulties in using mental health services:

- 57% regularly experience financial difficulties
- 41% sometimes experience these difficulties
- 2% rarely experience financial constraint

Some of the challenges experienced due to financial difficulties include the ability to travel, purchase of
medications which adversely impacts on adherence to medication and continuity of care.

Additionally, most of the respondent family members and caregivers report that the disease burden inhibits their ability to engage in economic activities.

Challenges of Accessing Mental Healthcare

Other challenges reported are

- 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 care to referral facilities in times of emergencies
- poor adherence to medications and check-ups and
- late utilization of mental health services due to users adherence to beliefs.

INFORMAL MENTAL HEALTHCARE AND SERVICES

TRADITIONAL MENTAL HEALTH CENTERS (TMHC)

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

Traditional medicine is categorized into two main groups: faith-based and non-faith based. The services identified below are not exhaustive but represent the
commonly used. It is worth noting that traditional medicine may be provided by either a facility (TMHCs) or an individual traditional health practitioner (THP).

2. Preferences for Traditional Mental Health Centers (TMHC)

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

The preference for prayer camps and pastors may also be grounded in strongly held Christian beliefs and routine practices especially as 71% Ghanaians are Christians.

The preference for native doctors, mallams and fetish priest is relatively low compared to herbalists, prayer camps and pastors.

The preference for TMHC/THPs may also be informed
by the belief that mental illness is spiritually induced. Although, only 17% of survey respondents believe mental illness is spiritual, majority of the interviewees share the same belief.

The services of these practitioners align with the beliefs of their clients, perceived efficacy and the reputation of the providers for curing certain ailments and diseases.

These services therefore address the needs of users in a cultural context.

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

Utilization of mental health services is not limited to the formal mental health providers but very fluid between the formal and informal providers due to lack of resources, lack of trust and quality of care and drive to find cure.

Additionally, 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 the decision to use alternative medicine.
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 data shows utilization to be relatively higher for prayer camps, herbalist, native doctors, pastors and mallams in descending order.

However, there is inconsistency between reports on usage and preferences on the one hand and narratives from THPs about the influences, roles and trust in their services on the other hand. All interviewees that provide traditional health services reported heavy use of their services for various healthcare including mental health care.

It is noteworthy that the patronage of one type of TMHC or other is also dependent on the location of a user. For example, while the use of prayer camps and pastors cut across the Regions of Ghana, use of mallams is more
predominant among the Moslem communities in the Northern and Upper West Regions. Similarly, the use of native doctors and fetish priests is commonly found among the southern Regions.

IMPACT OF TRADITIONAL MENTAL HEALTH CENTERS OR TRADITIONAL HEALTH PRACTITIONERS

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

1. Types of Health Condition TMHCs/THPs Deal With

THP and operators of TMHCs deal generally with different health and wellness problems. These include mental health, malaria, diabetes, asthma, high blood pressure/hypertension, cancers, mental illnesses, skin diseases.

Few TMHC/THP specialize in conditions such as physiotherapy, basic chronic diseases and mental health conditions. The practitioners who do not specialize in mental health services get most of their cases through clients’ testimonies.

2. Description of Mental Illnesses and Disability by TMHCs/THPs

Traditional mental health providers demonstrate an understanding of mental illness through the descriptions they ascribe to various mental health conditions based on the different symptoms. This informs a provider’s approach to the management of a condition.
**Description**

- ‘Madness’ or ‘Edam’/ ‘Abodam’
- ‘Drug addiction’ or ‘Ndroboni num’ (taking of bad drugs and things)
- Stress, or someone overburdened with deep worries or ‘Adwendwen’ (thinking too much/ distressed)
- Disappointment in marriage/ relationship
- Seizures or ‘Etwa’ / ‘gbiligbili’ (falls/ siezures)
- Forgetfulness or ‘Ariefie’
- Unstable person or someone suffering from mood swings i.e. ‘Onye papa biara’ or ‘Nadwen hehem’ (unstable and unreliable minds or mood swings)
- Serious or light mental problems

**Conditions**

Psychosis or Schizophrenia,
Drug related symptoms which may include psychosis, schizophrenia. Violent behaviours, etc.
Depressions

Depression (or mental health related to relationship breakdown)
Epilepsy

Dementia
Bipolar Disorder

Severe or serious psychosis or other forms of mental disorders whereas someone with depression, dementia or epilepsy may be described as having light mental problems
3. **Causes of Mental Illnesses and Disorders according to TMHCs/THPs**

THP ascribe the following causes to mental illnesses:

- 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 causes demonstrate knowledge and understanding of mental illnesses and disorders within traditional mental health practice. The causes are aligned with the belief systems of the people and their community values.
The causes are determined based on the history provided by the patients themselves, their families or the revelations gained by the THPs.

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

THPs and the operators of TMHCs administer either or both spiritual and physical treatment and management depending on the symptoms and causes of mental illness. 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. The following descriptions were ascribed to the conditions:

THPs and operators of TMHCs use indigenous and traditional practices including:

- plants and herbs;
- hypnosis and homeopathy;
- faith and religious healing i.e. cleansing, prayers, fasting and rituals,

In some cases, anti-depressants or anti-psychotic medications are used in combination with their practices.

