A Study of Stigma, Discrimination and Reintegration of Mentally Ill Persons in Ghana

YAO YEBOAH
KOJO OPPONG YEBOAH GYABAAH

ABSTRACT

Mental health is the foundation of human capability that makes each life worthwhile and meaningful. There has been great progress in mental healthcare in Ghana over the years but too many people are still left behind from reintegration into society after recovery due to discrimination and stigma. In order to harness the full potential of the human resource, there is the need to reintegrate all treated mental health persons. It is for this reason that the Christian Health Association of Ghana which operates over 280 healthcare institutions in Ghana is seeking to deconstruct the way mental healthcare is delivered. The programme seeks to shift from institutional care to community-based care involving interventions by health professionals, peers and key members of the community. The purpose of this study was to gauge knowledge and attitude to stigma, discrimination, and community-based mental healthcare. The country was divided into three zones; coastal, middle and northern. From each zone, an urban and a rural site were selected. Using mixed method approach, qualitative data from caregivers and religious leaders was purposively generated while quantitative data from Junior High School students and nurses was randomly collected. Results showed that age, ethnicity, education, religious affiliation, and occupation were some of the key variables which influence reintegration of treated mentally ill persons. The study concludes that stigma and discrimination against the mentally treated person is a complex issue which needs multifaceted and multi-disciplinary approach including community and home care to solving it.

Keywords: *Mental health, discrimination, stigma, community-based, reintegration*

Introduction

In many countries, people with mental disorders routinely suffer gross human rights violations. Many mentally ill/treated persons in Ghana are increasingly looking like outliers as they face exclusion and marginalisation in the form of social stereotyping, harassment and or denial of basic rights like healthcare, employment, education and refusal to admit them back home. This often leads to poor treatment outcomes, communication, interpersonal relationships, and reintegration. The national constitution, the mental health act, and other legislations in Ghana in no uncertain terms mandate citizens and organisations to provide the mentally ill person equal access to opportunities, services, and embrace diversity in order to promote exchange of creative ideas and improve performance.

Mental health is a state of well-being in which every individual realises his or her own potential, can cope with normal stresses of life and can work productively and fruitfully and is able to make a contribution to his or her community (WHO, 2004). Institute of Medicine (1997) attempted to provide a contextual framework for understanding health and its determinants by the introduction of a number of variables including the role of different environments and individual response to healthcare. It argued that what matters to individuals is not simply the absence of disease, disability, or death, but also their responses to symptoms or diagnoses; their capacity to participate in work, family, and community; and their sense of well-being in many spheres. The physical, psychosocial and spiritual contexts are therefore, key to re-integration of mental health patients.

Mental disorders impose an enormous disease burden on societies globally. Depression alone affects 400 million persons and it is the single largest contributor to years lived with disability worldwide (World Bank and WHO 2016). Despite its enormous social burden, mental disorders continue to be driven into the shadows by stigma, discrimination, prejudice and fear. According to the World Bank (2016), just about 3% of total Government spending worldwide is for mental health in spite of its importance.

The Mental Health Act of Ghana (Act 846, 2012) defines mental healthcare to include the "prevention and management of mental disorders and rehabilitation of persons with mental disorder". This definition encompasses the provision, equipment and maintenance of residential accommodation and the care of persons. Resourcing Mental Health Authority for efficient operation, however, is a major challenge facing the country.

Indeed, mental healthcare is a big challenge in Ghana reflecting in the number of mentally-challenged people roaming about on the streets thus posing risk to society. In spite of the fact that so many people are affected by mental health disorders in Ghana, people find it difficult to seek treatment, get integrated into their own families even after treatment or be economically self-supporting due mainly to stigma and discrimination (Tawiah, Adongo, & Aikins, 2015).

Stigma refers to stereotypes and prejudicial attitudes held by the public (Institute of Medicine, 2002). Mental health disorder-related stigma refers to any characteristics of mental disorder perceived as socially undesirable; hence, regarded as a spoiled identity that then exposes the affected person to social devaluation and discrimination (Goffman, 1963). Stigma and discrimination come from both the larger society and from families, friends and employers (Ogden & Nyblade, 2005). The stigma of mental illness deters people from seeking treatment for mental illness and thereby creates greater risk for suicide (Institute of Medicine, 2002). According to the chief psychiatrist of Ghana, stigmatisation, traditional beliefs and the law are some of the hindrances to patients opting for early medical attention in the country (Daily Graphic, 2015).

