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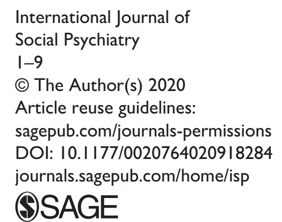

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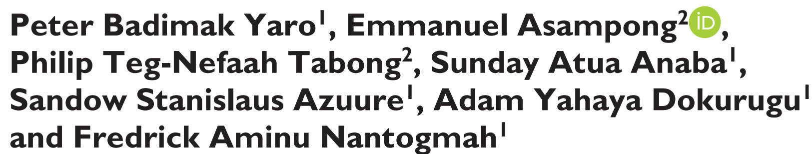
Stakeholders' perspectives about the impact of training and sensitization of traditional and spiritual healers on mental health and illness: A qualitative evaluation in Ghana



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Abstract

Background: Prayer camps and traditional healers have emerged recently as alternative sources of mental health care in Ghana. To increase their knowledge and collaboration between formal and informal mental health care providers, training and sensitization was organized for them.

Aims: This study aimed at assessing beneficiaries' views about the impact of this intervention.

Methods: We adopted narrative approach to qualitative enquiry using purposive sampling strategy to recruit formal and informal mental health care providers in Ghana for an in-depth interview. We analyzed the data thematically using QSR NVivo 12.

Results: Participants enhanced their knowledge about mental health and illness. They reported increased collaboration between formal and informal health care providers. Community psychiatric nurses (CPNs) give injections to patients instead of chaining and using shackles as was initially practiced. There are also regular visits by CPNs to traditional and spiritual healers to discuss the care of the mentally ill patients in their facilities.

Conclusion: There has been an increased collaboration among healers of mental illness resulting in quick recovery of patients who seek care at traditional and spiritual healers. There is also abolition of chaining and using of shackles by these healers, with increasing respect for the human rights of patients.

Keywords

Traditional healers, spiritual healers, community psychiatric nurse, training, collaboration

Introduction

Mental health service, although a very critical aspect of health and national development, remains one of the most neglected sectors in Africa (Faydi et al., 2011) and the situation is not different from what pertains to Ghana. It is estimated that Ghana has a treatment gap of about 98%, meaning that, for every 100 people suffering a mental illness, only two are likely to access treatment (World Health Organization (WHO], 2007). This figure excludes the number of unreported cases. This huge treatment gap is largely attributed to a scarcity of resources in terms of finances, trained personnel and facilities (Omar et al., 2010). According to the Executive Director of the Mental Health Authority, the doctor-to-patient ratio within the mental health setting of Ghana is 1:1.7 million compared with 1:1 million for Nigeria and 1:500,000 for Kenya (Osei, 2017). Again, the only three major government psychiatric hospitals are all located in the southern part of the country – two in the Greater Accra Region and one in the Central Region. There are also four privately owned psychiatric hospitals available, two in Kumasi, one in Accra and one in Tema. The lack of access to mental health facilities and the inadequate supply of mental health professions (Roberts et al., 2014) and the perceived causes of the condition (Borneman

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& Brown-Saltzman, 2016) sometimes make people to seek for help at traditional and spiritual healers. However, intense stigmatization, discrimination and inhumane treatment of the mentally ill have been reported in their quest to seek for spiritual and traditional healing (Dako-Gyeke & Asumang, 2013).

Ghana passed mental health act in 2012 which created the Mental Health Authority to spearhead the implementation of the provisions of the law. Although the law has been passed, mental health care is still largely provided at three public institutions (Accra, Pantang and Ankaful Psychiatric Hospitals) with little integration into primary health care, to enable prevention and early treatment of psychiatric disorders (Osei, 2017). Nonetheless, efforts are being made to strengthen community services which is required to decentralize management of mental health to the communities and foster early detection and treatment of mental disorders.

