

The Decentralization of the Ghanaian Mental Health System Through the Medical and Non-Profit Sector: A Case to Improve Access to Care and Disrupt the “Othering” of the Mentally Ill?

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Mental health services, with my research focusing on the most prevalent disorders, schizophrenia and depression, are under-resourced. Ghana has merely 18 practicing psychiatrists and only three psychiatric hospitals for the entire country. It is estimated that, “of the 24.3 million people living in Ghana, 2.4 million suffer from mental illness” (ACCA Global 2013). With less than 20 practicing psychiatrists, there is a 98% treatment gap in Ghana. Mental health services funding is nowhere near the level of funding concerning infectious diseases or reproductive health. The misconception that mental illness is contagious leads to the stigmatization of not only the mentally ill but also mental health professionals. Due to resource constraints and the stigma attached to mental illness, many of those suffering from psychiatric conditions are not treated with modern medicine like psychotherapy or medication. Instead, they are sent to spiritual churches or prayer camps where they are sometimes mistreated. This includes being chained up (sometimes outside in poor weather conditions) or prevented from using adequate medical care (ACCA Global 2013). Furthermore, the dearth of research in Ghanaian mental health care contributes to insufficient understanding of how the Ghanaian mental health system may influence the social differentiation, or “othering,” of the Ghanaian mentally ill and impact Ghanaian mental healthcare-seeking behavior. Those who are mentally ill are unfortunately ostracized from the rest of the community and perceived to be straying from what society considers normal. Through my ethnographic research with key actors in the Ghanaian mental health system, I analyze what “abnormal” means in this society and how the mental hospital and prayer camp may have different forms of othering the mentally ill. This study focuses on the following research questions: (1) How do Ghanaian mental health institutions influence the social “othering” of the mentally ill (primarily through confinement and social isolation)? (2) How does this not only impact the vulnerable population but also impact voluntary mental health care utilization and mental health care seeking behaviors in Ghanaian society? In my final analysis, I conclude the roots of the issues behind mental health are education, resource allocation, awareness that mental

health is on an expansive spectrum, and the understanding that people must heed to both their mental health and physical health. Thus, I argue, decentralization does not solve issues of stigma because the social and political body's issues are so deeply ingrained in the culture and cannot be changed with a complete revolution of what it means to have a mental illness -- normal life can still be maintained, the mentally ill can still contribute to society, etc.

Keywords: Mental Illness, Culture, Equity, Religion, Stigma

Introduction

Mental health services, with my research focusing on the most prevalent disorders, schizophrenia and depression, are under-resourced. Ghana has merely 18 practicing psychiatrists and only three psychiatric hospitals for the entire country. There are many misconceptions about mental illness. For example, the idea that children of mental health staff often inherit mental illness discourages providers from going into mental health care (ACCA Global 2013). Due to resource constraints and the stigma attached to mental illness, most of the population suffering from psychiatric conditions are not treated with modern medicine like psychotherapy or medication. Instead, “they are sent to spiritual churches or prayer camps where they are sometimes mistreated.” This includes being chained up (sometimes outside in poor weather conditions) or prevented from using adequate medical care (ACCA Global 2013).

Mental health care is a neglected area of medicine in Ghana. It is estimated that, “of the 24.3 million people living in Ghana, 2.4 million suffer from mental illness, such as Schizophrenia (18%), Depression (12%), Epilepsy (9%), Substance Abuse (9%), Acute undifferentiated Psychosis (9%), Dementia (3%), Mania (6%), Neurosis (2%), and Mental Retardation (4%)” (ACCA Global 2013). Mental health services funding is nowhere near the level of funding concerning infectious diseases or reproductive health. Misconceptions that mental illness is contagious lead to the stigmatization of the mentally ill and mental health professionals. Furthermore, the dearth of research in mental health contributes to insufficient understanding of how the Ghanaian mental health system (composed primarily of psychiatric hospitals, the government, non-profits, and faith-based healing in prayer camps and religious centers) may influence the social differentiation, or ‘othering,’ of the Ghanaian mentally ill and impact Ghanaian mental healthcare-seeking behavior. Those who are mentally ill are unfortunately ostracized from the rest of the community and perceived to be straying from what society considers normal. My research analyzes what “abnormal” means in this society and how the mental hospital and prayer camp may have different forms of othering the mentally ill.

This study focuses on the following research questions: (1) How do Ghanaian mental health institutions (the psychiatric hospital, prayer camp, and non-profit institution) influence the social “othering” of the mentally ill (primarily through confinement and social isolation)? (2) How does this not only impact the vulnerable population but also impact voluntary mental health care utilization and mental healthcare-seeking behaviors in Ghanaian society? This study will span colonial history to the present to ask how the Ghanaian mental health care system and its engagement with the Ghanaian population have shaped ideas of mental health and mental health service use.

Literature Review and Significance

Colonial History of Psychiatry and Biomedicine

The colonial period was crucial to the development of psychiatry in colonial Africa and the "African mind," as Europeans characterized Africans. Megan Vaughan's investigation in colonial East and Central Africa has described in detail this construction of the "African mind." These ideas have yet to be clearly detailed in Ghana and, therefore, serve as the basis for my research. During this period, Vaughan details how European colonizers characterized the "dangerous, dirty, and African other" (Vaughan, 1991). Historians have presented many accounts of how European definitions of madness in colonized populations were closely linked to "othering" characterization -- that the African mind was opposed and inferior to that of the average European. Vaughan argues this characterization impacted Africans who did not fit into this stereotypical box of "the African." These Africans (those who were educated or outside of this inferior stereotype) became the "insufficiently other" Africans (Vaughan, 1991). There was a clear pathologization of Africans who refused to respect the boundaries of "race" and ethnicity. A strong theme emerges that Fanon has described in psychoanalytic terms: the pathologization of the "modern" educated colonial subject, the African who rejected the ethnic or "racial" stereotype and aspired to be modern in fashion. The "modernized" African was portrayed in colonial discourse as a "degenerate hybrid," a state that made them vulnerable to various mental illnesses. It was educated, "modernized," and "detribalized" Africans who, according to this theory, filled colonial lunatic asylums and whose delusions were filled with images of the colonizer's culture (Vaughan, 1991). Colonial culture, which transcended the carefully drawn boundaries of an African's conduct, was said to have driven Africans mad. It made them forget who they were, and somehow, they lost their "true" identities. Leland Jock McCulloch et al. have repeatedly argued how colonial asylums and the othering of Africans were vehicles of explicit social control by colonizers to yield power over the colonized mentally, emotionally, physically, and economically (Heaton, 2013). This is a different analytical framework from Michel Foucault's description of "productive power," in which power is seen less as an oppressive or repressive force, but as a discursive force that positions people in different ways for the right to speak or participate in its institutions (Levett et al., 1997).

