SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

STIGMA AND DISCRIMINATIONS SUFFERED BY MENTAL PATIENTS AND THEIR CAREGIVERS IN THE HO MUNICIPALITY OF GHANA

BY

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DECLARATION

I, Priscilla Elikplim Tawiah, do declare that with the exception of other people's work that were used as references, which were acknowledged, all other works were carried out by myself under the supervision of Dr. Moses Aikins. This work has never been presented in whole or part for the award of any degree in any University. I would therefore accept responsibility for any error that occurs in this dissertation.

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DR. MOSES AIKINS DATE

(ACADEMIC SUPERVISOR)

DEDICATION

This work is dedicated to Gabriel, Phillip and Emmanuella, for everything.

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In coming this far in my academic life, I have the privilege of being supported and encouraged by many people at various stages in this journey. Many of these people, I may not be able to mention here. There cannot be enough words and space to express my appreciation to the numerous people who have helped me through this journey.

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ABSTRACT

Stigma and discrimination is becoming a global issue that permeates many communicable diseases. Stigma creates a barrier between the sick and the rest of society that prevents them from acting on their instinctive desire to seek curative treatment that will enable them to reenter into their everyday social activity. This study was done in Ho Municipality of Ghana. It explored the forms of stigmatization and discrimination against mental disorders, social meaning and the coping strategies adopted by mentally ill and their care givers. The study adopted mixed method using structured questionnaire and semi-structured interview guide. Two hundred and seventy seven mentally disordered patients were purposively interviewed. Four Focus Group Discussion were held for caregivers and five mental health professionals were interviewed as key informants. The quantitative data were analysed using SPSS and Excel whilst the interviews were coded and analysed thematically. The study generally revealed that Mental disorder appears to cut across all categories of human background; age, gender, education, ethnicity, employment, marital status. More females were stigmatized than males at the work/employment and educational levels. The forms of stigma and discrimination noted at the patient level were of social stigma (including hiding from public, verbal abuse, family blame, ridiculing and mockery of family members and colleague patients looking mean upon the individual) and psychological stigma (i.e. loss of self-esteem) and economic (i.e. no food). Social forms of discrimination associated with mental disorders include loss of friends, spousal desertion, exclusion from family and withdrawal or refusal of admission into schools. Others include refusal of the community members to marry from their families, and denial and delay of access to medical treatment. Economical discriminations suffered include loss of financial support, no access to clothing, loss of accommodation and no food. Caregivers also were stigmatized and discriminated as due to their specialty. The coping strategies adopted by the mental patients and their caregivers against

stigma and discrimination include aggression, hope in God, Prayers and hoping condition will change one day. In conclusion, stigma is a social sickness attached mental disorders thereby making the disease burden heavier.

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LIST OF ACRONYMS

DALY	Disability Adjusted Life Year
FGD	Focused Grouped Discussions
GHS	Ghana Health Service
GOG	Government of Ghana
HR	Human Resource
IGF	Internally Generated Fund
KII	Key Informant Interview
MDAs	Ministries Department and Agencies
MDGs	Millennium Development Goals
NGOs	Non-Governmental Organisation
RMNs	Registered Mental Nurses
WHO	World Health Organisation

DEFINITION OF TERMS

ITEM	OPERATIONAL DEFINITION
Psychosocial	Concerning the mind (psychological) and social aspect of live, as well as relationship with significant others and the society or the community in which the client lives.
Coping	Activities mental patients and their care givers engage in, in order to reduce their psychosocial challenges.
Caregivers	A person who is responsible for attending to the needs of dependent mentally ill person. It may be a relative of the patients or health personnel.
Mental Disorders/ Illnesses	A group of disease of the mind; the psychological state of someone who has emotional or behavioural problems serious enough to require psychiatric intervention.
Stigma	A mark of shame, disgrace or disapproval which results in an individual being rejected.
Discrimination	Doing things or inactions that directly or indirectly deny people opportunities or target them for abuse, neglect or harm.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

In recent years, the concept of stigma has attracted increased attention among health professionals and the general population, characterizing a distinct component of the social impact of illness. Because stigma contributes to the burden of illness and influences the effectiveness of case finding and treatment; major interests of disease control, stigma has become a matter of particular interest for public health. It is also a matter of particular interest because stigma is such a prominent feature of many diseases in low- and middle-income countries. Stigma and discrimination have an enormous impact on sufferers. That impact is felt at home, in the workplace and institutions, and in the community, (Health and Development Networks, 2001).

The modern understanding of disease stigma owes much to Goffman (1963), who suggested that people who possess a characteristic defined as socially undesirable (mental disorder in this case) acquire a ‘spoiled identity’ which then leads to social devaluation and discrimination. Malcolm *et al*. (1998) divide stigma into felt or perceived stigma and enacted stigma. Felt stigma refers to real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as mental disorders), or association with a particular group. Enacted stigma, on the other hand, refers to the real experience of discrimination. This takes the form of discrimination in job placement or loss of job as a result disclosure of mental health status, health benefits, or social ostracism.

WHO, (2003) defines mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community. From the definition, mental disorder therefore is viewed as any condition that makes it difficult for an individual to cope with normal stresses of life, or state of mental and social disequilibrium. Stigma and discrimination for the mentally ill individual is becoming a worry globally. A personal communication with a mentally ill has revealed that stigma and discrimination against them and their care givers is becoming of concern to them. 'People with mental illness, their friends and family often say that the stigma and discrimination they face is worse than the illness itself' (a 34 year old mental ill patient). Self-stigma occurs when people with mental illness and their families internalize society's negative attitudes towards them, leading to self blame and low self esteem. Stigma leaves mentally ill patients in state of grief. It also prevents people from asking for help and induces a feeling of helplessness and hopelessness when, in fact, people can and do recover from mental illness. It impedes investment in necessary mental health services and research as governments and granting bodies ignore this most important area of population health, (WHO,2004). The causes of the stigma and discrimination are many and varied. Society's perception of the cause of mental disorder may be one of the factors that influence how the mentally ill is treated. Though there are documented evidences of stigma and discrimination for the mentally challenged, few studies have been carried out in this area. This study therefore intends to explore the issues on stigma and discrimination for the mentally ill. This is needed to fill the gap in social research as many of the studies in stigma and discrimination are on communicable diseases such as HIV/AIDs, TB, buruli ulcer, etc (WHO,2004).

1.2 Problem Statement

Several reasons explain why stigma is such an important consideration for social and health policy and for clinical practice. The emotional impact of social disqualification adds to burden of any illness in various ways, and as noted already, stigma may delay appropriate help-seeking or terminate treatment for treatable health problems. For diseases and disorders that are highly stigmatized, the impact of the meaning of the disease may be as great or a greater source of suffering than symptoms of the disease. The emotional impact of social and cultural meanings of illness indicates the various ways by which stigma operates. Social science research on stigma regards it fundamentally as a problem arising from social interactions. Goffman and other researchers have also recognized self-perceived stigma, or the impact of anticipated interactions, which may be as distressing as actual interactions. Each of these various aspects of stigma may impair quality, (WHO,2004).

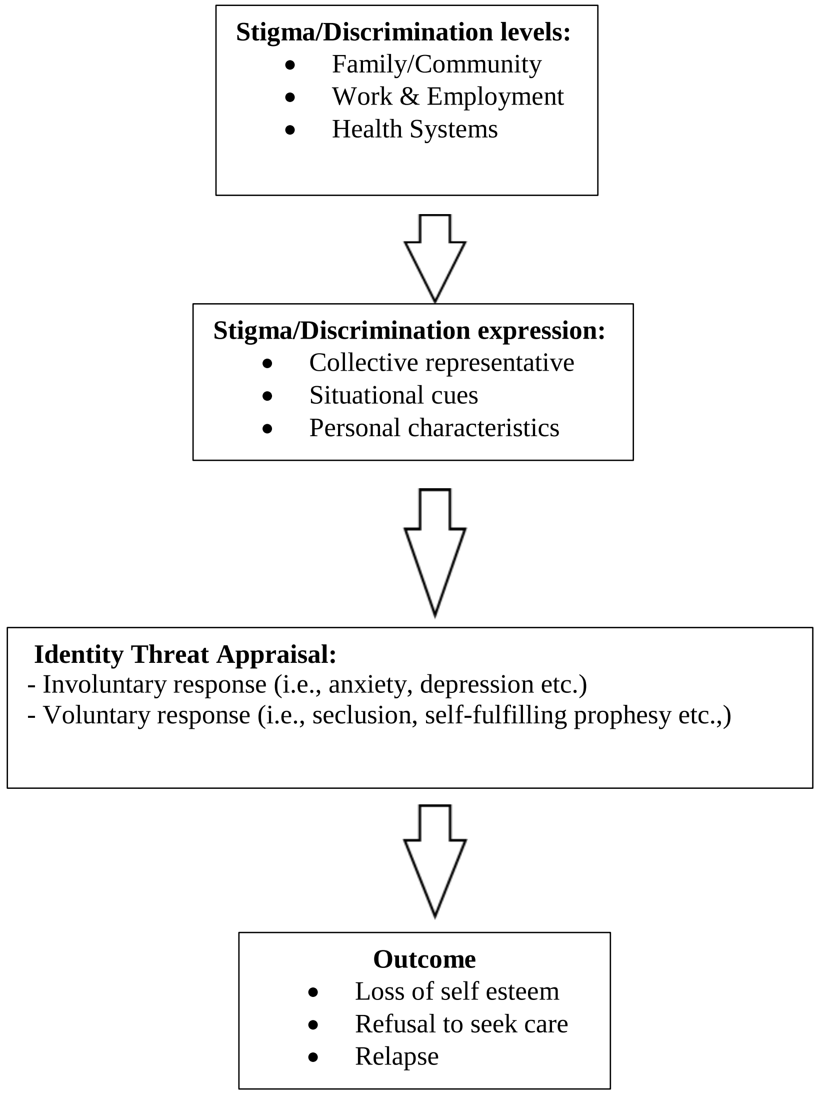
Stigma contributes to what a WHO fact sheet identified as the hidden burden of mental illness (WHO, 2001), and it constitutes a hidden burden for other stigmatized conditions as well. Research also showed that stigma and labeling may affect the course of recovery (Link *et al*., 1997). The WHO (2008) estimated that 25% of the general population suffers various forms of mental disorder. The same report estimated that mental disorder accounts for at least 160 million lost years of healthy life, of at least 30% could be averted with existing intervention. Stigma and discrimination make it difficult for people who have been treated with mental disorder and declared well to reintegrate into the community. Some families abandon their family member at the psychiatric hospital resulting in congestion at the hospital. Recent media reports in Ghana revealed that the two main Psychiatry Hospitals in Accra are congested with patients who have been abandoned by relatives, (GNA, 2011). This has even resulted in a recent intervention by