To increase access to community care, BasicNeeds Ghana secured a Department for International Development (DFID) grant for mental health care–related interventions over a period of 5 years. One of the interventions was to increase uptake of mental health services and reduce stigma in Ghana and foster greater engagement among stakeholders in mental health care. In this intervention, 400 traditional and 400 spiritual healers (informal health care providers) were trained on how to identify mental disorders and collaboration with formal health system. BasicNeeds Ghana implemented these projects with five other community-based organizations/non-governmental organizations (CBOs/NGOs) as project implementation partners, with an active collaboration with Ghana Health Services (GHS) and the Mental Health Authority of Ghana (MHAG) and the Christian Health Association of Ghana (CHAG). The training was aimed at building the capacity of informal health providers to identify and to refer people with mental illness or epilepsy to the formal Community Mental Health care service. These traditional healers and spiritual camps were located in nine of the 10 regions in Ghana. This study was therefore conducted to evaluate the impact of the intervention on mental health care and services in the selected regions.

Method and materials

Design

We adopted narrative and phenomenology approaches to qualitative studies (Creswell, 1998). We conducted in-depth interview (IDI) with community psychiatric nurses (CPNs), traditional and spiritual healers who are beneficiaries of the training and sensitization program and mentally ill patients who have had an encounters with the beneficiaries before and after the training. IDI is a strategy where a researcher interviews research participant one-on-one and this strategy is believed to be effective to elicit more private information (Bowling, 2014) and an essential approach for qualitative evaluation of health interventions (Green & Thorogood, 2004).

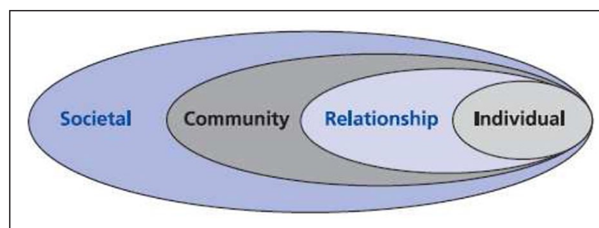

Figure 1. Ecological model for the impact of training and sensitization of informal health care provider (Garbarino, 1985).

We adopted the social ecological model (Figure 1). This model considers the complex interplay between individual, relationship, community and societal factors in affecting the phenomenon of interest (Dahlberg & Krug, 2002). The structures at each of the constructs in the model overlap illustrate how factors at one level influence factors at another level.

The individual constructs in the content of this study refers to the personal level factors such as personal benefits of the training and sensitization. The relationship which is the second level examines close relationships that may influence the care of mentally ill. It also looks at how the training has affected their world view about mental health and illness and how that has translated into care patients receive. The third level (community) explores the settings such as how the training has affected collaboration between traditional and spiritual healers and formal health system. The fourth and final level (societal) looks at the broad societal factors that help create a climate for the care of mentally ill patients. It also covers the laws and legislations that protect the human rights of the mentally ill patients.

Study area

We conducted this qualitative evaluation in the Republic of Ghana. Ghana is located on West Africa's Gulf of Guinea only a few degrees north of the Equator. Ghana shares borders with Côte d'Ivoire to the west, Togo to the east and Burkina Faso to the north. Ghana is also bordered to the south by the Gulf of Guinea and the Atlantic Ocean. The population of Ghana based on 2010 Population and Housing Census is 24,658,823 with an annual growth rate of 2.4% (Ghana Statistical Service, 2012). The nation has 10 administrative regions, which are further divided into metropolitan, municipality, districts and sub-districts. Health service delivery in the country follows a three-tier arrangement: primary, secondary and tertiary levels. The primary and secondary levels cover health facilities at the

sub-district, district and regional levels. An estimated 52,258 people are formally working in the health sector in Ghana, of which 81.5% are employed in the public sector. Ghana's doctor–patient ratio is approximately one doctor to 15,259 population (Ministry of Health [MOH], 2011). There are also about 21,791 registered traditional medical practitioners practicing in Ghana (MOH, 2011).