In 1888, colonialists founded the first Lunatic Asylum in Ghana. The historian E.B. Forster notes that the asylums in Ghana were not for psychiatric treatment, but a way of separating the mentally ill from society and locking them up. The staff did not provide treatment but focused exclusively on ensuring patients were fed and then reported on the physical health of the patients (Forster 2012). Jonathan Sadowsky's analysis of colonial asylums in southwest Africa similarly describes asylums as chronically underfunded and overcrowded. These historical analyses are rooted in Michel Foucault's description of the conversation

between “madness” and “reason,” which reveals the relationship between social constructions of madness and the social control mechanisms of the state, thus making power productive. They are also rooted in Frantz Fanon’s criticism of colonialism, which can produce pathological colonial subjects through the physical, social, and psychological violence of colonial experience, and how this can lead to claims of the asylum as a tool of political control (Heaton, 2013). Historical and anthropological works illustrate the extent to which hegemony has shaped biomedicine and psychiatry in the West and colonized spaces. Hegemony refers here to the ability of biomedicine and psychiatry to objectify, characterize, and marginalize certain groups. Other historians have shown how the development of “modern” biomedicine in the 20th century is linked to the historical context and hegemony of European colonialism within which it developed (Heaton, 2013). Though the construction of the “African Mind” and hegemony were critical to the formation of colonial psychiatry, my thesis will discuss Ghana psychiatry today in a new lens. I argue that psychiatry in Ghana today is a product of the internalization of colonial notions of what is “normal” and the ostracism of those who do not fill this subset, perhaps not as extreme as colonialism, but deeply ‘othering’ the mentally ill.

Today, Ghana is still struggling with the stigmatization of mental illness woven into Ghanaian societal norms. The stigmatization often leads to dramatic social consequences for the persons concerned. At Ankaful Psychiatric Hospital, almost 100% of all patients have been abandoned by their families after hospitalization (Barke, 2011). Also, at Pantang Psychiatric Hospital, a “special Vagrant Ward was created for patients who have been rejected by their families [due to] stigma” (Barke, 2011). The General Secretary of the Ghanaian Medical Association estimated that, “A third of patients on admission in the Accra Psychiatric Hospital are patients who have been treated and discharged, but whose relations have refused to readmit them to the family” (Barke, 2011). All these cases emphasize the gravity of othering of the mentally ill in Ghana -- especially by the family, the closest unit to an individual.

According to Link and Phelan’s model of stigma, stigma occurs when four related factors converge: “(1) people distinguish and label human differences; (2) dominant cultural beliefs link the persons thus labelled to undesirable characteristics, i.e. to negative stereotypes; (3) labelled persons are placed in distinct categories and a degree of separation of “us” from “them” is created; (4) the labelled persons experience a loss of status and discrimination” (Link and Phelan, 2001). Perceived stigma can lead to a patient’s reluctance to seek help for mental illness. Experiences and expectations of stigma can lead people with mental illness to seek ways to deal with the threat of stigma. A person may choose to conceal their illness or treatment history from employers, relatives, or potential partners to avoid the possibility of rejection or to limit social interaction altogether (Link and Phelan, 2001). Given the

impact of experienced stigma, it is important to investigate how the mentally ill may be othered and stigmatized to determine how to reduce such stigma.

Despite all efforts to de-stigmatize mental illness and improve access to medical care, the psychiatric hospital and prayer camp in Ghana separate the mentally ill from the wider community (during and after hospitalization). This separation creates physical barriers between those seeking mental health care and the rest of Ghanaian society. Moreover, in Ghana, where there are only three psychiatric hospitals, transport to “X Psychiatric Hospital” labels one as “abnormal.”

Current State of Ghana’s Mental Health System

Mental health has only recently been a recent topic of concern to Ghanaian health officials. Before 1951, there were no psychiatrists in the country (Forster 2012). The greatest need for mental health services is not met in countries such as Ghana with the fewest resources: “Most of the global burden of mental, neurological and substance use disorders occurs in countries with low-income and lower middle-incomes” (Roberts 2014). In a 2011 study, services were significantly underfunded with “only 1.4% of the health expenditure going to mental health and spending very much skewed towards urban areas” (Roberts 2014). In terms of infrastructure resources, there was overcrowding because Ghana’s mental health system consisted of only “three psychiatric hospitals, seven community-based psychiatric inpatient units, four community residential facilities, and one day treatment center” for the entire country (Roberts 2014). These facilities are usually located in the capital and the central region, placing a strain on families who have had to travel long distances in search of treatment. Additionally, there was an unhealthy ratio between patients and staff, as shown in the “18 psychiatrists, 1,068 Registered Mental Nurses, 19 psychologists, and 21 social workers” being mental health providers for the 2.4 million mentally ill population (Roberts 2014).

There is insufficient public education to combat the stigma surrounding mental illness. This inadequacy is likely to have a negative impact on the acceptance and rehabilitation of mentally ill people in the community and ultimately on future health-seeking behaviors. In a low-middle-income country like Ghana, poor mental health is often exacerbated or triggered by stressful life situations. These situations can be due to poverty, physical health problems, and disasters -- making care and prevention even more complex. Inadequate psychiatrists and other mental health professionals exacerbate the local African stigma towards mental illness, a disease “shrouded in witchcraft, juju, taboos, [and] religious cult influence” (Forster 2012). People with mental illness find their health gaps met in religion. Faith healers or priests / imams base their treatment on the power of God to cure diseases (Kale, 1995). They use prayer, fasting, and the sprinkling of holy water as methods for treating

diseases (Puckree et al., 2002). They also believe in the confession of sin as a crucial part of the healing process (Puckree et al., 2002).

In May 2012, the Ghanaian government was pushed to pass reforms on the aforementioned capacity, access, and funding issues through the passing of the Mental Health Law. After the Mental Health Law was initiated, Ghana implemented a Mental Health Act leading to the establishment of a Mental Health Authority. This Authority was created to ensure the implementation of mental health policies, such as the implementation of a community-based mental healthcare approach and the fight against stigma and discrimination of the mentally ill. The law integrates the spiritualist and prayer camp facilities, “which currently cater to 70% of patients with mental illness,” into the healthcare system; thereby, increasing the regulation of these traditional facilities (ACCA Global 2013). In recognition of the burden of mental disorders in Ghana and the relative paucity of financial and human resources, as well as its readiness for reform, Ghana is one of the countries identified by the WHO initiative Mental Health Gap Action Programme (mhGAP) to receive intensified support to scale up treatment for mental, neurological, and substance use disorders (Keynejad, 2017). Plans are being put in place to expand services, possibly by adding psychiatric units to larger hospitals. The Ghanaian government is also discussing increasing the number of specialist staff, but before this can happen, steps must be taken to remove the stigma attached to such roles. The plans are still abstract; thus, my purpose is to qualitatively chronicle what specific interventions the Ghanaian mental health care system is implementing that may impact the ‘othering’ of the Ghanaian mentally ill. There has also been little qualitative research on the progress this Act has produced on improving equity in health-seeking behaviors and mental health care use. Through qualitative interviews, my research offers a preliminary investigation into how recent policies might, if anything, change health-seeking behaviors.

The latest published research, mentioned in previous paragraphs, regarding mental health in Ghana is outdated in the sense that there are so few people in Ghana psychiatric academia with capacity to continuously publish research in this area, and mental health in Ghana is a fresh topic on the rise. My study provides new insights into the state of the Ghanaian mental health system by focusing on key actors (medical directors, non-profit leaders, political and religious leaders) to understand not only the progress and failures throughout history, but also to understand where the mental health system may label the Ghanaian mentally ill person as “other.” My research interest is in how institutional practices affect the social status of the mentally ill in Ghanaian society. My qualitative research is timely in light of new approaches to influencing health-seeking behaviors in the Ghanaian community. In order to combat the challenges and stigmatization of mentally ill people in Ghana, attention must be drawn to this issue.