The Context of Mental Health in Ghana and Objectives of the Study

According to a study by Tawia, Adongo & Aikins. (2015), the level of stigma and discrimination in Ghana was unacceptably high. They broadly identified economic, social and psychological forms of stigma and discrimination. Socially, females suffered greater stigma and discrimination at workplace and at the educational level, family blame, ridicule, mockery and loss of self-esteem.

A literature review of mental health research in Ghana conducted by Doku and Read (2012) *showed that mental health research in Ghana remains limited in both quantity (66) and quality (none on stigma and discrimination). In the absence of comprehensive research, much is assumed based on scanty evidence, and services are heavily influenced by the results of research conducted elsewhere, most often in high income settings.*

Though this 2015 study was very revealing, it nonetheless was focused on only Ho Municipality. A study of national character on stigma and discrimination of mentally ill people and their caregivers as this one has done is therefore, most appropriate to fill the existing information vacuum. Reintegration of mentally ill people after treatment is a big challenge in Ghana and the findings of this study will inform policy and programmes geared towards acceptability and eventual reintegration.

The main purpose of this study therefore, is to inform policy on the selection of appropriate interventions to reduce incidence of stigma and discrimination, increase access to treatment, care and support, and to reintegrate treated people into their families and communities to become socially and economically productive. The specific objectives were to identify the underlying factors that fuel or perpetuate stigma and discrimination against people with mental health problems, document how stigma and discrimination are influenced by the context in which they occur and understand how stigma and discrimination affect access to care, support and reintegration.

The research questions were - do stigma and discrimination impact negatively on health care and reintegration of mentally ill people, and how is health care of mentally ill people and their eventual reintegration made possible in the absence of stigma and discrimination?

Method

The contextual, psychosocial, economic and behavioural dimensions of stigma and discrimination are better suited to mixed methods that can effectively capture values, attitudes and beliefs that drive the phenomenon. Qualitatively, purposive snowball methods were used to get key informants for interviews while quantitative method complemented the data. The use of multiple methodologies to collect the data made it possible for the data to be triangulated and validated to ensure reliability of the findings.

In order to achieve the objectives, the research relied on both primary and secondary data. In gathering the primary data, interview and questionnaire instrument were employed. Convenience sampling was used to select 650 participants and respondents (saturation point) from multiple stakeholders comprising treated persons, nurses, Junior High School pupils, clerics, and community members. Treated persons, caregivers, nurses and clerics were included for their experiences while pupils were selected for their perceptions as a foretaste of future attitudes.

Based on ecological, cultural, income, human development (health and education), spatial, and historical characteristics (World Bank, 2004, Bukari, Aabeyir, & Laari, 2014), the researchers classified Ghana into coastal, middle and savannah belts. Out of these, a region demonstrating predominance of each belt's characteristics was purposely selected; Greater Accra Region represented the coastal belt; Ashanti Region represented the middle belt and Northern Region represented the savannah belt. In each Region, urban and rural sites were selected. For each site, data was collected from students of the Junior High School (both Christian

and Muslims), Clerics (Christians and Muslim), and caregivers of mentally ill or treated persons. In each of the 3 Regions, one (1) Hospital of the Christian Health Association of Ghana (CHAG) where the community-based mental health programme was on-going was selected and some nurses (both on the mental health programme and others) were sampled.

The typology used for the selection of two districts was that, one urban and the other rural, were selected from each of the three selected regions. Greater Accra Metropolitan Area was urban district and Ga East and Dangme East districts as rural districts study sites in the southern zone. Kumasi Metropolitan Assembly and Asante Akim North District were selected as urban and rural study sites respectively in the middle zone. Tamale Metropolitan Assembly and Kumbungu District were the urban and rural study sites respectively in the northern zone. The last typology of health professionals termed CHAG medics from Psychiatric Units of Pentecost Hospital, Madina, Agogo Presbyterian Hospital and King's Medicl Centre, Bontanga. This category had the least number of respondents (4.6%) while each district had at least 15%.