Accra Psychiatry Hospital to send patients who were abandoned at the hospital to their relatives. A personal communication with Chief Psychiatrist for Ghana in May, 2011 has revealed that stigma and discrimination is responsible for the congestions at the psychiatric hospitals. This study therefore intends to explore further the burden of stigmatization and discrimination for mental disorders.

1.3 Conceptual Framework

The study adopted the identity threat model of stigma (Chapple, 2004). Stigma and discrimination against the mentally patients and their care givers occur at three levels: family and the community, workplace and employment and the health system. The stigmatized individual then expresses the stigma and discrimination by considering collective representations of cultural stereotypes relevant to the self, adopts situational cues that signal the risk of being devalued or portrays some unusual personal characteristics. This results in perceived identity threat through involuntary responses (e.g., anxiety) or through voluntary response of seclusion and self-fulfilling prophesy. The stigma outcomes identified by this model include loss of self-esteem, refusal to seek care, and relapse (figure 1).

Figure 1; Conceptual framework of stigma and discrimination against mental patient households



1.4 Justification Of The Study

People who lived with psychiatric stigma and its consequences, often experience suffering that is devastating, and life-limiting (Schulze and Angemeyer, 2003). Stigma and discrimination prevent people with mental illness from obtaining the basic family and community care that others enjoy (Carne, 1998). They impede social integration, interfere with performance of social roles, diminish quality of life, and prevent timely access to treatment, effectively creating a vicious cycle of social disadvantage and disability (Stolzman, 1994). This study therefore will provide findings that can inform health policy development. An understanding of the various forms of stigma and discrimination has provided an evidence for minimization of stigma and discrimination. Few studies have been carried out on stigma and discrimination with regards to mental health. The study can therefore be used as one of the baseline studies for future research in mental health. The study also provided information on the issues of stigma and discrimination in Ghana.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Definition of Stigmatization and Discrimination

Stigma as defined by Goffman (1963), who is the seminal author on stigma, as an 'attribute that is deeply discrediting' and that reduces the bearer from 'a whole and usual person to a tainted, discounted one. In Goffman's view, stigma commonly results from a transformation of the body, blemish of the individual character, or membership of a despised group. He emphasizes the relationship between an attribute and a stereotype. Building upon this definition, Chapple (2004) define stigma as 'stigma exists when a person is identified by a label that sets the person apart and links the person to undesirable stereotypes that result in unfair treatment and discrimination.

Discrimination on the other hand refers to any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory, (Goffman,1963). Discrimination does not include any distinction, exclusion or preference necessary to protect the human rights of a person with a mental illness, or of other individuals (United Nations Report, 1991). Discrimination take two forms; direct and indirect. Direct discrimination occurs when a person is treated less favourably, on the grounds of their disease, than others are or would be treated in the same or similar circumstances. Indirect discrimination occurs when a requirement or condition is applied which, although applied equally to all persons, is such that a considerably smaller proportion of people with the disease can comply with it and it cannot be shown to be justifiable other than on health grounds (WHO, 2003).

2.2 Forms of stigma and Discrimination

2.2.1 Employment and Workplace

Employment discrimination describes the denial of equal opportunities to an individual in the work arena (Bharat et al, 2001). This may be the denial of employment, denial of career development opportunities or even social isolation and marginalization in the workplace. No documented studies on employment and workplace discrimination with regard to mental disorder in Ghana and globally, hence reference was made to studies on related conditions. Studies on stigma and discrimination in HIV and TB have revealed that it can occur in employment, health institutions and in the community (Bharat et al, 2001). A study in Uganda identified a range of issues relating to stigmatization and discrimination in the workplace. It was reported that some companies tested prospective employees prior to offering them appointment. Others, (including prominent multinational companies working in the country) were said to require workers to take a HIV anti-body test before sending them on what were considered to be expensive training courses. Still other companies were said to test workers opportunistically, assigning lighter jobs to those who tested positive (Bharat et al, 2001). According to statistics from the Zambia Demographic Health Survey (2001-2002) almost two thirds of women and three in five men believe that a worker who is sick with AIDS should not be allowed to keep working. Sixty one percent of Zambian women and 53% of men said they would not buy vegetables from HIV-positive food seller or shopkeeper.

2.2.2 Family and Community level

There are a few studies on the forms of stigma and discrimination at the family and community level with regards to mental disorders. Wahl's (1999) study of the stigma of schizophrenia among recovering patients found that more than a third of respondents identified relatives as perpetrators of stigma. HIV/AIDS -related stigma and discrimination in families and communities are commonly manifested in the form of blame, scapegoating, and punishment. Communities often shun or gossip about those perceived to have HIV or AIDS (Parker and Aggleton, 2002).

A study investigating knowledge and attitudes of the general South African public towards mental illness, (Hugo *et al.* 2007) found that knowledge was low and stigma was high. Such stigma appeared to be associated with the fact that mental illnesses were understood as a lack of willpower, and stress-related, rather than medical illnesses. Another study in Nigeria, where the first large-scale, community representative study of popular attitudes towards mentally ill, found stigma to be widespread, with most people indicating that they would not tolerate even basic social interactions with someone with a mental illness (Corrigan and Watson, 2007).

2.2.3 Health Care System

Stigmatizing attitudes towards people with mental health problems are also seen even within the mental health professions. Several surveys have indicated little difference between the attitudes of the general public and psychiatrists (Lauber, *et al*., 2006). Health-related stigma may be experienced and explained differently by people who have a target condition and others who do not, and self-perceived stigma may differ from enacted stigma (Scambler, 1998). A survey in Nigeria, conducted in 2002, reported that 9% of health workers interviewed had refused to provide care to an HIV-positive person. The presence or absence of institutional policies and procedures can contribute to the stigmatization and discrimination of individuals. For instance, rights are compromised when patients are detained in health facilities for their inability to pay for services, a practice that has primarily reflected and reinforced broader societal discrimination against women. In 2006, patients in Burundian public hospitals could be detained for weeks or months, guarded by hospital security and staff, and often kept in separate rooms from other patients.

In their report, Herek *et al.*, (2003) explain the role public health policies play in perpetuating illness related stigma. They contend that "when a disease is stigmatized, public health policy can help to protect those who are ill from popular prejudice or it can promote discrimination against them

2.3 Social Meaning of Mental Disorder

A social constructionist approach to illness is rooted in the widely recognized conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition). The WHO (2004) reports that individuals may be fearful of being discriminated against if they are labelled as having a mental health problem. This underutilization of services has been reported even in countries where there is no need to make out of pocket payments to access services. As members of the general population, they are also exposed to common misconceptions surrounding mental disorders – for instance that they cannot be cured or that drug treatments do not work. The social meaning of illness has direct effect on whether the condition will be stigmatized or otherwise. Kleinman's (1995) study of the stigma of epilepsy in China critically reviewed concepts of stigma, emphasizing the importance of considering broader social contexts of illness experience. This analysis emphasized the role of stigma as a force both shaped by and influencing the character of local worlds.

2.4 Effects/Impact of Sigma and Discrimination

The principal effects in developing countries are social isolation of patients, both outside the family, where the person may be avoided by former friends and acquaintances and inside the family where the patient may be forced to eat and sleep separately. Patients often isolate themselves to avoid infecting others and to avoid uncomfortable situations such as being shunned or becoming the subject of gossip. Being either a patient or an ex-patient is likely to affect employment and employment prospects. Unmarried women often find it difficult to get married, due to discrimination by prospective husbands and in-laws, while married women may find they are divorced because they have TB or if a history of TB is subsequently revealed.

(Hurtig , Porter and Ogden , 1999)

Stigma and consequent discrimination have a double impact on TB control. First, concerns about being identified as a person with TB make it more difficult for people with a cough of long duration who suspect they may have TB to seek care, because of the public nature of the TB diagnostic process (Baral, Karki and Newell, 2007). A study of leprosy counseling groups in Nepal from 1994 to 1998 showed that perceived stigma prevented individuals with leprosy from seeking care and resulted in lower compliance with treatments. HIV-positive women in Chile reported that they avoided necessary health services, or delayed seeking services until their condition had deteriorated, because they had been discriminated against in the past and so feared mistreatment in the future (Floyd-Richard and Guruing, 2000).