The study was, however, conducted in three regions. The regions include Northern, Brong Ahafo and Central regions. The Northern region was selected because it is the biggest of the three regions located in the Northern part of Ghana. The Brong Ahafo region is selected to represent the regions located in the middle belt. This region is central to MIHOSO, a partner to BasicNeeds during the implementation of this program. The Central region was also selected because it has one of the three mental health hospitals in Ghana.

Study participants and selection of participants

The study participants were spiritual healers and traditional medical practitioners, people with mental condition who are lucid and their carers and CPNs as way of triangulating data (Denzin, 2012). We sampled 21 traditional healers, 11 spiritual healers, 13 patients and their carers and nine CPNs. Analysis of the data was done during data collection with the ultimate aim of ending the study at the point of saturation (Creswell & Clark, 2007; Green & Thorogood, 2004). So the study was ended at the point of saturation. In all, 54 interviews were conducted across the three regions.

Purposive sampling technique was used to select participants in this study. Purposive sampling allows researchers to select rich cases or people who are deemed appropriate for addressing a particular research topic (Bowling, 2014; Green & Thorogood, 2004). The researchers first collected the list of traditional and spiritual healers in the three regions who were part of the training and sensitization program. From the list, purposive sampling was employed to select participants to reflect a maximum variation as recommended by Bowling (2014). In doing the sampling, consideration was given to gender. Hence in each region, the sampling was done in such a way to give gender representation in both traditional and spiritual healers where possible. For patients, they were selected based on receiving care from the traditional and spiritual healer either before the training or after the training to share their experience as required in phenomenology approach to research (Creswell, 1998).

Data collection strategies

IDIs were the main data collection strategy employed in this study. IDIs from a life history perspective can give rich information on personal experience and ideology, as well as on social structures and institutions (Plummer, 1983). Face-to-face IDIs were conducted with selected participants. All the interviews were conducted at suitable and agreed venue with the participants. The interviews were conducted between 7 June 2018 and 26 June 2018. All the interviews were recorded using a digital voice recorder. All IDIs took between 30 and 45 minutes to complete.

All the interviews were conducted by one of the principal investigators (PI; P.T.-N.T.) who has a wealth of experience in qualitative study design and interviews. He had in the past consulted for both local and international organization in qualitative research design and data collection. During the data collection detailed field notes were taken. These notes included pictures of consulting rooms, dispensary and other information that could not be recorded using the voice recorder. All the field notes were written immediately after the interviews (Mack et al., 2005). This enabled us to contextualize the field notes and this was very relevant during data analysis.

Data collection tools

Three different IDI guides were designed and used for data collection – one for traditional and spiritual healers (S1), one for CPNs (S2) and another for the patients and their carers (S3). The tools were tested in a pilot study among five traditional and five spiritual healers in the Greater Accra region. The guides were constructed according to the construct of the ecological model (Garbarino, 1985). The guides contained areas such as knowledge on causes of mental illness, management of mental illness, referral system, change in attitude and perception about mental illness after the training and collaboration between informal and formal health system. That of the patients and their caretakers focused on illness history, health-seeking experience with informal health care providers and treatment they received.

Data analysis

The voice recordings were transcribed verbatim by an independent person and was reviewed by the PIs because they have foreknowledge of the local languages. In doing transcription, we used pseudonyms to replace personal identifiers. Selected transcripts were reviewed and the emerging issues used to develop a codebook. The codebook were discussed and accepted by all the researchers. The transcripts were imported into QSR NVivo 12 software. The codebook was also imported into NVivo as nodes. We adopted thematic content (Bernard, 2006) in this study.

Results

Background information about participants

In all, 54 people were interviewed in the entire study – 19 in central region, 17 northern region and 18 in the Brong

Table 1. Background information about participants.