My qualitative research aims to understand the efforts that have been made to educate the public about mental health and promote health-seeking behaviors. Additionally, due to understaffing and overcrowding of the only three psychiatric hospitals in the country, "70– 80% of Ghanaians utilize unorthodox medicine from the 45,000 traditional healers, located in both urban and rural areas, for their vanguard healthcare despite recent advances in orthodox psychiatric services" (Roberts 2014). Thus, my interviews consisted of 30% of the Ghana's psychiatrists (n = 5 out of 15; one including the Chief Psychiatrist of the Ghanaian Mental Health Authority and the others directors of the three psychiatric hospitals in Ghana), three mental health non-profit CEOs, two pastors, two psychologists, and one psychiatric nurse. Overall, I gained a nuanced perspective concerning orthodox and traditional medical systems and how they impact Ghanaian perceptions of mental health services.

The internalization of colonial ideas concerning power, race, culture, medicine, and individual subjects continues to this day. I will assess the innovative changes taking place in addressing concerns about mental health and health-seeking and how these may or may not impact the "othering" of the Ghanaian mentally ill.

The Mindful Body

A significant portion of my thesis will cover the ways in which institutions perpetuate "othering." However, I think it is important to theorize the body of the mentally ill and how they fit into the Ghanaian mental health system. To understand how the mentally ill may be othered, I draw on the theoretical work of Margaret Lock and Nancy Scheper-Hughes in *The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology*. They argue there is an "assumption of the body as simultaneously a physical and symbolic artifact, as both naturally and culturally produced, and as securely anchored in a particular historical moment" (Lock and Scheper-Hughes, 1987). Basically, they argue the body is an entity with many meanings which relate, and/or influence, one another. They distinguish "three bodies" by which they label are the individual body (a phenomenological analysis of one's lived experiences), the social body (the analysis of the body as a symbol of nature, society, and its cultures), and the political body (the analysis of the body as an artifact of social and political). My research primarily focuses on the latter two, the "social and symbolic body" and the "body politic," as those areas are where I draw my qualitative interviews from; however, the phenomenological body certainly informs health care and the way health care is carried out as well.

The concept of the social body suggests that mental illness is not solely physical but is also symbolic. That is, it reflects how illness is interpreted in particular social settings and how particular societies define the "practical" way of dealing with such illness in a culturally appropriate manner. Thus, the "stigmatized mentally ill body" that is the focus of this research presents a symbolic idea of how Ghanaian society perceives

mental illness. In some ways, one can perceive this to also be a political dimension of illness because power structures in medicine inform the social structure and understanding of the body and illness.

The “body politic” analysis aims to describe how the body is a result of the power relations within society. Also supported by Frantz Fanon, many view the body as “an object produced and regulated by political, normative and discursive regimes” (Schilling, 2005). Therefore, the way knowledge about the body is structured is correlated to the power relations in a certain society. This relation can be better understood with a historical approach as used by Michel Foucault. It is critical to have a historical analysis of the body, particularly those of the mentally ill, and the way they became an object in different realms. In Ghana, the biomedical and religious systems play an important role in constructing such body politics, sometimes in conflict with each other and sometimes in concert with each other. The main power in biomedical and religious systems lies, firstly, in their ability to create new subjects of power, whether consciously or unconsciously through diagnosis, and, secondly, in their ability to exercise their authority through funding, institutionalization, and confinement.

My work in medical anthropology in Ghana is to understand how communities in Ghana conceptualize mental health and illness and act when faced with it. My research describes, interprets, and critically assesses the relationships between histories of stigma and sociocultural attitudes towards mental illness in Ghana by connecting them to the larger context of social, cultural, political, economic and historical ideas. A topic of particular relevance to my research is not only the way mental illness and measures to alleviate mental illness in Ghana are conceived by the ill person but also by those in the Ghanaian society.

The Mental Health System on the Mentally Ill

In constructing their theoretical model of three bodies, Lock and Scheper-Hughes argue the way the body is conceived is crucial not only to anthropology, but also for understanding how health care is deployed in western societies. The individual body entails a phenomenological approach that begins with the embodied nature of people. One question on this theory is how does illness and the search for adequate health influence our lived experience of illness and our body image? To understand this theory in relation to medical or spiritual healing, the relationship between embodiment and the social body must be analyzed. The social body entails a symbolic or structural exploration of concepts in a socio-cultural context, understanding the way society thinks about the body of the mentally ill and their own bodies. Illness speaks not merely to the physical body but also speaks to the social body by providing a relation between individual experience and the cultural realm. My earlier sections of this chapter detail the social implications and ideas that Ghanaian society

places on mental illness. Such ideas can also permeate into the biomedical realm and ideas of the mentally ill.

The body politic primarily refers to power relations. It contains an analysis of the ways in which different political and normative regimes regulate bodies. Health and illness are medical labels that have serious effects on the normalization or stigmatization (othering) of the body. Consequently, they have a social control function (not exactly to a colonial extent, as previously discussed, but still influence many social dynamics and othering of the mentally ill). Michel Foucault draws a distinction between the politics of the individual body – the way individual bodies are disciplined in a way that they be subdued, modeled, transformed – and the biopolitics of the human race – the regulation of populations by a concern for general life processes (birth rate, death rate, longevity, etc.) (Foucault, 1997). An important aspect of politics of the individual body is the therapeutic relationship. In it, the healthcare provider individualizes the ill person and the body is compared to the norm. Some studies and many of my interviews have described that traditional medicine can consist of a more embodied practice, as such institutions provide plenty of individualized care and attention to one's illness and social/biographical history. This holistic treatment does not simply place biomedical ideas upon a patient. However, my observation of this difference does not mean I do not believe that these institutions also participate in social control. Their practices also articulate power and knowledge relationships that produce docile bodies in the mentally ill, especially through the ideas they consider necessary for health (prayer, fasting, herbal diets, etc.).

Pulling everything together, it is clear that the social body overlaps with the political body in a matter of society being able to have coercive and political power over the body. Furthermore, the practical effects of power and influence certainly impact the individual body. Through my thesis, I will focus on how the social and political realm are influenced by stigma and perpetuate stigma in Ghana's mental health system -- impacting mental health seeking behavior and 'othering' the mentally ill from society.

Methodology

My methods primarily include qualitative interviews and observations conducted during my Chappell Lougee exploratory research trip during the summer of 2016. This research was gained through observations of parts of the Ghanaian mental health system: the only three psychiatric hospitals – Accra, Pantang, and Ankaful Hospitals; non-profits – Basic Needs, Progressive Life Center, and Inclusion Ghana; and political organizations/leaders – Ghana Mental Health Authority and the Ghanaian Minister of Health. I had consent forms to give to my interviewees before all interviews. I conducted in-depth, semi-structured interviews of five medical providers, four non-profit directors, three political leaders, and three traditional healers, all with mental health expertise across Ghana's

urban areas (Accra and Cape Coast). I used a digital audio recorder and my phone recorder to record the interviews. Questions covered a variety of topics from perception of mental illness, mental health-seeking behavior, the prophetic (prayer) healing system, and access to mental health care services. My purpose was to not have a biased view of “mental health professionals” and speak to people who have many experiences working in mental health (medical, political, religious, etc.). This strategy of talking to different types of people allowed me to get multiple perspectives of how mental illness is viewed in Ghana and understand the meaning of mental illness in Ghana, far beyond the roots of mental illness in medicine. My research design also allowed me to gain a ground level understanding of current strategies used to influence mental health care seeking behaviors and use in the mental health care systems. I hoped this would give insight into improvements needed for future mental health care systems to succeed in these areas. I also acquired data that was not in my research or archives through brochures and education materials from the non-profits and hospitals I visited – depicting their mental health education strategies.