Subjective perceptions of stigmatization is as important as objective exposure to discrimination in predicting adverse health-relevant outcomes among the stigmatized (Finch *et al.*, 2000). Subjective social status is positively related to health-related outcomes, even controlling for objective indicators of social status (Adler et al. 2000). Self-reported experiences of discrimination are positively correlated with psychological distress, and with self-reported physical health problems.

2.5 Coping Strategies for Mental Ill

People cope with stigma-induced identity threat in a variety of ways. Some coping efforts are primarily problem focused. Whereas others are primarily emotion focused. Coping strategies can also be characterized as engagement versus disengagement strategies. Engagement involves fighting the stigma-induced identity threat. Disengagement on the other hand involves avoiding the source of stigma-induced identity threat (Miller, 2004). When members of stigmatized groups encounter negative outcomes, one way they may cope with the threat to their self-esteem is by blaming the outcome. Another way in which the stigmatized coped with identity threat is by withdrawing their efforts and/or disengaging their self-esteem from domains in which they are negatively stereotyped or fear being a target of discrimination (Keller and Dauenheimer 2003) Members of stigmatized groups coped with identity threat by approaching, or identifying more closely with, their group (Allport, 1954). Groups can provide emotional, informational, and instrumental support, social validation for one's perceptions, social consensus for one's attributions, and a sense of belonging. Group identification is positively correlated with self-esteem among stigmatized groups (Bat-Chava, 1994) overweight women self-report lower personal self-esteem than do average-weight women (Miller and Downey 1999) and show lower collective self-esteem on implicit measures (Rudman *et al.*, 2002). Younger adults and older adults have equivalent levels of personal self-esteem on both implicit and explicit measures; however, both groups favored younger adults on an implicit measure of collective self-esteem (Hummert *et al.*, 2002).

2.6 Research Questions

1. What forms do mental disorder-related stigma and discrimination take?
2. What are the main sources of mental disorder-related stigma and discrimination?
3. What are the responses to mental disorder-related stigma and discrimination?

2.7 Objectives Of The Study

General Objective:

The general objective of the study is to determine the forms of stigma and discrimination experienced by mental patients and their care givers and the coping strategies in the Ho Municipality.

Specific Objectives

The specific objectives are:

1. To describe the forms of stigma associated with mental disorders
2. To describe the forms of discrimination associated with mental disorders
3. To describe the coping strategies of the mental patients and their care givers to stigma and discrimination

2.8 Hypotheses

The hypothesis of this study is: Mental patients and their care givers are not stigmatized nor discriminated against in the Ho Municipality of Ghana.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Research Design

The research design of the study was a cross-sectional exploratory one.

3.2 Study Site

Ho Municipality is one of the eighteen-political/administrative districts in the Volta region, Ghana. It is located in the middle zone of the Region. Ho town doubles as the Municipal Capital and the Regional Capital of the Volta Region. The municipality has four (4) sub municipalities namely; Abutia, Tsito, Kpedze- Vane, Ho-Shia and it comprises of 474 communities. The Municipality has an estimated population of 225,026 (Ghana Statistical Service, 2010). Ho Municipality is bordered on the north by the Hohoe District, west by Asuogyaman district, east and South-east by Adaklu-Anyigbe district, North-west by South Dayi district and North-east by The Republic of Togo. The Ho municipality has two health facilities that render mental health services. The municipal Hospital renders Outpatient Mental health service whilst Regional hospital renders both Outpatients and Inpatient mental health services. There is only one psychiatrist and four mental health nurses in the Municipality.

3.3 Study Population

The population of the study included all patients with mental health disorder and their care givers as well as service providers in the Ho Municipality.

3.4 Sample Size Determination

The estimated cases with mental patients who are presently registered at the mental health clinics in the Ho Municipality are 848. The study used 95% level of confidence, $Z\alpha/2 = 1.96$, the population proportion assumed to be $P=0.5$ and 5% degree of error.

$$n = \frac{Z^2\alpha/2 \times P(1-P)}{d^2}$$

$$n = \frac{1.96^2 \times 0.5(1-0.5)}{0.05^2}$$

n= 384

n= 384/1+ (384/848)

n= 264

A 5% non-respondent rate was added to the sample to make total sample size of 277.

3.5 Recruitments of Participant

Recruitment of participants for key informant interview was based on theoretical saturation. This means that participants were purposively recruited into the study until the point that recruitment provided no further insight into the study.

3.6 Sampling Technique

Patients:

There are two health facilities within the Ho municipality that render mental health service. Proportionate sampling technique was first used to allocate number of respondents to each of these facilities based on the number of registered mental cases. At the facilities, simple random sampling was employed. The number of recorded cases at the Volta Regional Hospital and Municipal hospital are 640 and 208 respectively. The proportion of cases in the Volta Regional Hospital is 75% whilst the Ho Municipal Hospital is 25% of 2011(Volta Regional Mental Health Annual Report, 2011). This therefore results in a corresponding sample size of 204 and 66 for the Volta Regional Hospital and Ho Municipal Hospital respectively as illustrated on table 1

Table 1: Sample Size Determination

Health Facility	**Total Population**	**Proportion (%)**	**Sample size**
Volta Regional Hospital	640	75.0	204
Municipal Hospital	208	25.0	73
Total	**848**	**100.0**	**277**

Focus Group Discussion (FGD):

Four FGD were held; one each for caregivers; that is; health care providers and relatives of patients who care for the patients, two for community members who care for patients as well. Purposive sampling was used to select the participants for the focus group discussion. The FGD was held in two communities based on number of cases that came from that community.

Key Informant Interview (KII): Four community mental health practitioners and the one psychiatrist were interviewed as key informants.

3.7 Scope of the Study

Inclusion Criteria: The inclusion criteria were those who have been diagnosed of having mental disorders and their caregivers (children, male, and females) and registered at the Volta Regional Hospital and Ho Municipal Hospital in 2011. All mental health personnel working in the two hospitals in the Municipality that render mental health services were also included in the Research. Members of communities from which reported cases came from were also included in the study.

Exclusion Criteria: The study excluded those who were diagnosed of having mental conditions, who attend hospital at Ho municipality with their caregivers but do not live within the Municipality. Epilepsy or seizure disorders were excluded from the study. Participants who fell within the inclusion criteria but refused to give consent to take part in the study were also excluded from the study.

3.8 Data Collection Tool

Structured questionnaire, and focus group discussion guides as well as in – depth interview guide were the main tools for the study. The tools were designed in English and translated into Ewe and Akan. The structured questionnaire was used to elicit responses from the respondents who are mentally ill. The questionnaire elicited information on the demographic characteristics of the respondents, forms of stigma and discrimination, coping strategies and the social meaning of mental disorders. The questionnaire was four section; demographic data, forms of stigma and discrimination, social meaning of mental disorder and coping strategies for respondents. An

Interview guide was designed and used to facilitate the FGD for the caregivers and the community members. Finally, an interview guide was used for the key informant interviews. Both the interview guides elicited information on forms of stigma and discrimination, social meaning of mental disorder and coping strategies that are employed by mentally ill and their caregivers.

3.9 Data Collection Procedure

Mentally ill patients were first randomly sampled from the two facilities (Volta Regional Hospital and Ho Municipal Hospital). Informed consented subjects were interviewed. Those who could read and write were given the questionnaire to complete. However, the questionnaire was translated into the appropriate language for those who were unable to read and write. Their responses were documented appropriately. The focus group discussions and key informant interview were facilitated by the researcher with the assistance of two trained researcher assistants acting as secretaries. The interviews were also tape recorded and transcribed after the interviews.

3.10 Quality Control

Research assistants were trained and exposed to the protocol for the study. Back-to-back translation of the questionnaire was done by each research assistant to ensure uniformity of the interview. They were also supervised throughout the study to ensure that they do not depart from the protocol for the study. The questionnaire and interview guide were pre-tested in a pilot study using ten patients and their care givers at Ketu South District Hospital.

The data was cleaned before entering into the software for analysed. Outliers were removed. Tape recorded interviews was played for the participants in FGD and KII. Appropriate comments were made. The data was transcribed verbatim.

Pre – Test

Questionnaire was pre-tested in a pilot study using ten patients at Ketu South District Hospital's Mental Health Unit. The patients who attend this clinic share the characteristic as those patients at the Ho municipal Hospital. The pilot was done at Ketu South hospital to avoid diffusion of information or the possibility of re-sampling participant that took part in the pilot into the main study. The questionnaire and interview guide were reviewed appropriately before the main study.

3.11 Analysis of Data

The quantitative data cleaned and entered into SPSS and analysed descriptively. This was then summarized into frequency tables and graphs. The FGD and KII were coded using thematic coding and transcribed. This was then presented in the form of narrative and quoting verbatim to support the quantitative data

3.1 Ethical Consideration

Institutional approval was sought from **the Ghana Health Services Ethical Review Committee Administrator, through the School of Public Health** by submitting a proposal for ethical clearance. An introductory letter was collected from School of Public health to the Volta Regional Director of Health Service and the Directors of the two health facilities. The objectives of the study were explained to participants for informed consent. Participants were informed that participation is based on willingness. They also have the right to withdraw from the study at any point of the study if there be any suffering from any form of discrimination. There was no harm or injury by participating in this study, hence no compensation was given to participants. Information collected was treated confidential and the identities of the respondents not disclosed in writing the report. The data collected was only used for the study and not released to any person not connected to the study without their consent. The participants were also provided with contact addresses and telephone numbers for contact person. The study was funded by Principal Investigator.

CHAPTER FOUR

4.0 RESULTS

4.1 Background of the Respondents

The background information comprised the age, sex, marital status, occupation, religion, educational level and ethnicity. On tables 2 are the distribution, it showed that cases of mental disorder cuts across almost the age distribution. 35. 54.9%, 32.5% and 12.6% were above age 35, 21- 35 and less than 20 respectively.