Type of participant	Central region	Northern region	Brong Ahafo region	Total
Traditional healers	6	10	5	21
Spiritual healers	5	–	6	11
Patients/caretakers	5	4	4	13
Community psychiatric nurses	3	3	3	9
Total	19	17	18	54
Socio-demographic characteristics	**Traditional healers**	**Spiritual healers**	**Patients**	**Total**
Sex[a]				
Male	11	6	7	24
Female	10	5	6	21
Marital status[a]				
Never married	2	2	3	7
Married	19	9	10	38

[a]$N = 45$ (excludes health workers).

Ahafo region. Twenty-one traditional healers, 11 spiritual, 13 patients with caretakers and nine CPNs were interviewed across all the three study regions (Table 1).

View about benefits of training

Traditional and spiritual healers interviewed across the three study sites clearly indicated that the training organized for them was very useful in several areas. Interviewees revealed that the training increased their level of knowledge and understanding about mental conditions and the Mental Health Act of Ghana. The training also exposed them to the human rights issues embedded in mental health care, particularly the need to respect the human rights of patients and relatives. The following quotes support these points:

> I now know that there is something call mental health act which protect the rights of mentally ill patients. We are compelled to treat them better than we used to do because we can be arrested if we abuse their human rights. (Female spiritual healer, BAR)

> The training exposed me to the mental health act and the need to respect the human rights of patients that we take care of. Now I tell all the people who work with me to respect all patients including those who are mentally ill. (Male traditional healer, CR)

> The training was very helpful. It increased my knowledge about mental illness and the need to collaborate with hospital. (Female traditional healer, CR)

Mentally ill patients who have had encounter with traditional and spiritual healer revealed that they were satisfied with the care they received. One patient shared his experience with traditional healer:

> I have been coming here for treatment for close to nine years now. First anytime I come here they chain me. But the last time I had the attack and was brought, they did not chain me. They told me sister that they received training and were told not to chain patients again. (Male patients, CR)

Another patient also shared her experience regarding the quality of health care:

> This time they treat us very well when we come because they said they received training and the help the, to understanding that not all mentally ill patients are caused by spiritual factor. So they invited nurse here to also give me their drug which I am taking alongside their treatment. In the past they will ask you to stop the medicine you have received from the hospital. (Female patients, BAR)

Traditional and spiritual healers have abolished the use of chains and shackles

One of the key areas that was covered in the training was orientation on respect for human right and abolition of chaining and use of shackles. Traditional and spiritual healers have several strategies to restrain aggressive patients. Some participants indicated they have special herbs which is smeared around the nose of the patients. The patient becomes calm and falls to sleep upon inhaling the gas produced by this herb. Others also bath the patient with special herbal preparation as illustrated by the following quotes:

> . . . Usually when we have such cases (referring to aggressive patients) and the person run into someone around, we have some young guys around who will help us to sit the person down. We then prepare some herbs and bath him/her and afterwards the person will calm down. (Male traditional healer, NR)

> I have special herb which I can bring close to the nose of the patients and when he inhale the scent he/she will sleep or I bath the patients with the herb and that is enough to calm down the patient. (Male traditional healer, BAR)