Experts in this discipline of global health and mental health, including my faculty mentors, Dr. Alvan Ikoku, Dr. Duana Fullwiley, and Dr. Ann Watters, supported me in this endeavor. My field mentor, Dr. Teddy Totimeh, was instrumental in connecting me to my first interviewee, a mental health professional who then connected me to most of my other interviewees. My access to these interviewees was due to the snowball effect – one mental health professional connecting me to another and continuing the cycle – that was rather easy to accomplish with the Ghanaian psychiatric professional community being small. The product of my research is an understanding of what has impacted health seeking behaviors and use of mental health systems in Ghanaians/Ghanaian immigrants throughout history and today and areas to focus on in the future. More details concerning interview questions are in the appendix.

Chapter 1: The Biomedical Mental Health Institution

2.2 million suffering from a moderate to mild mental disorder...650,000 suffering from a severe mental disorder...3 government psychiatric hospitals (only in urban cities close to the capital and servicing only a small proportion of the entire population)...15 practicing psychiatrists (ACCA Global, 2013). Mental healthcare in Ghana has severe gaps in funding, workforce, and resources from a biomedical, political, and economic standpoint. Access to biomedical psychiatric care is challenging due to issues with transportation, funding, and the few community psychiatric institutions being private. Why is the state of the mental health care system in disarray? Could it be that many in the psychiatric field are plagued by stigma and misconceptions of contagion in the profession? Could it be that the level of resources in the system not only prevent the highest quality care but also reduce the amount of patients that are willing

to come forward or workers willing to work there? In this chapter, I will focus on the origination and social history of psychiatric institutions in Ghana, my fieldwork experiences (observations and interviews) with medical directors and psychiatrists, the psychiatric hospitals' current relationships with the larger political, economic, and biomedical landscape in Ghana, and plans for the future. I will investigate the biomedical mental health system's role in Ghanaian society and how this came to be. I will ground my analysis in my interview data, participant-observation, and a close reading of pivotal literature. My interviews with mental health workers offer invaluable insight into psychiatric hospital organizational structure, societal perception and relations, strategies, and relationships with other actors in my fieldwork (religious and political professionals), and, therefore, form the foundation of this chapter. Media discourse is an integral part of the perception of the psychiatric hospital and its place in society; therefore, at the end of this chapter, I will analyze the psychiatric hospital's role in othering the mentally ill and mental health-seeking behavior and its relationship with the mainstream media, TV, film, radio, etc.

The journeys I had to speak to each mental health professional were revealing of some internal stigmas I had. Though I was a researcher, I could not help but feel a tinge of embarrassment or stigma when I would tell my taxi driver I wanted to go to a psychiatric hospital. What did they think of me? Did they think I was mad? Did they think someone in my family was mad? Did it matter? Why did I care so much when this very stigma was the stigma that I was researching? Here I was embodying it. I came down awkwardly from each taxi, aware of my environment and those watching me. Is this how those seeking mental health services feel? ... As I stepped into the compound, I encountered a group of medical students being lectured. For further insight, though Ghana has ~15 practicing psychiatrists, typically only one or two psychiatrists will direct these types of psychiatric institutions (the others working in general hospitals). Below the psychiatric directors, there are typically three medical officers and supporting nurse staff who run the hospital and consult the psychiatrists when necessary.

Historical Precedence and Psychiatric Care in Ghana

Though I have provided significant statistical and descriptive framework on the status of the Psychiatric System in Ghana, I would like to dive into the social and political body further as they implicate the individual body of the mentally ill. In order to understand the severity of stigma and social issues in mental health in Ghana, I would like to begin my analysis with the statistic that Ghana had only about 15 psychiatrists for the entire country (at the time this study was conducted). To be frank, before my research began, I was frustrated by the number of Ghanaian doctors in psychiatry. I had several African friends who had experienced stigma associated with mental illness, with some cases ending in

unfortunate events such as suicide. I was motivated to research how to reduce such stigma of the field and increase the number of professionals in this area. Through intensive literature research, I understood why it can be difficult to be in a field with such limited resources but such a high stigma. If one understood such obstacles to providing mental health care, why would they be happy going into it? I hoped these questions could be answered by medical directors and health care providers at the three Ghanaian psychiatric hospitals. This is a systemic problem that requires historical and political analysis of how the system is financed and how care is provided. Can this analysis be combined with social research to explore what can be done to solve the problem of so few people going into the field and influencing the paradigm of mental health care in Ghana?

Hospitals + Medical Directors

Why did these psychiatrists come into psychiatry, an overly stigmatized and under resourced specialty in the first place? One of my interviewees, Dr. Appau, first described as a medical student that she and most of her peers rarely took psychiatry seriously during their medical studies. They would come to the government psychiatric institutions amazed at the neglect and age of facilities and lack of doctors. In the students' minds, this was "a rotation that [they] took for granted like it was sort of a holiday, a break you know from the intensive surgery, the intensive medicine, peds and so on..." However, unlike many other medical students in Ghana, Appau took strong interest in the people mainly because she witnessed the neglect in the institution. She observed how few doctors were managing so many people and was moved to make the decision to come into psychiatry. However, that decision was surely met with significant opposition. Many discouraged her, saying that this was only her first rotation and that she did not know what she wanted. Eventually, this young aspiring doctor was so overwhelmed by the social stigma and discouragement of going into psychiatry that she went into a surgical residency and almost never looked back. However, disinterest in surgery and family problems at the time pushed Dr. Appau to go to the UK and write an exam for psychiatry. Without this change of heart, the many Ghanaian patients that she helps each day would not have such access to a pioneer of Ghanaian psychiatry today. Dr. Appau's passion for psychiatry was something I saw in everyone I interviewed. For physicians like Dr. Cudjoe, the passion for psychiatry stemmed from the belief that it was the highest form of medicine, in the sense that a person without a functioning mind is medically and metaphorically incapacitated. He believes his work not only helps his patients physically but also allows them to start contributing to society again. This is something I've learned is vital to one's awareness of themselves and their place in society.

Nevertheless, despite such fervent passion identified in these mental health professionals, there are thousands still left without access to biomedical psychiatric care. All psychiatric hospitals are located in the

southern or coastal part of Ghana, which means that the northern rural part of Ghana does not have access to psychiatric care or is forced to undertake lengthy and expensive journeys for psychiatric treatment. However, the positive thing about Ghana being a predominantly religious country is that there are pastors and prayer camps practically everywhere. Since mental health is a condition with often unexplained origins, many Ghanaians attach spiritual significance to it and understandably do not seek psychiatric care. Rather, the first points of contact for Ghanaians with mental illness are to consult a spiritualist in or near their community. Dr. Appau and Dr. Codjoe cannot offer this accessibility and proximity to the community.