Males were 37.9% whiles females were 62.1% indicating that more females surfer mental disorders than males in the Ho Municipality. Married, never married, divorced and widowed respectively were 28.9%, 52.3%, 14.7% and 4.1% showing that both married and never married suffered mental disorder with never married composing the majority. Those who had no formal education contributed to 14. 8%, whilst 33.6%, 27.7%, 12.9% and 11% respectively had primary, basic, secondary and tertiary educations. Due to the fact that geographical setting of the study area was of Ewe origin, 8.1%, 89.3%, 1.5% and 1.1% were Akans, Ewes, Kabres and other ethnicities respectively. Mental disorder had no influence from ethnicity though, Ewes had higher frequency than others, it was as a result of the ethnic background of the study area which is predominantly ewes. Because the geographical settings of the study had Christian origin, Christians, Muslims and Africa traditionalists were 93.4% and 3% each respectively. Therefore religion had no relation with mental disorder since other religions had been represented.

The occupation of respondents cuts across all types of professions, self-employed and the employed. Included were the white-colour jobs, farming, fishing and those unemployed. This indicates that mental disorder befalls any person with any type of occupation.

Tables 2 Background of Respondents

Variable	Number	Percentage (%)
Age		
Less than 20 years	35	12.6
21-34 years	90	32.5
Above 35 years	152	54.9
Sex		
Male	105	37.9
Female	172	62.1
Marital Status		
Married	77	28.9
Never Married	139	52.3
Divorced	39	14.7
Widowed	11	3.9
Non-Responses	11	3.9
Educational Level		
None	40	14.8
Primary	91	33.6
MSLC/JHS	75	27.7
Secondary	35	12.9
Tertiary	30	11.0
Non-Response	6	2.2
Occupation		
Farming	63	22.7
Trading	58	20.9
Civil Servant	27	9.7
Unemployed	18	6.5
Others	108	39.0
Non- Response	3	1.1
Total	**277**	**100.0**

4.2 History of Disease Conditions

Tables 2 shows the percentage distribution by sex of causes of mental conditions among males were 19% for biological , 10.5% for spiritual/curse and 6.9% for do not know out of 38% whiles among females the percentages were 20.9% biological, 24.9% for spiritual/curse and 15.2% for do not know out of 62% respectively. Figure 2 also shows the percentage distribution by sex of duration respondents were afflicted with the mental condition. Among males, 11.6% were inflicted 1-4 years, 9.4% were inflicted for over 15years, 6.1% were inflicted for 5-9 years and 3.2% were inflicted less than a year ago out of total of 37.8% male respondents and among the

females, 24.2% were inflicted for 1-4 years, 13.4% were inflicted for 10-14 years, 9.4% were inflicted less than a year and 8.3% were inflicted for more than 15 years out of a gender total of 62.2%. It is noted that there is disparity in gender distribution of duration of ones affliction with mental disorder. The modal age group within which respondents were afflicted by the mental condition was 1-4 years.

Concerning the first source of treatment, table 4 provides the percentage distribution by sex of respondents. From males 24.9%first sourced treatment from Health Facility, 7.9% from Faith based and 4.0% had self/home management out of total of 37.9% whiles among females the 32.1% sourced from Health facility, 23.8% from faith-based and 5.1% had self/home management out of total of 62.1%.

With regards to the preferred treatment sought by the respondents, 217 representing 78.3% preferred Biomedical treatment (comprising 33.2% males and 45.1% females) whilst 50 representing 18.1% of total respondents preferred faith based(comprising 4.0% males and 14.1% females and 7 representing 2.5% preferred other forms of treatment such as herbs (comprising 0.7% males and 1.8% females as shown in figure 4.

Table 3 Causes of mental Disorders

Causes of Mental Disorders	Male	Female	Total
Spiritual/Curse	29(10.5%)	58(20.9%)	87(31.4%)
Biological	54(19.5%)	69(24.9%)	123(44.4%)
Don't know	19(6.9%)	42(15.2%)	61(22.0%)
Non-Responses	3(1.1%)	3(1.1%)	6(2.2%)
Total	**105(33)**	**172(67%)**	**277(100%)**

Table 4: First Source of Help/Treatment

Source of Help/Treatment	Males	Female	Total
Health Facility	69(24.9%)	89(32.1%)	158(57.0%)
Faith based healing centres	25(9.0%)	66(23.8%)	91(32.9%)
Self/Home Management	11(4.0%)	14(5.1%)	25(9.0%)
Non-response	0(0.0%)	3(1.1%)	3(1.1%)
Total	**105(33)**	**172(67%)**	**277(100%)**

Figure 2: Duration Afflicted with the Condition

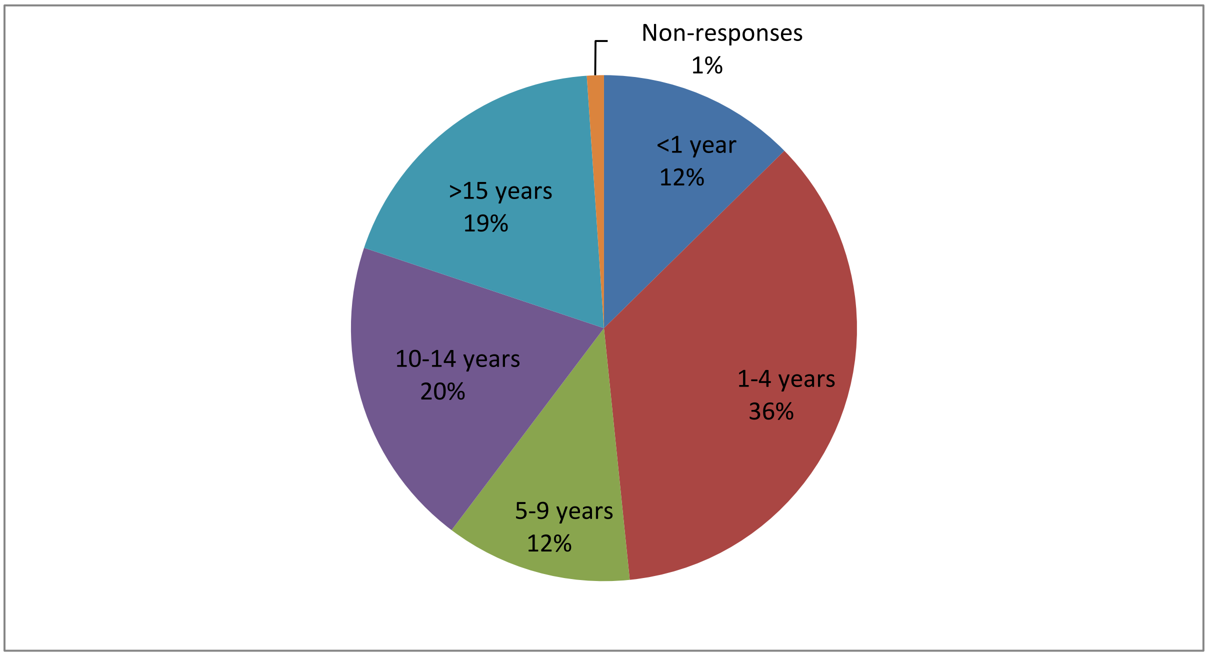
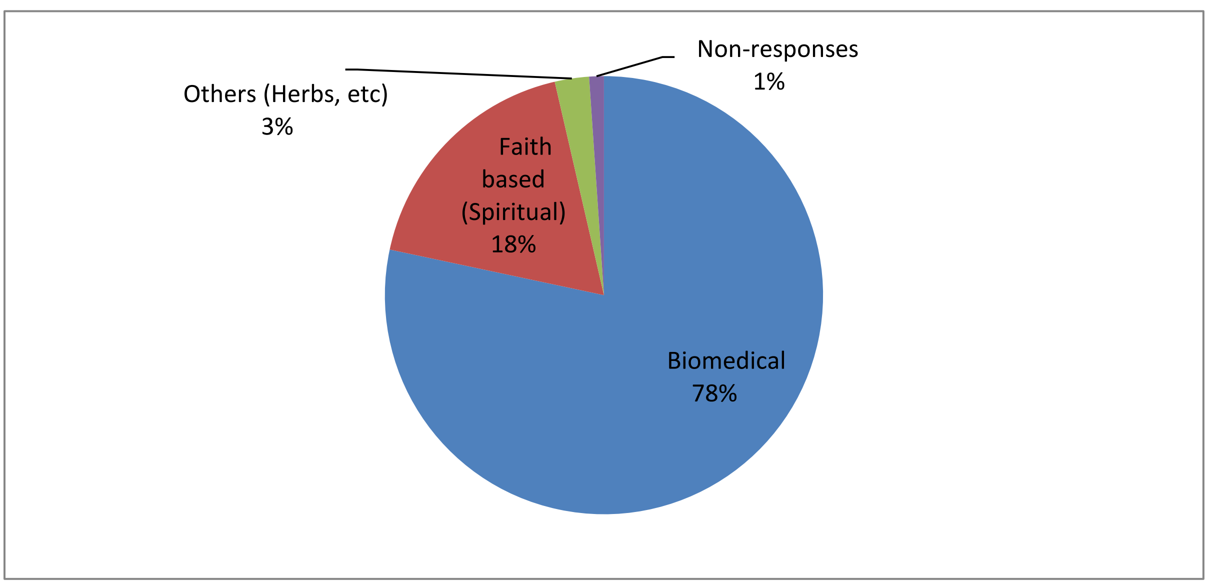