The data which were gathered were analysed using Statistical Product for Service Solutions (SPSS). Relevant tables and figures were generated to aid better understanding of the issues being discussed. The secondary data used were relevant materials such as journals, books and the internet.

Study Limitations

The main limitation of the study was mainly the timing of the survey which was in December, a time when some of the Schools in Ghana were on break; so, getting students of the Junior High Schools was a challenge. In certain situations, the research team had to conduct house-to-house visits in order to reach the target students.

Ethical Considerations

Due to the sensitive nature of the research topic and its associated questions, great care was taken about ethical concerns. The purpose of the survey was conveyed to the respondents and they were assured that any information provided would be strictly kept confidential. The fact that, their personal names and even code numbers were not put on the forms relaxed them and this engendered effective interviews. The cost of the study to participants was their time. There was no remuneration. Participation in the study was voluntary and participants were told that they could withdraw at any point of the study without giving reasons for doing so and would not suffer any disadvantage of any kind. The findings were to be shared with policy makers, programme managers, religious bodies and others who are directly or indirectly linked to the mental health care and its related issues such as reintegration.

Findings

Demographic Characteristics of Key Informants

Using snowball and purposive sampling methods, 30 key informants were identified and interviewed. They consisted of 3 types comprising 3 mentally healed (recovered) persons, 7 caregivers mainly relatives and 20 religious leaders (Table 1). The sex of the afflicted comprised 2 women and a man. All the key informants from the clergy were male. Islamic clerics were predominantly male while no female Christian priests were found in selected areas. Table 1 also highlights the themes, challenges and key findings.

Table 1: Demographics of Key Informants

Types of informant	No.	Gender	Details	Themes/issues	Challenges	Observation
Afflicted	3	1 male 2 females	Agogo 2, Dalun 1	Causes, costs, coping, treatment	Relapse, stigma, treatment	Lack of continuity in care
Caregivers	7	1 Males 5 females	Ashaiman 3, Kumasi 2, Agogo 2	Causes, cost of care, recovery, integration	Lack of support	Care fatigue
Priests	15	All male	Catholic 4, Assemblies 2 Methodist 2, Baptist 2, Pentecost1, Kings Min. 1, Castle Zion 1 Presby 1, EP Church 1	Definition, causes, treatment, discrimination, role of religion, integration	Recognizing The differences between natural sicknesses and spiritual ailments	Fixation on capacity of afflicted and affected people to make the right care choices
Imams/ Sheikhs	5	All male	Ashaiman, Kasseh, Agogo Zongo, Asawase, Tamale & Dalun	Definition, causes, treatment, discrimination, role of religion, integration	Abstinence from haram	Less engaging in the management of mental health cases beyond orthodox care

Source: Field Data, 2018.

Analysis of the responses in Table 2 revealed that almost half of the respondents indicated that they were not in any gainful employment as they were either in school (46.5%) or just unemployed (4.3%). The data showed that nearly 8 in every 10 respondents professed to be Christian. The original design was to cover no more than 15% of respondents professing Islam. This target was exceeded largely due to the fact that 98% of people in Tamale and Kumbungu were Muslims (Ghana Statistical Service, 2011). More than two-thirds (67.5%) of the respondents were single, 30.6% married and 0.9% were divorced and widowed respectively. Just over a third of the respondents (35.2%) indicated that they were raising at least a child. About two-thirds (67%) of the respondents were between 10 years and 30 years of age or youth. The number of males and females interviewed was nearly even at 51.2% and 48.8% respectively. Over 8 of the 52 ethnic groups of Ghana were represented. Two-fifths of the respondents were Akans, 11.1% Ewe, Mole-Dagbane 17.8% and Ga-Adangbe 8.2%. Nearly 9 out of every ten of the respondents (91.1%) had attained at least basic education.