A key aspect, which concerns not only access to all types of care, but also proximity to the care received, is reintegration into the community -- which psychiatric hospitals cannot offer fully. Dr. Appau describes how “patients will have to move from their community and into the institution, sometimes staying for a long period...so getting them back into the community becomes a whole big problem because people do not accept them as you would like them to.” Those who go to the psychiatric institution are often unable to fully reintegrate back into the community and stay in the institution. This not only places a further strain on the system, but also feeds into the stigma of the mental institution -- a last resort in which hope of returning to the community is lost.

Despite the positive services the psychiatric institution may provide, it is still highly stigmatized for many reasons. According to Dr. Darko, one of the psychiatrists I met at the general hospital Korle Bu, “Once you have any mental illness, you are sentenced for the rest of your life as not having any cure. You are looked at as someone who is dangerous, someone who can be aggressive, somebody who can harm people at any moment, someone people would not like to marry or have someone in their family marry (because it is viewed as a “contagious” condition).” Therefore, anyone who may have a condition of mental illness and perhaps needs to seek care, finds it difficult to identify with that condition for the fear of such stigma.

Not only is it hard for the mentally ill to identify with such issues, but it becomes a major problem for their family members. Every individual member of the family is protective of that person. They do not want to let the secret out. They do not want the person to be associated with psychoactive drugs, let alone go for psychiatric checkups and be seen by someone in the community. Dr. Darko says they even rebuke any sort of diagnosis their family member receives. It is a serious blow to parents and relatives when they learn that their child or family member is suffering from an illness. It shifts from the patients themselves to their relatives -- the social body becoming more and more powerful. The family prefers to keep them in the prayer camps because they consider them less stigmatizing and isolating, thus preventing further scandal. They see

mental illness as a demon, a demon that will one day leave and the patient will return to normal.

Another problem that discourages people from seeking treatment in the psychiatric institution is the fact that psychiatric patients are often medicated for a long period of time, because many mental illnesses are chronic illnesses that must be managed. These medications are effective but costly. Dr. Darko tells me Parxx, a topnotch medication they use in Ghana, costs 1600 Ghana cedis (approximately \$400). The average minimum wage in Ghana, at the time we spoke, was 7 Ghana cedis (approximately \$1) per day. Not only does stigma play a role in seeking care for the mentally ill, but economic issues, where the government does not adequately fund the psychiatric hospitals, also present an incredible economic barrier.

Another major obstacle to mental health care in psychiatric institutions is the location of the main psychiatric facilities. There are three of them in Ghana and both of the three are in the southern part of the nation. If someone has a mental illness in the North, he or she must travel all the way to the South and that has significant economic implications for the family. For some severe mental illnesses, there must be frequent communication between the patient and mental health provider. This becomes financially stressful for patients and their families. The cost of transporting patients from their place of residence to their place of treatment is a major obstacle to them receiving continuous care as they should.

Hospitals + Policy/Government

In 2012, Ghana passed its first Mental Health Act. The law focuses on mental health institutions managing patients in the community. The strategy is if all hospitals in Ghana have an attached psychiatric unit, people may simply walk into the hospital and receive the care they need, with less stigma attached compared to going to one of the three main psychiatric centers. The hope is that people may get the help they need and return to the community. The law also regulates the spiritualist so they do not violate certain human rights issues of the patients they see (i.e. chaining). Dr. Appau discusses how she gets staff to go to prayer camps and talk to the spiritualists to teach them what to do with someone who is aggressive, so they no longer feel the need to utilize chaining.

However, because of funding, she feels they are far from being perfect. I will never forget my time in Ghana when I tried to contact Dr. Appau two weeks after our interview. When I finally reached her, she told me how busy she had been because there was no food or water in the hospital for two weeks because they could not pay the food suppliers. She tells me how things she works with are usually not even available. Even gloves and things psychiatric hospitals should have are not a priority for the government. In the eyes of Dr. Appau, the government thinks that “because it is a psychiatric hospital...what is the need for gloves?”

Psychiatric hospitals are stigmatized on all sides - from society and the government.

Dr. Darko believes the key to beating down stigma is decentralizing care and moving it to the community level. Dr. Darko imagines, “It is one of the objectives of the mental health law to make sure that every health facility, teaching hospital, and regional hospital has a psychiatric unit.” As a psychiatrist working in one of the largest hospitals in Accra, Dr. Darko feels he has minimized the effect of stigma and improved patient compliance because patients can access care. He says, “If you tell somebody, I am coming to Korle Bu, the person may not think [about] psychiatric cases, they may think more of surgery or internal medicine.” Yes, that masks the stigma associated with visiting a main psychiatric facility, i.e. Accra Psychiatric Hospital, Ankaful Psychiatric Hospital, Pantang Psychiatric Hospital. However, I argue this does nothing to target the deep-rooted issue of societal stigma and is merely a band-aid that will work for now.

Religion + Mental Health

Fundamentally, I believe the strategy of decentralization is noteworthy in increasing access but fails to target serious fundamental issues in mental health education and stigma. With over 90% of Ghana’s population religious, the role of religion on mental health is significant. Many believe that one can demonstrate one’s faith by stopping medication. Dr. Wiredu, a clinical psychologist whom I interviewed, tells me that mental health issues are often chronic conditions of unknown origins that can only be managed and not fully cured -- creating significant barriers to care. He says, “Mentally ill patients might take their medication, but once they realize they have not been cured, it means there is a spiritual component... So faith means stop taking your medication. And when you stop taking your medication and you relapse, they’ll say well it’s probably something you didn’t do or you sinned.” As much as he feels the psychiatric system may attempt to work with these spiritual institutions, according to the Mental Health Act of 2012, he believes these obstacles will always be there for certain psychiatric disorders that require significant medication to prevent relapses, e.g. schizophrenia.

Other psychologists, such as Dr. Odoom, agree that patients’ spiritual beliefs should not be discouraged, but do not believe that the religious system offers the same respect. Dr. Odoom tells me he would like to work collaboratively, but the problem is it is not reciprocated with the religious systems. He tells me that many pastors in the prayer camps view the intake of medications as an act of disbelief, a sign of poor faith. According to some, if one believes God will heal them, then they supposedly should not be taking any medication. Dr. Odoom describes a cycle he sees commonly,

I start treatment and [imagine] I’m doing well for the patient’s [schizophrenia condition] and then I stop seeing the patient and the patient disappears off to a herbalist or prayer camp or pastor’s retreat and stays there forever and a day,

relapses, gets worse, comes back, we start the whole process all over again. Then, I think this time I might have done it...they might have understood what I've been trying to say, but then the same thing happens again. It feeds into this impression that mental illness cannot be managed well because the patient is constantly relapsing...the more it happens the worse it gets. So it looks like, "Oh yeah, this guy [was going] to the hospital..but he's still a mess - which is you know it's not my fault." It looks like [we as the hospital] can't do anything. So, with the next person that gets sick, they point out [how] the person who's been allegedly going to the hospital [is] not well. So what's the point in taking him there? You know there's this new wonderful pastor on the TV. He touches five people and all of them fall down. [They] are miraculously healed. That's the guy you want to go to... So it's a big problem. It's a big moment. It stops them from coming in. It stops them from staying committing to treatment in the end. It worsens their prognosis.