Figure 3: Preferred Type of Treatment



4.3 STIGMA AND DISCRIMINATION

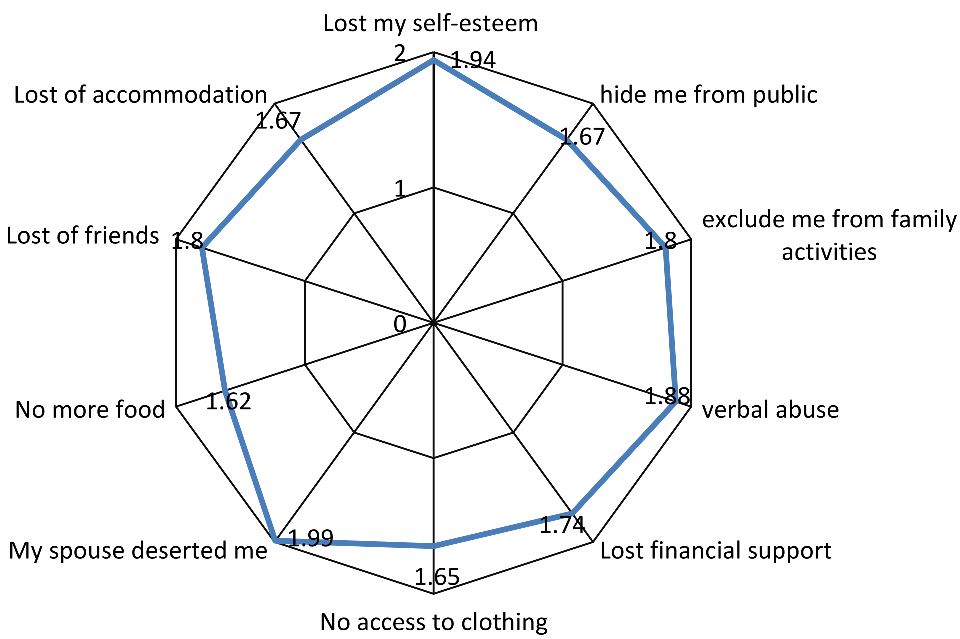
Table 5: Stigma and Discrimination at Individual Level

Individual Level	Male	Female	Total
Strongly Agree	43(15.5%)	48(17.3%)	88(31.8%)
Agree	54(19.5%)	111(40.1%)	165(59.6%)
Neutral	8(2.9%)	10(3.6%)	18(6.5%)
Strongly Disagree	0(0.0%)	3(1.1%)	6(2.2%)
Total	**105(33%)**	**172(67%)**	**277(100%)**

4.3.1 Stigma and Discrimination at Individual Level

Stigma and Discrimination at individual level associated with mental disorder suffered by respondents were rated by the respondents as indicated in Table 5. Generally, 88 respondents representing 31.8% and comprising 43 (15.5%) males and 48(17.3%) females strongly agreed they experience stigma and discrimination. Furthermore, 165 representing 59.6% comprising 54 (19.5%) Males and 111 (40.1%) Females Agreed they experienced various forms of stigma and discrimination whilst 18 representing 6.5% comprising 8 (2.9%) Males and 10(3.6%) females were neutral with regards to the various forms of stigma and discrimination at the individual level. From figure 5, both sexes averagely, had similar pattern of rating, so mean of the sexes was sought. Agree and strongly agree received the higher frequencies respectively. This implies that both sexes suffered strong stigma and discrimination with their mental disorders at the individual levels.

Figure 4: Stigma and Discrimination at Individual Level



At the individual level, the following revelations and experiences testify the level of stigmatization and discrimination experienced.

> *"When people know in this town that one is having mental disorder, they point out accusing fingers to the person, claiming it is as a result of curse or punishment from their gods or misdeeds, so is better not to disclose your status. So prayer camps and traditional healers are our help, even if it is a curse or punishment they will help you." Mental illness is "madness" which means the person with queer, bizarre, strange behaviour and in tattered and dirty clothing or naked , wondering and roaming around aimlessly, picking from the ground, eating garbage, it is a curse, punishment from gods, is better you visit a prayer camp than hospital people will shun your company in the community."*(A 48year old woman caregiver)

> *"If you accept you are mad, people will shun your company, no job, no marriage, no home, so one has to deny it and when the sickness grows, they roam on the streets, beg for food and that is their end, they cannot get well again."* (A 38year old man caregiver)

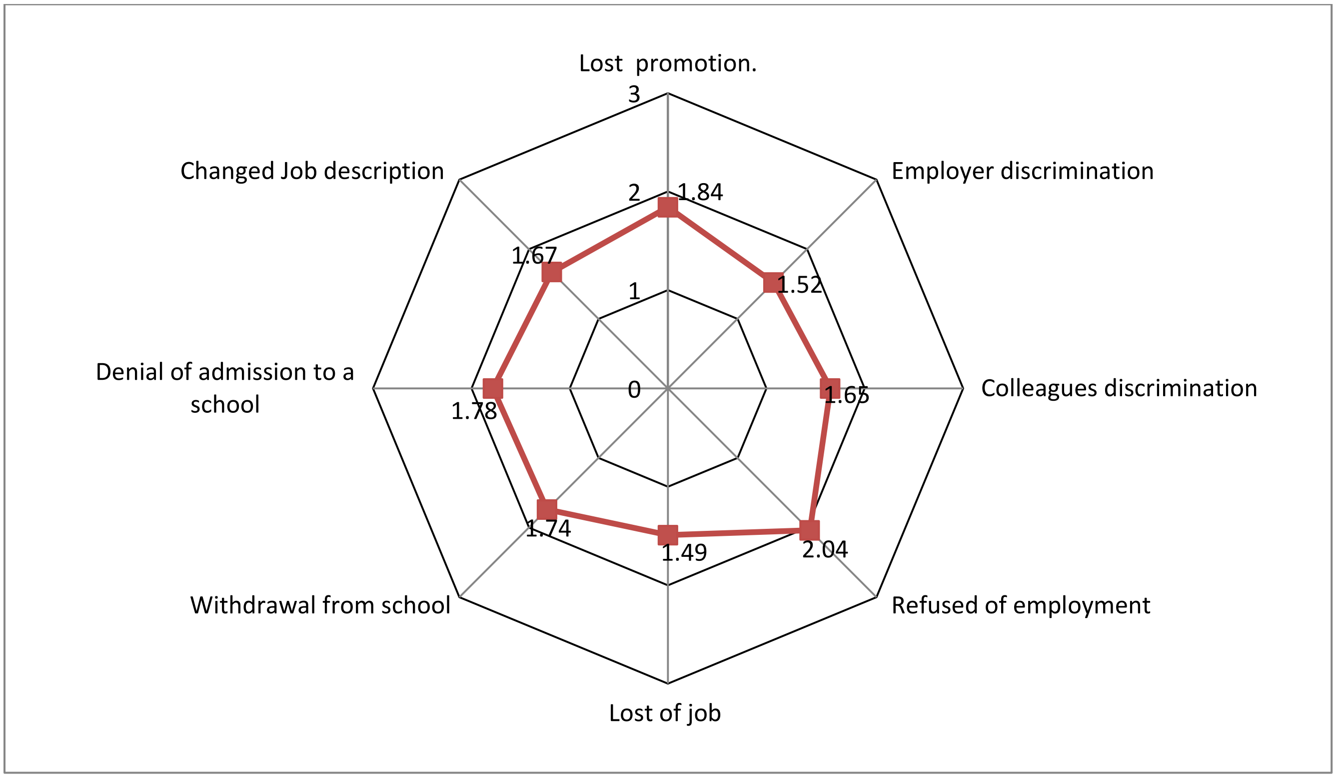
4.3.2 Stigma and Discrimination at Work, Employment and Education Level

Stigma and Discrimination experienced at work, employment and education levels associated with mental disorders by respondents were rated by the respondents is presented in Table 6. Out of the 277 respondents, 215 (76.5%) did not respondent whilst 11(4%) strongly agreed the experienced stigma and discrimination at work, employment and educational level. In addition, 43 respondents, thus 15.5% agreed and 5(1.8%) were neutral whilst 6 (2.2%) disagreed that they experienced stigma or discrimination at work, employment or educational level. From figure 2, female rated with more of agree and strongly agree respectively whiles males rated more with agree and neutral respectively indicating more females acknowledged being stigmatized and discriminated at work, employment and education levels than males.

Table 6: Stigma and Discrimination at Work, Employment and Education Level

Work, Employment and Educational Level	Male	Female	Total
Non-responses	81(29.2%)	131(47.3%)	215(76.5%)
Strongly Agree	1(0.36%)	10(3.6%)	11(4.0%)
Agree	16(5.8%)	27(9.7%)	43(15.5%)
Neutral	5(1.8%)	0(0.0%)	5(1.8%)
Disagree	2(0.7%)	4(1.4%)	6(2.2%)
Total	**105(33%)**	**172(67%)**	**277(100%)**

Figure 6: Stigma and Discrimination at Work, Employment and Education Level



4.3.3 Stigma and Discrimination at Family Level

Stigma and Discrimination at family level associated with mental disorder suffered by individual respondents were rated by the respondents. Table 7 shows ratings by sex at family level. It also shows that, both sexes had the same pattern of rating with strongly agree and agree receiving the higher frequencies respectively. This implies that both sexes had strong stigma and discrimination associated with their disorders at the family levels.