TMHCs/THPs may provide ‘in-patient’ care or ‘out-patient’ care. While prayer camps may provide ‘in-patient’ care herbalist, fetish priest and native doctors are more likely to provide ‘out-patient’ care.
5. **Role and Contribution of TMHC/THPs to Mental healthcare and Service Provision**

TMHCs/THPs play the following roles in providing health services including mental healthcare and services:

- They provide holistic response to clients’ health needs by addressing spiritual and physical as well as their socio-cultural needs.
- They provide a one-stop shop for every health need by addressing all kinds of ailments.
- Their modalities for healing and dealing with clients like dedicated attention to each client is more preferred than the bio-medical health facilities.
- They are highly accessible to all, as they are usually located in rural areas, yet they are obscured enough to anonymously accommodate PMDs/PMI.
- They provide therapeutic and rehabilitation services i.e. for stroke, accident and injured persons as well as for PMDs/PMIs.
- They provide advice and counselling as well as deeper meanings of ailments to their clients.
- THPs have 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 them, the cost, impersonal relationship, and perceived efficacy.

• The traditional explanations to mental illnesses and disorders help to curb stigma and derogation of the illness or experience.

Respondents rate the roles of prayer camps, pastors and herbalists to be most prominent compared to mallams, fetish priests and native doctors.
6. **Challenges associated with the traditional mental health service provision.**

**Resource Constraints**
- Inability to support the residential needs of mental health clients
- Lack of funding opportunities for their near gratuitous services

**Abandonment by Family**
- Abandoned clients become the responsibility of practitioners.

**Limited Capacity**
- Inability to manage aggressive clients without the use of physical restraints like chaining.
- Inadequate training opportunities including on the guidelines and the law to enable practitioners fully comply with standards of treatment.

**Collaboration in Mental Health**
- Reluctance of government to engage TMHC/THP in matters concerning mental health
- Lack of government recognition for THMCs/THPs work

**Prejudice against traditional mental healthcare**
- Misconceptions about THMCs/THPs work and their contribution to society, including perceived substandard service and exploitation of clients
• Underestimation of the role of THMC/THP in the health sector due to the oversimplification of the practice. For example, traditional practitioners are often perceived as focused on sexual problems.

Regulatory Gap
• The flooding of the traditional health space by fake practitioners due to absence of tailored regulations.

Accessibility
• The rural location coupled with inaccessible roads to TMHCs inhibits easy access by clients.

• Transferring clients to health facilities in emergency situations is a challenge due to location of TMHC

NATIONAL FRAMEWORK

1. Mandate for mental Healthcare and Services in Ghana
The MHA is deemed to have a regulatory and service provision mandate. National stakeholders however opine (in accordance with section 3 of the Act) that MHA’s role should be collaborative for service provision, policy implementation and regulation.

These key stakeholders’ opinion is based on the following:
- their roles are complementary to that of the MHA.
- Bureaucratic hierarchies in service delivery, reporting and budgeting exclude MHA

Other stakeholders (National Council on Persons with Disabilities) however believe that MHA has the funding and mandate to deal with all issues on mental health, thus extricating themselves from any duties relating to mental disabilities.

The Traditional Medicine Practitioners Council acknowledges collaborating with the MHA to promote allopathic mental health practices. This limits the role of the MHA in acknowledging the significance of traditional providers of mental health care and services which adversely impacts on the MHA’s legal objective to promote culturally appropriate mental health care.

Traditional practitioners express the concern that this challenge emanates from the Act’s failure to streamline the informal sector by categorically including it in health care delivery. The MHA also excludes the traditional practitioners from strategic forums which would otherwise have created the platform for the understanding of their operations.

2. **Framework for Mental Healthcare and Service Provision & Funding**

The pathways for mental healthcare in Ghana are through both the formal and informal structures.

While the delivery of care and services is entrusted to providers in both the public and private sector, functions
particularly within the public sector appear not to have been clearly defined as a result of which there is an overlap of functions between the Ghana Health Service and the MHA at the District and Regional levels. This is further compounded by funding and accountability shortfalls. In the case of the former, it is reported that all funds in relation to mental health are allocated to MHA although the GHS is expected to deliver services on mental health at these levels.

The funds allocated to MHA however are deemed woefully inadequate to address the nation’s mental health needs. There is also the challenge of consistent late release of allocated funds. These have resulted in an over-reliance on donor funding for the MHA which creates another challenge about the sustainability of services in fulfilment of MHA’s functions and mandates.

3. 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) have trained traditional health providers in both the formal and informal sectors on the rights of PMDs/PMIs. The trainings are aimed at
improving rights protection for PMD/PMI and collaboration between MHA and the informal sector.

These efforts notwithstanding, rights violations including involuntary treatment and chaining persist especially in the informal sector. THPs and some family members however do not consider these practices as violations but believe they are mere practices in the best interest of PMD/PMI. Others however consider them as derogatory with negative impact on PMD/PMI.

As a result of legislation on restraining and regulation thereof highlighted through capacity building programmes, THPs are reassessing and redefining their ability to provide services to some clients. For example, some only provide services to aggressive clients if relatives are willing to assist in their management; refer aggressive clients; providing only ‘out-patients’ services; and collaborating with community mental health nurses to support their clients with medication and visits at the TMHCs.

For other practitioners however, there is a perception that there is no alternative to the chaining to restrain PMD/PMI who may require it. THPs who continue to violate these regulations are however yet to be held accountable under the law as no convictions are reported.
RECOMMENDATIONS

*Stigma elimination and education*

The MHA and stakeholders within the mental health space need to intensify national level education and sensitization to mental health. Efforts must also be made to revise derogatory local language ascribed to mental illness.

*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.

*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 involve THPs in training on new and/or relevant policies and guidelines in mental health whilst building their capacities on standards of care and practices.

Additionally, the GES must 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 condition for support and early treatment.

Collaboration
The MHA needs to 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 healers; and, build confidence between the two sectors.

Prevention
Mental health service providers (both orthodox and unorthodox) need to drive specialized preventive and treatment services having regard to the factors that heighten vulnerability to mental illness.

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.