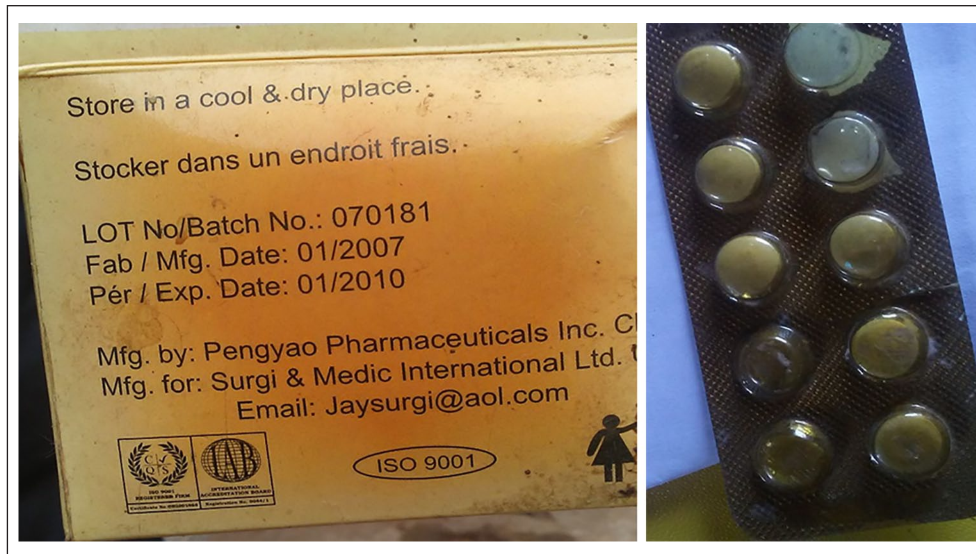

Figure 2. Expired largactil use to calm down aggressive patients.

Some herbalists also use chlorpromazine (lacgartil) which they buy from drugstore. In Northern region, for example, a traditional healer brought out largactil when asked about how he restrains aggressive patients. An assessment of the drug showed it had expired since the year 2010 but was still being used (Figure 2).

The traditional healer was of the view that there was shortage of the drug that they receive from health workers. So they have no option than to use the expired medication. Traditional healers were of the view that they have received training and were told not to use chain or shackles on patients. So the only way to restrain aggressive patient was to use the expired medication:

> As we seated here if they should bring an aggressive mentally ill person, then the person is usually tied before they bring the person here. What I usually do is to plead with the person then give a tablet I took from the big hospital. Within a few minutes he/she will sleep. (Male traditional healer, NR)

> At first, when they bring a mentally ill person and he/she is aggressive we forcefully hold the person down and tie the hands before we give the person the medicine. But after the training we do not tie them again. We make people hold them then we use the herb to bath them. So after obtaining that knowledge we do not tie them up again. (Male spiritual healer, CR)

> Before the training I used chains and shackles to restrain aggressive patients but now I do not do that. During the training we were informed to respect the human rights of patients. So if a patient comes here and is aggressive we should contact the nurse and come and give them drugs to calm them down. (Male traditional healer, BAR)

Across all the three regions, no single patients or carer revealed that we were chained or put on shackles despite having indicated they were brought in an aggressive state.

Traditional and spiritual healers collaborating with CPN

In addition to the increase in knowledge, interviewees were of the view that it fostered collaboration between traditional/spiritual healers and formal health system (hospital and clinic). In this collaboration, health workers are able to visit shrines and camps of traditional and spiritual healers to screen for people with mental health conditions and offer biomedical medications. The following quotes illustrate these points:

> I must be frank with you the training was very useful and has helped us in our practice. I call the nurse anytime I get a patients and they bring me medications to add to what I give to the patients. So we should keep up the collaboration and training. (Spiritual healer, BAR)

> The training is very helpful. Now when I get a patient who is violent, I call the nurse to come and give the injection. They have given me drugs for some of the patients here and I give it to them according their (nurses) instruction in addition to the prayers. So it is very helpful. The only problem is that recently he told me they have run short of the medication and as a result of that one of my patient's condition is going backward. (Female spiritual healer, CR)

> The nurse now come here and I accept them because of the training. We can even call them and they come to give the medicine to the patients here. We take care of the spiritual aspect of the illness and they take care of the physical illness, it is very helpful because now people with mental conditions do not keep long here because of the collaboration. (Female traditional healer, NR)

CPNs interviewed in this study acknowledged that they are often invited through telephone calls by traditional and spiritual healers anytime there is an aggressive patient.