According to a 44 year old, Sub-Contractor;

> *"I lost my job when they find out that I'm having a mental disorder, my wife left me, and the children are in- between us, they sometimes come to me, now I have nobody except my family members though they too do not receive me well, they sometimes think of what I have done for them when I was wealthy before and do good small to me sometimes."*

Table 7: Stigma and Discrimination at Family Level

Family Level	Male	Female	Total
Non-responses	0(0.0%)	17(5.4%)	17(6.1%)
Strongly Agree	48(17.3%)	72(26.0%)	120(43.3%)
Agree	57(20.6%)	79(28.5%)	136(49.1%)
Neutral	0(0.0%)	2(0.7%)	2(0.7%)
Disagree	0(0.0%)	2(0.7%)	2(0.7%)
Total	**105(33%)**	**172(67%)**	**277(100%)**

4.3.4 Stigma and Discriminations at Health Level

Stigma and Discrimination at health delivery seeking level associated with mental disorder suffered by individual respondents were rated by the respondents. Table 8 shows the frequencies of levels of ratings by sex, both sexes had the same pattern of rating with agree and strongly agree receiving the higher frequencies respectively. This implies that both sexes had strong stigma and discrimination with mental disorders at the health seeking levels.

Table 8: Stigma and Discriminations at Health Level

Health Level	Male	Female	Total
Non-responses	3(1.1%)	8(2.9%)	11(4.0%)
Strongly Agree	39(14.1%)	63(22.7%)	120(43.3%)
Agree	63(22.7%)	101(36.5%)	136(49.1%)
Total	**105(33%)**	**172(67%)**	**277(100%)**

Figure 7: Stigma and Discrimination at Health Level

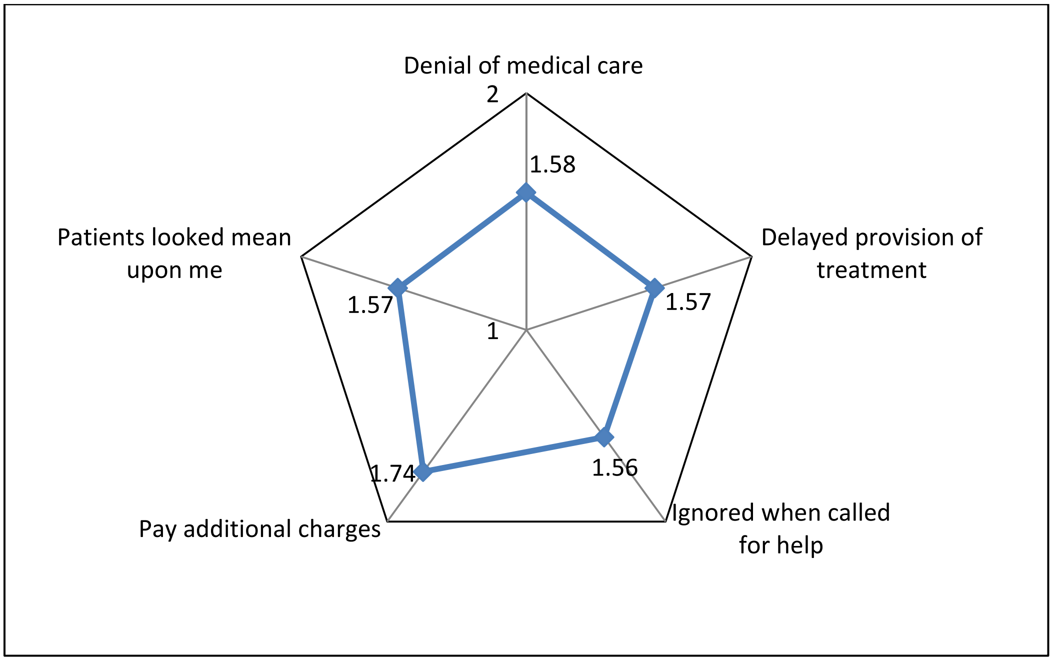
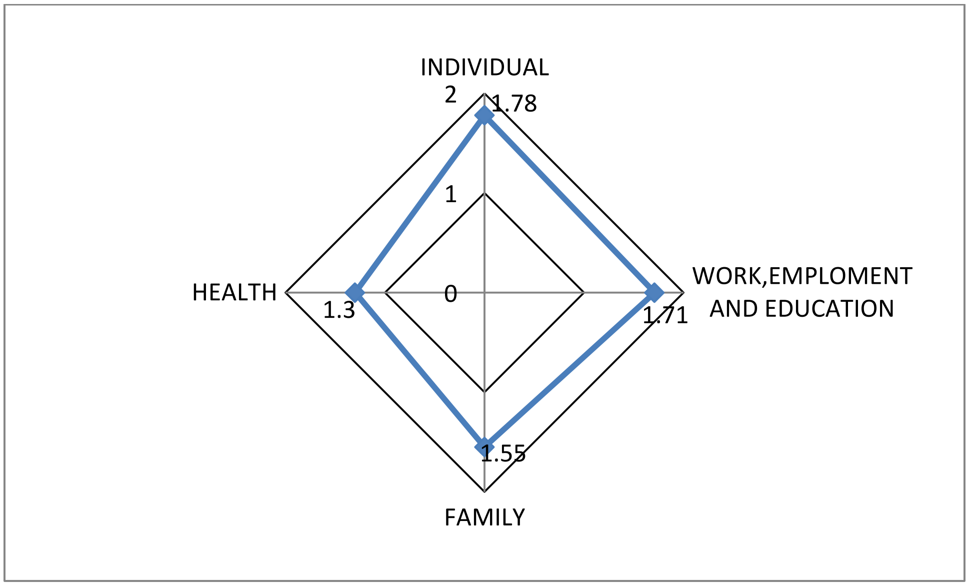


Figure 7 shows the comparison of average rating of stigma and discrimination at the individual, family, health and work, employment and education levels. All the levels received the similar average level of stigma and discrimination name 'agree' on the rating scale. This indicates that stigma and discrimination is associated with mental disorders equally at all the four level.

This narration by 34 year old man who is a composer and singer and a son of mental patient summarized stigmatization and discrimination at all the four levels. According to him

> *"when my mother got pregnant of me, she became mad, I was told by people in my community. People called me mad person's son. I could not complete my elementary education because of financial difficulties and no one was willing to help a mad woman's son in my community, everybody shun my company. Any woman I proposed to; the family will influence her to refuse my proposal, look at me, at my age I am not married and I feel shy to sing on stage. I am a good composer and a singer; I sing well in studio but cannot perform publicly for the fear that people might not accept me since I am a mad person's son"*

Figure 7: Average for the four Levels of Stigma and Discrimination



4.4 Forms of Stigma and Discrimination Associated with Mental Disorders

4.4.1 Forms of Stigma

Table9 Shows the form of stigma associated with mental disorders at the patient level. With respect to classification of stigma into special areas, it was noted that most of the stigmas were of social class and a few psychological type. The main economic form of stigma identify is no food.

Table 9: Forms of Stigma

Forms of Stigma	Number of responses (n)	Percentage (%)
Economic		
No Food	235	13.9
Psychological		
Loss of self-esteem	227	13.4
Social		
Hide from Public	225	13.3
Verbal Abuse	224	13.2
Family blame	258	15.3
Family Members ridiculed and mocked	256	15.1
Colleague patients looked mean upon me	266	15.7
Total	**1691**	**100.0**

4.4.2 Forms of Discrimination

Table 10 shows the form of discrimination associated with mental disorders at the patient level. It can be noted that economic discriminations and social discrimination respectively were frequently associated with mental disorders. From the Focus group discussion had with the care givers, the following were the extent to which the Caregivers think they were stigmatized and discriminated.

> *"I am stigmatized by the specialty in which I am. Other colleagues always refer to me as being like my clients, because of that I cannot feel proud of what I do. Even the populace fears us because we care for mental patient. Someone once told me, is people who are dread who do mental health."*

> *"My in-charge told me, those who are about to go develop mental disorders are those that they recommended they specialized in Psychiatry. Anytime there is a seminar or workshops concerning health, mental health personnel's are not involve because the health managers claimed we are not needed. We are relegated, in everything at this institution, you look at our physical infrastructure, when it rains the whole place is flooded, we have to pack our folders at one side and all of us stand at this corner till the rain stops. Sometimes if you sedate clients, you have to ask relatives to look for vehicle to take their relations home, though not professionally sound because when you admit client on the general ward, your colleagues in the hospital will ask you to stay and care for your client as if you own the client. Other health personnel's do not regard us as colleague, they look mere upon us."*

Another health worker also revealed that

> *"My Health manager said we do not generate any fund, so logistics to work with are difficult to get. We feel less important and if one cannot stand it any longer, one has to specialized in a field where you will be given the necessary respect and attention. Most of my colleagues travelled abroad, those in the country, majority are Medical Assistants, Anaesthetics, Midwives yet still some are working as general nurses. There is no attention given us, we take same salary like general nurses, why should we remain in Mental Health Unit and be stigmatised and discriminated against. We are forgotten by health managers*

Table 10: Forms of Discriminations

Forms of Discriminations	Number of responses (n=1691)	Percentage (%)
Economic		
Loss of Financial Support	256	9.7
No access to clothing	258	9.7
Loss of Accommodation	259	9.8
No Food	258	9.7
Loss of prospects for promotion	62	2.3
Refusal of employment	64	2.4
Loss of Job	58	2.2
Sub-Total	**1215**	**45.8**
Social		
Exclusion from usual family activities	250	9.4
Spouse desertion	118	4.5
Loss of friends	235	8.9
Employer discrimination	55	2.1
Colleagues discrimination	65	2.5
Withdrawal from school	78	2.9
Denial of Admission to School	74	2.8
Change of Job description	54	2.0
Community members refusal to marry from my family	260	9.8
Denial of Access to Medical treatment	112	4.2
Delay in the provision of health services/treatment	116	4.4
Health personnel ignored me when I called for help	11	0.4
Payment of additional charges for medical services	7	0.3
Sub- Total	**1435**	**54.2**
Total	**2650**	**100**

4.5 Coping strategies of the mental patients

Table 11 shows the coping strategies adopted at patient level in response to the stigma and discriminations associated with the mental disorders. The Table 4.9 indicated that the majority of coping strategies adopted by the patients were more of social nature, thus out of the strategies revealed 6% were of Economic, and 5% Psychological and 91% social.