Table 2: Profile of respondents

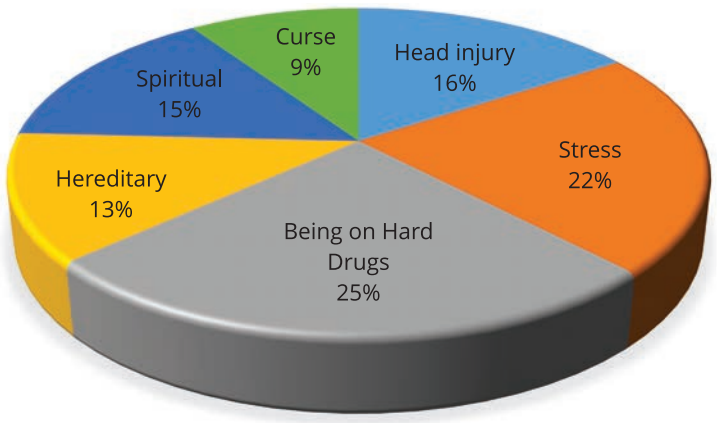
Occupation	No. of respondents	Percent
Artisan	36	5.5
Farmer	21	3.2
Health professional	35	5.4
Pensioner	2	0.3
Private Service Provider	2	0.3
Public/Civil Servant	34	5.2
Self-employed	44	6.8
Student	302	46.5
Trader	63	9.7
Unemployed	28	4.3
Other	83	12.8
Total	**650**	**100**

Source: Field Data, 2016.

Assessment of Perceived Causes of Mental Illness

Respondents were asked 'what are the causes of mental illness?' (multiple responses) and were allowed to name specific causes of illnesses or mental health problems that they had heard or knew of. Responses included depression, overthinking, stress, academic workload, drug and alcohol abuse or addiction, epilepsy, curse (affliction of the demons or genie, rukayah), accident, marital problems, financial challenges, and poverty among others. Figure 1 shows that 25% of respondents perceived drugs as the cause of mental illness, stress (22%), head injury (16%), spiritual factors (15%), hereditary (13%), and curse (9%).

Figure 1: Perceived Causes of Mental Illness



Source: Field Data, 2018.

Respondents were asked the question '*will you be prepared to go closer to a mentally ill person?*' The data shows that reaction of the respondents to the mentally ill person was generally favourable (50.3%), yet a significant percentage (37.5%) was not prepared to go closer to the mentally ill person. About three quarters (76.7%) of CHAG medics and 56.9% of respondents with tertiary education were prepared to go closer to a mentally ill person. Respondents aged 10-19 years (67.2%) and the non-employed (67.7%) were less likely to go closer to a mentally ill person. Respondents aged 40-59 years (23.0%) and those who had attained tertiary education (23.4%) were most likely of being indifferent to go closer to a mentally ill person.

When asked whether they will feel ashamed or embarrassed if a family member should be a mentally ill person, about 6 in 10 people interviewed (61.7%) said they will not feel ashamed, 36.0% said they will feel ashamed, and just 2.3% was indifferent. About 3 in 10 people (26.0%) said the mentally ill people were their own causes, 26.2% said the mentally ill people cannot be blamed for having caused their own illness, while about 3 in 10 people (27.9%) of the respondents were indifferent.

Assessment of Stigma of and Discrimination against Mentally ill/ Treated Persons

Key findings to the question, "have you seen an incidence of a mentally treated person being abandoned by a partner"? the results showed that 50% of the respondents know of abandonment of partners.

Key findings to the question, "have you seen an incidence of a mentally healed person being abandoned by a family"? showed that 4 in every 10 people (42.8%) had information about mentally healed people being abandoned by their families. Those with the highest level of information about this phenomenon were those with tertiary education and health personnel.

Key findings on knowledge of incidence of mentally treated person being excluded from social gatherings showed that 5 in every 10 people (50.5%) of the respondents said they had seen incidence of mentally treated people excluded from social gatherings. Those with relatively higher knowledge of exclusion of mentally ill/treated persons from social gatherings were health personnel, tertiary graduates, Mole-Dagbanes, rural people and teenagers.

Key findings to the question, "have you seen an incidence where a mentally treated person was being abandoned by employer or lost job"? showed that 54.6% had knowledge that mentally treated person were denied job by employers.

Key findings on knowledge of incidence of mentally healed person being teased showed that 67.7% had seen mentally treated person being gossiped about. The segments of those sampled with the highest level of information seeing mentally treated people being denied jobs were Mole-Dagbanes, people with tertiary level education, those aged 20-39 years and health personnel.