Fundamentally, the idea that diseases must be cured, not managed, is a major obstacle to mental health providers. It causes many in Ghanaian society to value the prayer camp much more than the biomedical institution in such circumstances, because of the promise of total healing. Failure to heal leads to a cycle of relapse, which harms the patient further and also leads to this eternal stigmatizing belief that mental illness is unmanageable. The urge to stop medication usage in the prayer camp harms not only the individual body, but also harms the social body and body politic by generating negative cyclical images of the mentally ill when medicine is stopped, and harmful relapses occur.

Originally a proponent of decentralizing the psychiatric system for improved access, I could not help thinking of the many physicians and allied health professionals outside of psychiatry who shared similar misconceptions about mental illness and its treatment. Dr. Appau even tells me about her own medical colleagues who mock her for working in psychiatry. She tells me that people will even call her "Abodamfuo Doctor," basically "crazy doctor," because she works with the mentally ill. She finds it so absurd because she does not go around calling people Hypertensive doctor or HIV doctor. However, these are the types of people in Ghana's health system that will take charge of creating more access to mental health care. How can that decentralization come about when they share similar stigmatization and misconceptions of mental illness in society?

Another obstacle to decentralization, in my view, is the lack of oversight. There has been increased training of Clinical Psychiatric Officers, essentially Nurse Physician Assistants, who have had further training in Psychiatry to allow them to prescribe medication. However, there are often diagnostic challenges associated with the use of this allied health care system. Dr. Appau conducted a study on schizophrenia and realized the Clinical Psychiatric Officers over diagnosed individuals with the disease in comparison to the amount of diagnoses other psychiatrists gave. Along the line of decentralization of the mental health system, there may be many misdiagnoses that may not reach a psychiatrist and may actually affect patient mental health. It is therefore a fine line between

increasing access and decentralizing the system, but also ensuring supervision to prevent misdiagnosis or misinformation.

Education and Media

I argue that education is one of the best tools to address challenges of stigma and misconceptions of mental health. As someone who grew up in West Africa as a young child and still visits, I believe the film and television industry is a major perpetrator of misconceptions of mental illness. Dr. Odoom feels strongly about this topic and is disappointed that Ghanaians do not use films to teach valuable information. He tells me,

All the films I watched growing up, every mentally ill person had a spiritual attack, and the way they treated them was spiritual. At the end of the film, the illness disappears completely because God intervenes and now the person now leads a wonderful life. They are married, have two and a half children and everything is wonderful.

Young people learn something from this and it takes root in our society. You grow up in this millennium and you come out thinking like that. I argue that it is much easier to transform media than to try to shift multigenerational stigmatization towards mental illness, especially given how accessible radios, televisions, and the Internet are.

A good deal of mental health care providers, like Dr. Cudjoe, are very involved in changing misconceptions in the media, and take every opportunity they get to educate others. Dr. Cudjoe writes articles in newspapers and speaks in churches, on radio, and on television. He has had people come to him with an article that he wrote, such as “Insanity is from home: The expression of mental health challenges in Akan,” saying they believed they had those symptoms and were moved to come visit him. He feels that he has a huge impact because if he can teach one person, he can have a multiplier effect to reach others.

However, some believe that mere education in the media is not enough. For example, Dr. Odoom believes that education can work, but it must begin with the leaders of spiritual institutions because of their large following. Many believe that a paradigm shift in mental health is possible by authorities / celebrities educating the public about mental health or presenting their own experiences with mental health. Dr. Cudjoe tells me how he had a patient who is a chief of the area where the hospital is located. When community members see their chief get well in a psychiatric hospital, they can change their misconceptions and educate others that anyone can get mentally ill and still be okay, even their chief. So, because of the commitment of mental health professionals in the community, we are seeing many positive signs and desires to seek care.

Reflexive Anthropology

In spite of everything I have discussed in this chapter, I wanted to make sure that I share a reflexive anthropology on my part and make it clear that I do not feel that one mental health system - biomedical or spiritual - is superior to the other, but rather requires cooperation among

themselves. Of particular importance to my topic is how the spread of Western medicine has created a dichotomy and sense of inequality between traditional African healing and biomedicine, the latter being superior in the eyes of society. The fact that Western medicine is supposed to be this neutral, unbiased entity can be dangerous. It is startling how this neutrality has allowed Western medicine to spread like wildfire, like colonialism and Christianity, and how this can be understood as a form of foreign control. It was important to me to focus my research on how the biomedical and spiritual system work together and what this means in a broader, global and political context.

Mental illness has a political, economic, and religious rhetoric that makes the problem relevant not only to the medical system, but also to government, economic productivity in society, health-care spending, prayer camps, and others. Reading Fullwiley's, *The Enculturated Gene* and *The Biological Construction of Race*, I came to understand how something so deeply rooted in medicine like sickle cell can also have deep body politics and social bodies, like my own study. I appreciated Fullwiley's statement, "The markers collected for this technology were triangulated to reflect race in North America, a mutable trait of the science that will continue to correspond to aspects of researchers' cultural and political lives that are currently (un)seen within the technology itself." Although we are inspired to conduct research meaningful to ourselves, it is critical to ensure that identity politics, pertaining to these scientists being scientists of color, do not misdirect the work that we do. As a West African woman, I grew up with the ideas that religion and culture prevented me from normalizing aspects of mental health because that was what my social networks and familial relationships believed. Recognizing this and reading Fullwiley's articles has made me more reflexive about the biases I carry into the field to mitigate them in my work. It also opened my eyes to see how the psychiatric institution can perpetuate some notions of superiority through the body politic and social body by othering individual bodies of the mentally ill whom it is trying to help.

Chapter 2: The Mental Health Non-Profit Sector

The mental health non-governmental organization system in Ghana provides a compelling medium between the biomedical and spiritual healing systems. Grassroots organizations like the ones I research in Ghana produce tremendous progress each day by being directly accessible to the community, actively participating in policy change, participating effectively in education campaigns, and being able to solve non-severe psychiatric issues. They serve areas typically left in need -- like Northern Ghana, mid-Ghana, and the Southern/Coastal Belt. My last chapter entailed a deeper analysis of the work being done by the Ghanaian Psychiatric system; and, I hope to do the same thing here by focusing on the Ghanaian Mental Health NGO system. Chapter one describes in detail how access to biomedical psychiatric care is challenging due to

transportation and funding issues. How are NGOs able to combat these problems and support mentally ill populations in underserved areas? Is it possible, through increased education, to dispel myths to change paradigms related to mental illness and motivate others to invest in mental health, creating a virtuous circle?

I argue that the NGO strategy of reintegrating the mentally ill into society (by creating work for them and normalizing them in the eyes of Ghanaian society) is a way to break the cycle of the stigmatization of the mentally ill and gather more support and funding for mental health. An observation from both the prayer camp and the biomedical psychiatric institution is metaphorical “walls.” People go there and seem unable to fully return and integrate into their own communities, thereby ‘othering’ the mentally ill. The NGOs have thus dispelled the myth that the mentally ill cannot function or are not useful to society. The NGOs have empowered those suffering from mental illness with work skills, thereby ‘normalizing’ them in the eyes of the community. In this chapter I will focus on the history of the NGOs I have researched, my field experiences with the CEOs and psychologists of these organizations, and the relationships of the NGOs with the larger political, economic, and biomedical landscape in Ghana. I will investigate the NGO’s role in Ghanaian society and how this came to be. I will ground my analysis in my qualitative interview data and participant observations. My interviews offer invaluable insight into NGO structure, societal perception, and relationships with other actors in my fieldwork (religious, biomedical, and political professionals). Media discourse is an integral part of the perception of the psychiatric hospital and its place in society. Therefore, at the end of this chapter, I will analyze the NGO’s role in impacting mental health-seeking behavior through its relationship with the mainstream media.