Table 11: Coping Strategy of Mental Patients

Coping Strategies	Number (n=101)	Percentage (%)
Economic Strategies		
Fast when hungry	3	3.0
Animal rearing	3	3.0
Sub-Total	**6**	**6.0**
Psychological Strategies		
Smoking Marijuana	3	3.0
Sleep	2	2.0
Sub-Total	**5**	**5.0**
Social Strategies		
Hide from public	8	8.0
Prays and hopeful condition will be resolved	21	20.8
Do nothing	6	6.0
Aggressive and react	13	12.9
Supportive spouse	6	6.0
Avoid Marriage	12	11.9
Caring Family	15	14.9
Sub-Total	**90**	**89.0**
Total	**101**	**100**

4.6 SUPPORT

Table 12 shows the coping strategies adopted in the form of support from others in response to stigma and discrimination among mental disordered patients. Out of 277 respondents, only 26(9.4%) of them acknowledged receiving any form of support. In classifications of the supports were of social class mainly from close family members (61.6%) than economic (38.4%). It was also seen that no Psychological support is being given as a coping strategy to reduce the stigmatization and the discrimination. In addition, caregivers could not identify any support from any angle.

Table 12: Support as form of Coping Strategies

Type of Support	Number	Percentage (%)
Economic Strategies		
Financial support from Family	7	26.9
Financial support from friends	3	11.5
Social Strategies		
Family Supportive	16	61.6
Total	**26**	**100**

CHAPTER FIVE

5.0 DISCUSSIONS

5.1 Discussions

The study revealed that the forms of stigma and discrimination associated with mental disorder ranges from economic, psychological and social at the individual level. At the economic level most people inflicted with mental disorders are mainly denied food. Psychologically, they loss their self-esteem and socially they are hidden from the public by their relatives, verbally abused and their family members ridiculed and mocked. In addition their families are blamed. This study also established that both sexes experienced strong stigma and discrimination with mental disorders at the individual levels. According to Goffman (1963), stigma exists when a person is identified by a label that sets the person apart and links the person to undesirable stereotypes that result in unfair treatment and discrimination. According to Mental Health Foundation of UK (2000), people with mental health problems say that the social stigma attached to mental ill health and the discrimination they experience make their difficulties worse; that is additional burden to mental disorder and make it harder to recover from mental disorders.

5.2 Forms of Stigma and Discriminations

In their study, Parker and Aggleton, (2002), in HIV/AIDS -related stigma and discrimination in families and communities came across the following, blame, scapegoating, and punishment. Communities often shun or gossip about those perceived to have HIV or AIDS. This study has similar findings as that of Parker and Aggleton (2002), forms of stigma and discriminations include; loss of self-esteem, no food, and family members are ridiculed and mocked, loss of financial support from family, loss of friends and so on. More females acknowledged being stigmatized and discriminated at work, employment and education levels than males. Stigma often rears its head in the workplace. This study collaborated with Canadian Mental Health Association (2007) assertion that there are incidents of mentally ill individuals losing their jobs for having spent time in hospital. In other cases, employees experience a loss of credibility and a concomitant loss of responsibility. Perhaps most telling is the fact that 61% mental patients are outside the labour force. Among these are people with major depression, 40 to 60% are unemployed; 20 to 35% with an anxiety disorder are without work; 80 to 90 percent of individuals with schizophrenia are unemployed. This study however did not look at the conditions that are suffering the severest of the stigma and discrimination at the work, employment and educational level.

At the family level, both sexes suffered strong stigma and discrimination with mental disorders. According to Ostman and Kjellin (2002) in a study of 162 people with a family member afflicted by a mental illness revealed that 83% experienced at least one psychological factor of associative stigma, with spouses in particular affected. Of the group affected by stigma, 20% reported suicidal thoughts versus only 3% of the non-affected group.

At the health level, both sexes suffered strong stigma and discrimination with their mental disorders. This study therefore supports a study by Mental Health Foundation of UK (2000) that is; in the UK, 44% of people with mental illness reported experiencing stigma from their primary care physician, and 32% reported stigma from other health care professionals.

On average, patients and caregivers suffered stigma and discrimination with mental disorders equally at all the four level, thus individual level, work/employment and education level, family level and health level. At patient level, the forms of stigma and discrimination noted were of social and a few psychological, economic discriminations and social discrimination respectively in order of frequency. Individual clients and caregivers also gave accounts during focus group discussions of the form of discrimination and stigma meted them in the community and workplace. It was realised that theses stigma and discrimination came from all levels of the community including family members, work colleagues and friends. It includes denial of access to social places, termination of employment, denial of access to basic needs like food, water, shelter and clothing. Others include the award of punishment in any form as a way of registering displeasure about the behaviour and attitude of the victims. In their study in Nigeria (Corrigan and Watson, 2007) where the first large-scale, community representative study of popular attitudes towards mentally ill, found stigma to be widespread, with most people indicating that they would not tolerate even basic social interactions with someone with a mental illness. These it is sometimes assumed will send a signal and force the victims to behave or live to expectations.

5.3 Coping Strategies for Mental Disorders

In the midst of every storm there is some amount of calm to be enjoyed as such the people suffering from mental disorders look for means to cope with all stigma and discrimination suffered. There were few coping strategies identified with mental disorders in the Ho Municipality. The coping strategies were noted to be social class (89%) than economic and psychological (5%) at patient and other copying strategies, economic (6%). In terms of social support as a form of coping strategy only 26(9.4%), out 277 respondents acknowledged they had any form of support. Out of these support,38.4% is Economical and 61.6% as social supports.

Keller and Dauenheimer, (2003) in their study, identified ways in which the stigmatized coped with identity threat as by withdrawing their efforts and/or disengaging their self-esteem from domains in which they are negatively stereotyped or fear being a target of discrimination.

In this study, the coping strategies identified ranged from staying indoors, retaliations to insults and attacks, avoidance of people that attract dislike, begging for alms and prayers that is those who are made to understand that prayer could aid their healing, isolating oneself among others.

5.4 Social Meaning of mental illness

The WHO (2004) reports that individuals may be fearful of being discriminated against if they are labelled as having a mental health problem. This underutilization of services has been reported even in countries where there is no need to make out of pocket payments to access services. As members of the general population, they are also exposed to common misconceptions surrounding mental disorders – for instance that they cannot be cured or that drug treatments do not work.

Focused Group Discussion conducted in this study revealed what mental illness is, socially. Mental illness is “madness” which means the person with queer, bizarre, strange behaviour and in tattered and dirty clothing or naked , wondering and roaming around aimlessly, picking from the ground, eating garbage, it is a curse, punishment from gods. The respondents also claimed, it is better they visit a prayer camp than hospital since people will shun your company in the community if they realised you have mental disorder. Socially, if you accept you are ‘mad’, people will shun your company, no job, no marriage, no home, so denial of having suffering mental disorder is paramount in the community. They also believe that if the sickness grows, the patients roam on the streets, beg for food and that is their end, they cannot get well again. Further, one is not to associate oneself with the sufferers of mental disorders

CHAPTER SIX

6.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

On the whole the study revealed that anybody associated with mental disorder is stigmatized and discriminated. All patients both males and females usually experience social, economic and psychological discrimination. However, at the work, employment and educational levels, more females are acknowledged being stigmatized and discriminated against. However at the family level and at health level, both sexes have been similarly stigmatized and discriminated. Caregivers also experienced barrages of stigmatization and discrimination from their colleague health workers. Averagely, stigma and discrimination were suffered by mental patients and their caregivers equally at all the four level outlined by this study. There were few coping strategies adopted by the respondents in the Ho Municipality. The coping strategies were more of social types than economic and psychological at patient level. Other coping strategies took the form of support comprising more economic than social.

6.2 Conclusions

In conclusion, Mental disorders are not respecter of person's status. From this study, everybody can be afflicted with this condition. Stigma and discrimination make people to hide and denial their mental state, coupled with ignorance of the fact that everybody could be affected. Few people who could not hide their mental state any longer are stigmatized and discriminated against by the society in which they find themselves.

6.3 Recommendations

The study recommends the following;

1. Health education needs to be intensified and to include care givers on the activities of mental health workers to help minimize these stigma and discrimination to the barest degree for the care givers to ensure that they give out their best to ensure that dignity is restored for patients also.
2. Finally further analytical studies into the specific areas such as what type of mental conditions attracts much stigma, and so on this study made findings about should be conducted, to determine the causes and relationships between factors. This can improve the knowledge base of the mental health and help in the planning and implementation of relevant mental health programmes.

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APPENDIXES

APPENDIX 1 DATA COLLECTING TOOL 1

Demography

Questionnaire Code : 001 Number of Patient: 001

Date of the Interview : ....