Key findings on knowledge of incidence of mentally treated person being gossiped about showed that 75.7% had seen mentally treated people being gossiped about and had been observed mostly by teenagers, Mole-Dagbanes, people with tertiary level education and those unemployed. Key findings on knowledge of incidence of mentally treated person losing respect or social standing within the family, the community or both showed that 66.3% confirmed having seen and had been observed mostly by teenagers, people with tertiary level education, Akans, Christians and people living in rural areas. Key findings on knowledge of incidence of mentally treated person being denied health services, education or other social services showed that 36.5% had seen such cases and had been observed mostly by people aged 60 years and above.

Key findings on integration of the mentally ill-treated into the family and the community showed that 82.9% indicated that they were prepared to

stay with a mentally treated person and this behaviour was observed mostly among all health personnel (100%), people with tertiary level of education (88.2%), married people (87.4%), Muslims (86.9%), Ga-Adangbe people (86.8%) and those aged 40-59 years (86.0%). Conversely, those least prepared to stay with mentally treated people were Ewe people (19.7%), teenagers (18.1%), unemployed (16.6%), unmarried (16.2%), basic education (16.3%), Christians (14.8%), and Urban people (14.5%), and men (14.1%).

Discussion

Poor Understanding of Mental Conditions Create 'Attitudes'

Attitudes toward mental illness vary among individuals, families, ethnicities, cultures, and countries. The basic values that are common to all religions are solidarity, compassion and respect for the human person. Beliefs about mental illness can affect patients' readiness and willingness to seek and adhere to treatment (Nieuwsma, Pepper, Maack, & Birgenheir, 2011). Understanding individual and religious beliefs about mental illness is therefore, essential for the implementation of effective approaches to mental health care.

A Roman Catholic Father in Tamale explains as follows:

> *Human beings are made up of physical and spiritual components. These components coordinate together to be normal. Challenges emanating from both the physical and spiritual realms push people to behave abnormally. The person's background (family, community, and social environments where he/she was raised) counts in relation to ability to withstand shocks or otherwise (mental health and stability). Influences and pressures push people to do things that result in mental illness*.

Fear Causes Stigma and Discrimination

A careful analysis of assessment relating to attitudes toward the mentally ill persons highlights fear and violence as leading to the behaviours observed. At the same time, three variables namely age, education and employment have greater correlations to preparedness either to go closer to the mentally ill person or not. For each of these variables, the percentage of respondents that was not prepared to go closer to the mentally ill person was greater than those who said they were prepared to go closer to a mentally ill person. One religious leader in Kumbungu District offered insight into why this is so:

> *People tend to reject the mentally ill person because of the way they (the mentally ill persons) behave including stealing, vulgarism, aggression, nudity, demonic possessions, and unpredictability.*

Among the reasons given by the 50.3% respondents for indicating that they were prepared to go closer to the mentally ill person included the fact that, they want to show compassion.

Unkempt Appearance Results in Moral Judgement

Cultural and religious values often make us judgmental of others whom we feel do not conform enough. This way of assessing the mentally ill persons can be very misleading and may lead to reinforcement of culturally and religiously held views or stereotypes which could pose challenges to the success of health and social interventions.

Although the quality and effectiveness of mental health treatments and services have improved greatly over the years, the impact of therapeutic revolutions is less than desired due to stigma of shame especially from family members. Feeling of shame is a risk factor leading to negative mental health outcomes. It is responsible for treatment seeking delays and reduces the likelihood that a

mentally ill patient will receive adequate care (Shrivastava, Johnston, & Bureau, 2012).