Interestingly, my trips to these NGO sites were less nerve wracking and had reduced the stigma surrounding them simply because their appearance hardly showed what they really were - mental health organizations. I saw no sign that these places were for the “mad,” as some would say. As I wondered the reasoning behind the designs of some NGOs, a psychologist at the Progressive Life Center (PLC) described, “I realized that the majority of the people who I was consulting didn’t feel comfortable when they were visiting the clinic...so due to that we had to disguise the name, PLC, so that people around would not accurately describe or could not exactly know the type of services that are being rendered.” In this sense, this non-profit, deep within the community, was making their services accessible and decoupling it from mental health. But is it enough to disguise mental health services? Is this merely a band-aid to deeper issues of othering and stigmatization, major principles that are deeply embedded in the social body and politic?

NGOs, Policy, and Normalization of the Mentally Ill

Stigma is observed at the highest levels of policy. When first written in 1992, the Ghanaian Constitution espoused that those who could vote were those who were citizens, of age 18 years and above, and with “SOUND MIND.” Lawyers have fought to remove such a clause and may go to the Supreme Court because “SOUND MIND” refers to people without mental health issues or intellectual disabilities. Many opponents to this clause consider it irrational, because who can honestly determine “sound mind?” There are people who appear to be healthy on the outside, but who have struggled with anxiety and depression all their lives.

Kofi Gyasi, the CEO of Inclusion Ghana, an NGO that supports individuals and families dealing with children with stigmatized Intellectual Disabilities (ID), recognizes challenges in educating the community on misconceptions concerning mental health and “sound minds.” He describes that when it is difficult to put a cause on a particular matter, like mental illness or intellectual disabilities with no “cure,” by default the cause is spiritual in Ghana and similar predominantly religious countries. For example, some parents have been in denial about their children’s illness for years. Some may believe an “aunty” in the family who believes that their child will be more successful than her children curses their child and causes their disability.

In another case, there was a meeting Mr. Gyasi had with a man who came all the way from the North to talk about his child. The wife was waiting on the phone with the man to find out if Mr. Gyasi would have a cure for the child’s ID. As the meeting went on, the wife eventually said “If they don’t have any cure, you just come home.” In another instance, Mr. Gyasi told me about some members of Parliament, one in particular from the Parliamentary Select Committee on Agenda of Children and Social Protection, asked him, “Why do we really want to keep these children that can’t even be cured? For what?” It was appalling for him to hear that from an individual working on such a committee in Parliament because their commentary showed ignorance and insufficient regard for the Social Protection of children with ID. If these are the kinds of people who make policy decisions, one can imagine how difficult it is to make progress in mental health without the government’s will. Mr. Gyasi even details stories of how when some children get a disability, some parents will not give the child medicine, not take the child to the hospital, and try to get to a situation where the illness can kill the child and end the story.

How can Ghana address deep-rooted issues of stigmatization of mental health or ID? The key is education and attacking ignorance head on. Mr. Gyasi has witnessed many changes in how parents realize the legitimacy of their disabled childrens’ lives and recognize the importance in supporting and caring for these children. The strategy he uses centers on raising awareness. He has developed a strategy to teach parents, who understand their children better than anyone else, to create “The Parents Health Goals” and communicate these goals in support groups. Mr. Gyasi tells me that there are over 150 parent groups like this and each parent

group has no less than 12 people. The point of these groups is that they have different experiences and understanding of their children, but they can share common interests in supporting their children. Mr. Gyasi describes how some children with ID throw tantrums due to high sugar intake. Sharing such things in these support groups can help other parents who have experienced similar problems and help them look after their children. Sometimes people are surprised that other people have children with similar issues to their children. It gives them hope with their own children. Another way in which these support groups work is to advocate for the rights of disabled children on a grassroots level. If, for example, a child is refused admission to school, people who are connected through the support group can go to that school and say that we cannot accept that. There is power in numbers.

Furthermore, Mr. Gyasi's organization drives efforts to educate authorities in the community about ID. He tells me that people would be surprised that some of these chiefs even have children with ID but do not allow their children to be in the palace or in public. He tries to change this dynamic and encourages people to speak about their own issues to normalize perceptions on mental illness or ID. Mr. Gyasi and other mental health advocates forge efforts each day to educate others on how mental illness can be managed and how one can live a normal life. Crucially, however, people, especially those in authority who have dealt with mental health issues or ID, have the opportunity to shift the paradigm concerning perceptions about "sound minds."

Basic Needs Ghana and its CEO, Peter Yaro, are very focused on normalizing mental health conditions and breaking stigma by supporting these individuals with "basic needs" to reintegrate into the community. They reach out to people with mental illnesses and help them get treatment. As these people get better, Basic Needs helps them with productive activities such as creating crafts they can sell. From there, they can show their families and communities that they are valuable members of society despite what many believe. Some of them even engage in income-generating activities, which helps them to reintegrate into the family, because their economic abilities give them a certain status within their family.

Education + Stigma

PLC, an NGO I brought up earlier in the chapter, organizes workshops and programs for schools so they can spread messages about mental health. They have a workshop for parents with children with developmental delays. Numerous Ghanaians with these children lock them up in rooms. They are not comfortable with the criticism or comments towards their children. So, these children are locked in rooms and sometimes are not allowed out until it is nighttime and no one is around, which makes the condition worse and violates their human rights.

Another agenda which the PLC psychology unit aims to address is surroundings. Dr. Acquah, a psychologist at PLC, details how the Ghanaian government spends millions to control malaria but fails to realize how the issue is affected by psychology and social factors. She says, “So if we are spending millions [of Ghana cedis] to buy treated mosquito nets and to buy malaria medications. How about the people’s behavior? How can there be a behavioral change so that people will take responsibility? [So that] people will understand hygiene and cleanliness?” She makes a striking point that can be a major strategy in her education agenda. If one is mentally unfit and unaware of various behaviors, they cannot solve certain problems that affect their health, such as malaria, which requires lifestyle changes.

The only problem others have with such education campaigns is the use of too much psychiatric terminology that the average person does not understand. Mr. Gyasi senses that it becomes dull and people will turn off the television or skip such new articles. He also believes that there is not enough of this education in the national language and that it is therefore not accessible to the people who need it most, those in rural and northern areas of Ghana. This may require considerable work, but it would be most helpful in reaching those who are difficult for the mental health system to reach.