1. Age: [ ]
 1. < 20 years 2. 21-34 3. >35 years

2. Sex: [ ]
 1. Male 2. Female

3. Marital status: [ ]
 1. Married 2. Never Married 3. Divorced/ Separated 4. Widowed

4. Occupation: [ ]
 1. Farming 2. Trading 3.Civil Servant 4.Others (specify).............

5. Religion [ ]

 1. Christianity 2. Islam 3. African Traditional Religion 4. Others (specify) ....

6. Educational Level: [ ]

 1.None 2. Primary 3. MLSC/ JHS 4. Secondary 5.Tertiary

7. Ethnicity: [ ]

 1. Akan 2.Ewe 3.Others (Specify) ………………………

8. Has your place of residence changed due to the condition you are suffering from? [ ]

 1. Yes 2. No

HISTORY OF DISEASE CONDITION

10. What do you think is the cause of mental disorders? [ ]

 1. Spiritual/ Curse 2. Biological 3. Don't Know

11. Where were you diagnosed of this mental disorder? [ ]

 1. Health Facility 2. Faith based Healing Centre 3.Self/ Home management

12. How long have you been afflicted with this disease condition? [ ]

 1. < 1 year 2.1-4 year 3. 5-9 years 4. 10-14 years 5. ≥15 years

13. Where was your first source of help/ treatment for this condition? [ ]

1. Health Facility 2.Faith based healing centres 3.Self/ Home management

14 .What type of treatment do you prefer? [ ]

1. Biomedical 2. Faith- based (Spiritual) 3. Others (Specify) …………

QUESTIONS ON STIGMA AND DISCRIMINATION

Please read the questions below and tick [√] the appropriate response against each question below?

15. Individual Level

s/n	Question	Strongly agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly Disagree (5)
1	I have lost my self-esteem in the community.					
2	Family members hide me so no one knows I have mental disorder					
3	Family members exclude me from usual family activities					
4	People stare at me and pass remarks/ I experience verbal abuse by the community.					
5	Lost financial support from family members					
6	I am giving a special name					
7	My spouse deserted me					
8	No more giving food					
9	I lost my friends because I have a mental disorder					
10	I was banned by community not to talk at public.					

16. Work & Employment & Education

s/n	Due to my mental condition	Strongly agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly Disagree (5)
1	I lost my prospect for a promotion.					
2	My employer discriminated against me					
3	I am discriminated against by my work colleagues					
4	I have been refused employment					
5	I lost my job					
6	I lost my benefits at work					
7	I was withdrawn from school					
8	I was denied admission to a school					
9	My employer offered me early retirement.					
10	My job description was changed					

17. Family Level

s/n	Due to my mental condition	Strongly agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly Disagree (5)
1	Family is often excluded in community events.					
2	My family members are discriminated against.					
3	Nobody marries from my family in the community.					
4	My family is blamed for this condition by the community.					
5	My family members are ridiculed, mocked, in the community					

18. Community Level

s/n	Due to my mental condition	Strongly agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly Disagree (5)
1	My community is labeled with a special name.					
2	My community is prevented from grand durbars					
3	People are afraid to visit my community.					

19. Health System

s/n	Due to my mental condition	Strongly agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly Disagree (5)
1	I have been denied access to medical treatment or care by health personnel					
2	I have experienced a delay in the provision of health services/treatment by health personnel					
3	Health personnel ignored me when I called for help					
4	I have been forced to pay additional charges for medical services					
5	My colleague patients looked mean upon me at the health facility.					

CHALLENGES

Economic

20. What is the main economic challenge you faced with this condition? [ ]

1. No money to meet basic needs
2. No employment
3. No capital to start small scale business
4. Reduced earning capacity

Psychological

21 What is the main psychological challenge you faced with this condition? [ ]

1. Boredom
2. Lowered self esteem
3. Shame
4. Fear of stigma and discrimination
5. Helpless for not getting well again
6. Self blame and guilt

Social

22 What is the main social challenge you faced with this condition? [ ]

1. Loss of Identity
2. Loss friends and relatives
3. Inadequate social care
4. Physical and Verbal abuse

COPING STRATEGIES

Economic coping

23 What is the main coping strategy you use to cope with economic challenge you faced with this condition? [ ]

1. Begging for alms
2. I/ My Children stopped schooling

3. Do demeaning jobs for a living

Psychological Coping

24 What is the main coping strategy you use to cope with psychological challenge you faced with this condition?[ ]

1. Visit to several Faith based healers camp
2. Stop orthodox treatment and visit to mental health facilities
3. Deny I have mental disorder
4. Praying
5. Continuous Counselling
6. Singing

Social Coping

25 What is the main coping strategy you use to cope with social challenge you faced with this condition? [ ]

1. Leaving that geographical area
2. Aggression
3. Nothing

SUPPORT

Economical Support

26 What is the main form of economic support you have received? [ ]

1. Friends and family members providing my basic needs.
2. Financial assistance from the District Assembly
3. Others specify ………………

Psychological Support

27 What is the main form of psychological support you have received? [ ]

1. Family members reassuring me.
2. Counselling from health personnel
3. Prayer from my spiritual Leader
4. None

Social Support

28 What is the main form of social support you have received? [ ]

1. Shelter provided by District Assembly
2. Others (Specify) ……………….

29 What is the main group you get support from?

29a. Economic support [ ]

1. Family members
2. Health personnel
3. Friends
4. Colleague patients
5. NGO
6. Social Welfare

29b.Social Support [ ]

1. Family members
2. Health personnel
3. Friends
4. Colleague patients
5. NGO
6. Social Welfare

29c. Psychological support [ ]

1. Family members
2. Health personnel
3. Friends
4. Colleague patients
5. NGO
6. Social Welfare

30. Have you disclosed your condition to? [ ]

1. Nobody
2. Only immediate family
3. Only my spiritual Head
4. Widely known in the community

31. If an association is to be formed for people afflicted by mental conditions would you like to join? [ ]

1. yes 2. No

32. What is the main thing you can do to reduce the likelihood of others being affected by mental condition? [ ]

1. Talk about the condition to others
2. Form association to educate others on the condition
3. Others Specify ……………………

33. Do you freely visit social gatherings? [ ]

1.yes 2. No

34. Do have any other comment or suggestion..

....

DATA COLLECTING TOOL 2

Interview Guide

1. What are the various direct and indirect forms of expression of mental disorder-related stigma, discrimination and denial in Ho Municipal (probe answer further on family, community, work and employment and health care systems)
2. What are the different contexts, namely kinship relations, work settings or caring settings, in which discrimination and stigmatization occur, and how do such expressions vary according to the contexts and level at which they occur?(probe answers further)
3. What are the dominant individual, socioeconomic or cultural factors that influence or contribute to mental disorder linked stigmatization, discrimination and denial?(probe answers further)
4. What is the overall status of mental disorder related stigma and discrimination on the national agenda regarding human rights debate, public health issues and existing social tensions and conflicts? (probe answers further)
5. What is the role played by policies, media and advertisement to support or contain mental disorder related stigmatization and discrimination? What has been the role of MDAs and nongovernmental organizations?(probe answers further)
6. What are the outcomes of mental disorder related stigma, discrimination and denial, and can some of these experiences be used in interventions?(probe answers further
7. What does it mean in the community to have a mental disorder (probe answer further)
8. How do mentally ill patients and care givers cope with stigma and discrimination? (probe answers further)

APPENDIX 2 CONSENT FORM

Project Title: Stigma and Discrimination suffered by mental patients and their caregivers in the Ho Municipality of Ghana.

Stigma and Discrimination suffered by mental patients and their caregivers in the Ho municipality of the Ghana.

Institutional Affiliation:

School of Public Health,

College of Health Sciences

University of Ghana

Legon

Background

Personal Introduction:

The Principal Investigator is Priscilla Elikplim Tawiah, currently a masters student of the School of Public Health, Legon and conducting a study on the Stigma and Discrimination suffered by mental patients and their carers in the Ho municipality of Ghana.

This study is for academic purposes and a requirement for the award of Master of Science Degree in Applied Health Social science Degree and supervised by Dr. Moses Aikins of School of Public Health, University of Ghana, Legon.

Procedure:

An interview was conducted using questionnaires that were designed purposely for this study.

Risks and Benefits

There are no reasonably foreseeable harm that may arise from participating in this research while benefits that may arise include a greater contribution to the development of mental health policies.

Right to refuse:

Although there are no known risks associated with the research protocols, if you feel uncomfortable you have the liberty to opt out. You are also at will to withdraw from participating if you desire to do so.

Anonymity and confidentiality:

You are assured that the information collected will be handled with the strictest confidentiality, will not be shared with third parties not directly involved in the research and thus will be used purely for academic purposes.

Before taking consent:

Do you have any questions that you wish to ask? If yes, questions to be noted.

If you have question you wish to ask later, or anything you wish to seek clarification on regarding the research, please do not hesitate to contact the Principal Investigator (Priscilla Elikplim Tawiah) on;

Telephone number: 0243307228

Email:cillaeli@ymail.com

PARTICIPANT

I …………………………………………………a parent / guardian of Master/ Miss ……………………………………… having been adequately informed about the purpose, procedures, potential risks and benefits of this study. I have had the opportunity to ask questions and any question I have asked have been answered to my satisfaction. I know that I can refuse to participate in this study without any loss or benefit to which I would have otherwise been entitled. Having gone through the consent form thoroughly I agree to enroll / my child in this study.

Name of participant: …………………………………………………………………..

Signature or Right thumb print: …………………………………………….

Date: ……………………………….

Interviewer's Statement:

I have explained the procedure to be followed in this study to the client / client's parent or guardian, in the language that he/she understands best and he/she has agreed to participate in the study.

Signature of interviewer………………………………………………………….

Date……………………………………………………………………………………….