One of the religious leaders interviewed during this study aptly and succinctly explained this point in the following words:

> *The human person is full of honour, respect and dignity and mental illness diminishes these traits and attributes. Due to these circumstances society judges both the afflicted individual and affected relations as having failed in their duty to train rightly and this makes them not wanting to identify with the mentally ill person.*

Other reasons adduced to justify why they 'will feel ashamed if a member of their family is mentally ill' included comments like: *"People will gossip about me". The mentally ill may be shabbily dressed, be naked or behave violent towards other people".*

Blame Undermines Efforts to Reintegrate the Mentally Treated Persons into the Community

Changes in societal attitudes towards the mentally ill persons are often based on lack of understanding about the nature of the illness itself and behavioural symptoms associated with the conditions. Some of the leading explanations offered by the respondents who agreed with the view that 'mentally ill persons are the causes of their own illness' to justify their perceptions included opinions like:

> *If one does not smoke or abuse substances as marijuana and alcohol, one will not suffer/will not be afflicted by any mental illness*", "*the mentally ill persons are the causes of their own illness.*

Nonetheless, some respondents disagreed with the claim that 'mentally ill persons are the causes of their own illness' included opinions as:

> *It is not their fault, mental illness can happen unexpectedly*", "*mental illness can be caused by an individual's genetic make (hereditary).*

Conclusion

Stigma and discrimination are great barriers to care, support and reintegration of the mentally ill/treated persons globally. To the extent that some family members feel shy to visit their members with mental illness at designated psychiatric hospitals amply demonstrates the level of stigma associated with mental health. Until recently, not much attention was given to mental health care in Ghana. The institutionalised system of health care for the mentally ill persons has further worsened the issue of stigma. Health personnel have not been properly trained to provide comprehensive health care in the non-designated psychiatric hospitals. Thankfully, Government of Ghana is gradually demonstrating some commitment to mental health. The Mental Health Act is now in operation but resources for its effective implementation are woefully inadequate.

The study revealed a gap in the knowledge, attitude and practice of some members of the community concerning mental illness. Some of the correspondents indicated a high level of awareness of discriminatory practices against the mentally ill/treated persons which they are not happy about, yet said they would feel ashamed if a member of their families was a mentally ill person. They were unprepared to go close to

a mentally ill person and also blame the mentally ill as having caused their illness. This disconnect is worrying.

The stakeholders such as Christian Health Association of Ghana have shown the way to improving the health situation of the mentally ill and to support them to be effectively reintegrated into their families and communities. Since 2013, when the programme started with funding from DfID, a number of initiatives have been instituted by the CHAG Secretariat including the training of a number of health personnel from designated CHAG member Hospitals. CHAG commissioned this study of stigma, discrimination and reintegration of the mentally ill/treated persons in order to inform policy and reshape strategic interventions so as to make the right impact. The recommendations which follow are aimed at reducing stigma and discrimination against the mental ill persons and to effectively reintegrate the mentally treated persons into their families and their communities at large.

Recommendations

Create more Awareness about Stigma and Discrimination.

To effectively tackle stigma, greater recognition needs to be given to it. People should not shy away from openly discussing stigma and discrimination against the mentally ill people in the family setting, community, workplace and in the church/mosque. More education needs to be done to reduce stigma and discrimination.

Use Mentally Treated Persons to Champion the Stigma and Discrimination Strategies.

In order to give a human face to stigma and discrimination, programme managers should use mentally treated persons as ambassadors. The use of HIV/AIDS ambassadors to educate people to stop stigma and discrimination against People Living with HIV/AIDs has to some extent, demystified the menace. A similar approach should be adopted for the mental health programme.

Empower Families to Provide Care and Support for the Mentally Ill Persons

The study shows that some families with high level of compassion, continue to provide care and support to their mentally ill family members. This has however, not been easy emotionally and financially. Mental health programme managers should find strategies to empower families providing care and support to mentally ill/treated persons to confront stigma and discrimination they and their loved ones face.

Use School Health Education Programme for Stigma and Discrimination Reduction Interventions.

Stakeholders in healthcare should take advantage of school health programme for stigma and discrimination reduction interventions. The study found out that, teenagers are among the segments of the population who are judgmental about the mentally ill and are unprepared to stay with mentally treated persons at home. A collaboration with the programme managers of the school health programme could engender positive and compassionate attitude of the young people in the society.

The Role of Faith-Based Organisations, Religious Leaders and Congregants.

Faith-based organisations, religious leaders and congregants play central role in both perpetuating or reducing stigma and discrimination against the mentally ill/treated persons. Religious leaders

should develop non-stigmatisation service provision and stigma reduction programmes in churches and in mosques and emphasise non-stigmatisation messages in sermons, religious and other faith-based activities.