Decentralization

Although there has been a huge push to decentralize the mental health system, I wondered what people on the ground have thought of such strategies. Mr. Danso of Mind Freedom Ghana, another mental health NGO, believes the Ghana Mental Health Authority must ensure they take all the people suffering from schizophrenic illnesses off the streets. Only then, such organizations in the community can give them sheltered work - meaning give them a type of work with demands that are not extreme, flexible time to work according to their own pace, and an opportunity to feel useful and helpful to society. Secondly, Mr. Yaro of Basic Needs senses the need to encourage psychiatrists to come out of the psychiatric hospitals and go into the outlying areas, rural districts, district healthcare facilities, district hospitals, and sub-district healthcare facilities. In these areas, psychiatric units can be set up to provide specialized services like diagnosis, prescriptions and associated mental health care, thereby improving the capacity for better early detection and monitoring. In this way, anyone requiring mental health care can have access to and receive accurate, quality care.

Many agree with such views, but they also believe this movement must not only involve the psychiatrist. Dr. Acquah, of PLC, believes there is insufficient manpower, in the administration of medications for mental health problems. She had some negative views about the psychiatric assistants because she believed they had limited training and experience, as some of them had recently graduated from high school but were trained

to administer drugs. Ghanaian psychologists like Dr. Acquah consider this inappropriate. Instead, they believe that training in the medication administration can be directed at some psychologists interested in prescribing limited drugs, perhaps for emergency use at the community level. Those requiring long-term care will continue to be referred to psychiatrists. Dr. Acquah also believes referral to psychologists for behavioral therapy from psychiatrists can be improved. She understands that medical doctors cannot do much behavioral therapy because their staff are stretched compared to the numbers of cases they are observing. What she does say, however, is that they should refer patients to mental health units where psychologists are present so that they can conduct behavioral therapy for patients.

Collaboration

Last, but not least, I wanted to understand what NGO leaders envisioned as a collaborative realm between religious, biomedical, and NGO leaders. Dr. Acquah, head of the PLC, made some illuminating remarks about religion in the mental health system. She calls on religious individuals to understand that “God himself created man to discover science.” As long as science is discovered, Dr. Acquah describes, both systems can be used, prayer and science, if there is a problem, Dr. Acquah says both systems can be utilized, prayer and science.

What she has also realized is that some people who run spiritual centers are people who make things worse for the patient. She wonders, for example, how some pastors can ask someone suffering from serious mental illness to fast. She questions the basis of some of the practices pronounced in prayer camps and wonders where the ideas these pastors incorporate into the bodies of these patients come from. She wonders if these are truly directives of the creator. Sometimes these practices make things worse, because even when people are sick, they have to stay up all night in prayers. Therefore, she believes that pastors who use such spiritual methods need to be trained and take a mental health management course so that they know how to treat the person correctly. Prayers and the spiritual system will not simply disappear in Ghana; but, we must learn how to work with them.

Many see the positive in working with the prayer camp / religious system. Peter Yaro, director of Basic Needs Ghana, describes the positive aspects of prayer camps and how one becomes like a member of the family. This draws parallels to Chapter 3 in Fullwiley’s *Enculturated Gene* and how social networks can improve healthcare outcomes. Spiritual healers offer a considerable amount of talk therapy for which the few Ghanaian psychiatrists or psychiatric nurses do not have as much time to do. Mr. Yaro describes how “They also have all these kinds of drumming, dancing, and singing that may not be pills but have a sobering effect on people who are agitated. This may bring people out of stressful situations when they [experience] a degree of relief, even if only for a short time.”

There is a substantial amount of emotional healing that can be gained from prayer camps.

Another important therapeutic approach that NGO leaders see in the prayer camp is occupational therapy. Most psychiatric hospitals do not have functioning occupational therapy departments. At the time, there was only one occupational therapist for the whole country. Mr. Yaro explains, “Some of these traditional and faith-based healers have farms where people who they perceive to have improved a little are encouraged to come to the farm and work.” This helps to support the healers and provides the opportunity for the mentally ill to undergo occupational therapy. This is why I argue that cooperation in all sectors is crucial to progress in Ghana’s mental health system.

Conclusion

In my final analysis, I conclude that the roots of the problems behind mental health are education, resource allocation, awareness that mental health covers a wide range, and an understanding that people need to look after their mental health and well-being, combined with concern for their physical health. In many parts of Ghanaian society, there is insufficient education about mental illness, which contributes to stigmatizing the mentally ill. This further contributes to negative interactions with the individual body of the mentally ill by maintaining a negative social body and environment for mentally ill people. Stigma also contributes to lower use or access to mental health services due to negative perceptions. This stigma also has deep colonial and political roots that contribute to the body politic by reducing government funding for mental health facilities. As one community health nurse put it best in one of my interviews,

There are funds for TB. There are funds for HIV. There are funds for whatsoever but mental health. We suffer even before we get to the prayer camps... Some of [these patients] came from home or directly from the psychiatric hospital and are just abandoned. Sometimes I realized that I would even call the relatives and that they even [turned] off their phone because you are calling about their son or daughter.

This is a never-ending cycle in the history of mental health in Ghana. Furthermore, the social safety net of the prayer camp, as a place where all those who have been abandoned by their family are cared for, reinforces this cycle. Therefore, I argue, decentralization does not solve this problem, because the problems of the social and political body are so deeply rooted in culture and cannot be changed without a complete revolution of what it means to have a mental illness (normal life can still be maintained, mentally ill people can still contribute to society, and so on).

From my interviews, I give a clear picture of what needs to be done in Ghana to achieve sustainable progress. The government must show as much respect for mental health as they do for communicable diseases like TB. This could be achieved by increasing funding for medical necessities for mental health institutions or perhaps by providing rehabilitation facilities for the mentally ill so that they do not have to live on the streets

of Ghana. This respect can also be found if more trained staff, equipment, and infrastructure are available to deal with mental illness, rather than overburdening the biomedical psychiatric system. The social body can profoundly help the body politic through social agencies or mental health non-profit organizations such as Basic Needs, which provides rehabilitation and reintegration services. Such organizations are crucial to changing the perception of what it means to live with a mental illness that affects the individual body and self-esteem, the social body and its stigma, and the body politic and notion that mentally ill people can make an economic contribution to Ghanaian society.

Once these foundations are in place, I would like to see mental health services available in every health facility so that anyone can go to the nearest health facility and be cared for by a psychiatric nurse, psychologist, or mental health professional or assistant. Once there is a human resource that includes basic education so as not to stigmatize the mentally ill, real and sustainable progress may be made.

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Appendix

Interview questions

1. Opening question to make interviewee comfortable: How did you come into this job (i.e. working in mental health/with mentally ill patients)?
2. What is your experience engaging with the local Ghanaian community concerning mental health?
3. What are your thoughts on what the local Ghanaian community thinks about mental illness and the mentally ill?
4. What do you think is the view/reputation of the mental health system and asylum in the African community?
5. Do you agree with this view/reputation? If so, why? If not, why not and what do you think can be done to combat this representation or misconception of the system?
6. Can you describe the religious system of healing to me?
7. About how many people do you think use the hospital mental health system, religious healing, or both?
8. Why do you feel people may use one system or the other or both? Why do you think people may turn to religious healers such as pastors rather than psychiatrists for mental illness? Or possibly even use both?
9. If there was only one mental health system that incorporated both aspects of the medical and religious (e.g. prayer based healing - the casting out of demonic influences and the lifting of curses) systems, what would it look like?
10. In the next five years, what changes do you believe need to occur in the mental health system? What role do you feel the economy, politics, and/or religion plays into this?
11. What would you say have been the most profound signs of change in the mental health system? What is getting better or worse?