The Role of Health Care Institutions

In line with the Mental Health Act 2012, training should incorporate non-stigmatisation and caring attitudes in the training of health personnel at all levels. It should also improve case management of mental illnesses at all levels of care, strengthen community mental health services, referral and support systems. Government should show more commitment to mental health by allocating deserving resources for it.

References

Angermeyer, M. C., & Matschinger , H. (2005). The stigma of mental illness in Germany: A trend analysis. *International Journal of Social Psychiatry, 51*, 276-284. Retrieved 02 11, 2017

Daily Graphic. (2015, September 15). *Ghana records 1,500 suicide cases annually.* (G. A. Nyav, Ed.) Retrieved 06 03, 2017, from Grahpic Online: http://www.graphic.com.gh/news/general-news/ghana-records-1-500-suicide-cases-annually.html

Galderisi , S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015, Jun 4). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231–233. doi:10.1002/wps.20231

Ghana Statistical Service. (2011). *2010 Population and Housing Census, results, findings.* Accra, Ghana.: Ghana Statistical Service.

Hinshaw , S. P., & Cicchetti, D. (2000). Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy. *Development and Psychopathology, 12*(4), 555-598.

Institute of Medicine. (2002). "9 Barriers to Effective Treatment and intervention.". In Institute of Medicine, & Institute of Medicine (Ed.), *Reducing Suicide: A National Imperative* (pp. 331-374). Washington, DC: The National Academies Press. doi:https://doi.org/10.17226/10398.

Limited, G. P. (2012). *Mental Health Act 2012 (Act 846).* Accra: Assembly Press.

Nieuwsma, J. A., Pepper, C. M., Maack, D. J., & Birgenheir, D. G. (2011). Indigenous perspectives on depression in rural regions of India and the United States. *Transcultural Psychiatry, 48*(5), 539-568. Retrieved 02 2017, 18

Shrivastava, A., Johnston, M., & Bureau, Y. (2012, Jan-Dec). Stigma of Mental Illness-1: Clinical reflections. *Mens Sana Monographs, 10*(1), 70-84. doi:http://doi.org/10.4103/0973-1229.90181

Tawiah, P. E., Adongo, P. B., & Aikins, M. (2015, March 15). Mental Health-related Stigma and Discrimination in Ghana: Experience of Patients and their Caregivers. *Ghana Medical Journal, 49*(1), 30-36. doi:http://dx.doi.org/10.4314/gmj.v49i1.6

WHO. (2004). *Promoting mental health: concepts, emerging evidence, practice (Summary Report).* Geneva: World Health Organisation.

World Health Organisation. (2002). *Gender and Mental Health.* World Health Organisation, Department of Gender and Mental Health, Department of Mental health and Substance Dependence,. 20, Avenue Appia, Geneva, Switzerland: World Health Organisation. Retrieved 02 21, 2017, from http://apps.who.int/iris/bitstream/10665/68884/1/a85573.pdf

ABOUT THE **AUTHORS**

Yao Yeboah, currently a Lecturer in Health Systems Management at the Pentecost University, Ghana is a Ph.D. Holder in Health and Development Planning. He also holds M.Sc. in Epidemiology and Health Planning and Postgraduate Certificate in NGO's, Decentralisation and Management. He has several years teaching experience in a number of Universities in Ghana. He is currently a Member of the Christian Health Association of Ghana (CHAG), the 2nd biggest provider of health service in Ghana and also the Chairman of the Ghana Health Service Governing Council. He can be reached on 0243-581014/ E-mail yaoyeboah@yahoo.com

Kojo Oppong Yeboah Gyabaah, a Ph.D. holder is a Lecturer in Medical Geography (Population, Gender and Health) in the Department of Geography Education in the University of Education, Winneba, Ghana. His teaching and research interests are structure and trends of the population, demographic change, ageing, immigration, fertility, changes in ethnic, racial composition, health and well-being, disease, illness, spatial epidemiology, disease ecology, spatial aspects of healthcare delivery, and health care policy. His contact is +233-(0) 2440-28819/ Email koygyabaa@uew.edu.gh.