This afford them the opportunity to give injections to calm down the patients, thus preventing them from being restrained using chains and shackles. These points are illustrated by the following quotes from health workers:

> I always visit them to screen people for mental illness. Anytime they bring a patient with mental illness they call me and I go to assess and also put the person on medicine. The training was good because they now understand we are all doing the same thing to ensure that the patients get better. (Male CPN, NR)

> We are now collaborating better than before. They now call us when they have cases and we go and give them the medication there. The only challenge now is the shortage of the medicine. So when they call us now you go there and you are not able to help because you do not have injections to calm down aggressive patients. So the government must do well to provide us with the medication as our patients are relapsing. (Female CPN, CR)

> They call us anytime they have cases and we also go to do our assessment and give medications. They even agree to take the medications for patients without relatives and give them medicine accordingly. They have realized that our medication help their patients to get better quickly. (Male CPN, BAR)

This collaboration according to interviewees has had a positive impact on patients' recovery and prevent relapse of patients. According to traditional and spiritual healers, the concurrent use of their medicine and the psychotropic medications from the hospital leads to faster recovery. They have also indicated that the continuous use of the medicine after discharge prevents relapse of the condition. This has therefore reduced the number of cases in their facility to prevent congestions they used to experience in the past. The following quotes support this point:

> Our patients now recover fast and do not stay here for long. I have realized that any person who combines our spiritual exercise with the medicines from the nurses recover faster. So it is having positive impact on patients. (Female traditional healer, BAR)

> In the past when you come here you will see several people with mental conditions because they stay here for months without recovering. However, when they take the medicines from the hospital and our own they recover very fast and do not relapse. Because before I discharge you I call the nurse to come and give you the medicine and I encourage them to take that medicine at home and to return to the hospital for more when it is getting finish. This has prevented the congestion I used to experience because my facility is small. (Male spiritual healer, CR)

Ways of improving mental health care

Four main sub-themes emerged as ways to improve mental health care in Ghana. These include passing of the Legislative Instrument (LI) to operationalize mental health act, increase funding of mental health activities, provision of medication or integrating psychotropic medication into the national health insurance (NHIS) and increase collaboration between formal and informal health system.

Health workers who participated in this study called on the government to pass the LI to operationalize the mental health act. To them the absence of this LI was negatively affecting funding of mental health activities in the country. Health workers indicated that mental health activities are currently being funded by civil society groups, NGOs and multi-national organizations. However, this funding has plummeted in recent times which was adversely affecting patients care. The following quotes illuminate these points:

> We have challenges funding mental health activities in our district and the country. I have a motorbike which was given to me by BasicNeeds Ghana but fueling is a problem. So it is difficult to regularly visit patients and traditional and spiritual healers. The government must pass the LI so that mental health care can have dedicated funding source. (Male CPN, BAR)

> Now even psychotropic drugs are not available in our facilities. No hospital buys the medicine because it is not covered by NHIS. So most of our patients are now relapsing. When you complain, they tell you the government has not passed the LI which will make it possible for the government to fund mental health activities. We are seriously neglected and the government seem unconcern. (Female CPN, CR)

> Mental health is a neglected area even though everybody can become mentally ill at any point in time. I am not able to visit prayer camps because I do not have the drugs to give them. It was BasicNeeds that supplied us some drugs in the past but when it got finished that is all. So is a big problem. (Male CPN, NR)

To help ameliorate the frequent shortage of psychotropic medications in health facilities across the country, participants suggested government should consider including drugs for treating mental conditions on the list of medications covered by the NHIS scheme. This way, hospitals can procure the medications to be given to mentally ill patients. The following quotes from health workers who participated in this study support this view:

> The government should add the psychotropic medications to health insurance. Because treating mental conditions in free and the drugs are not reimbursable by national health insurance authority, hospitals are reluctant to procure the drugs and only wait for donation or supplies from the government. This is responsible for the shortages we are experiencing. (Female CPN, CR)

> It is time for the government to add psychiatric drugs to national health insurance to reduce the shortage. No hospital

> is willing to use their money to buy the drugs and give it to patients for free and government is also not supplying the hospital with the drugs. So now some patients are forced to buy it from pharmacy shop. (Male CPN, BAR)

Participants also revealed that increasing funding of mental health activities will enable health workers to reach out to communities to educate them on mental health. To them, strengthening the community mental health service will prevent the congestions at health facilities. There was an appeal to government to allocate some percentage of district assembly common fund to mental health activities. The following quote illuminates these points:

> The government must find innovative ways to increase funding of mental health activities. Majority of the cause of mental illness are preventable. We need to reach out to communities to educate them but how do you that when there is not funding? Funding is major a drawback to mental health in Ghana. (Male CPN, NR)

> The government must force district assemblies to allocate some percentage of the district assembly common fund to mental health activities. When you walk around town you will find many mentally ill patients that we could take care of but we do not have funding. (Male CPN, BAR)

Finally, participants believed good collaboration between formal health system, traditional and spiritual healers was an essential strategy to improve mental health care. According to participants, a good collaboration among the traditional/spiritual and orthodox medical practitioners will provide an opportunity for the training of traditional/spiritual medical practitioners in current scientific knowledge and enhance inter-practitioner referral system, which can cater for both biological and spiritual aetiologic factors as was observed in this study. The following quotes support these points:

> A good collaboration between the traditional and spiritual healers and the nurses is very helpful and provides a holistic approach to managing health illness. Some people believe that the condition is caused by spiritual factors. So the spiritual healers take care of that and we also give our drugs based on our assessment. This helps the patients to recover fast and create trust among us. We also use that opportunity to teach the traditional and spiritual healers and also learn from them. (Male CPN, NR)

> The collaboration between us (spiritual healers) and hospital help the patients recover very fast. We learn from each other and we refer patients to them. They come and give drugs and we give it to the patients and also help them deal with spiritual aspect of the illness. Before I discharge any patent, I invite the nurse to come and give the patients the drugs to take home and this prevent them from coming back. (Female spiritual healer, CR)

Discussion

Mental health care in Ghana: impact of training and sensitization of traditional and spiritual healers

Participants were unanimous in the positive impact of the training and sensitization about mental health. One important benefit of the training is ongoing collaboration between traditional/spiritual healers and orthodox health practitioners. Although Ghana has created a traditional and alternative medicine directorate which is aimed at ensuring integration of non-orthodox medical practitioners into the formal health system, this is yet to be fully implemented across health facilities in Ghana. This collaboration provided the opportunity to use the outlets of the traditional and spiritual healers to screen for mentally ill patients. In India, a study found that outreach service to traditional and spiritual healers by health workers for people with schizophrenia which provided psychosocial support and advice, alongside psychotropic medication, was shown to reduce symptoms, disability and family burden (Murthy et al., 2005). Hence, this collaboration is essential to patients' recovery. This collaboration could be extended to other disease conditions especially infectious ones.

Ghana currently operates a Community-based Health Planning and Services (CHPS) strategy where Community Health Officers (CHOs) are deployed to live in communities to provide door-to-door care to patients (Nyonator et al., 2005). These CHOs could be orientated to also collaborate with traditional and spiritual healers in their community. Their outlets could be used to screen for people with community disease since they have emerged as alternative health-seeking outlet with high patronage among community members. For example, a study in Ghana reported that tuberculosis was believed to be a spiritual condition and caused by ancestral punishment and health care was sought at traditional healers (Cofie & Liu, 2014). Hence, good collaboration could lead to early identification of communicable diseases such as tuberculosis.

Another area of impact is the change in practice of restraining aggressive patients through the use of chains and shackles. This is an important intervention as chaining and use of shackles to restrain mentally ill patients is one of the dehumanizing practices that has received global attention. The mistreatment of the mentally ill in many low-income countries is widely reported within psychiatric hospitals, informal healing centers and family homes. In Ghana, an earlier study found that chaining and beating of the mentally ill was conventional in homes and treatment centers in communities (Read et al., 2009). It is therefore noteworthy that any intervention that has led to the abolition of this practice is a step in the right direction.

Critical to the impact of this training is the sensitization on human right of people with mental illness. All traditional and spiritual healers acknowledged a change in their attitude toward people with mental conditions. They indicated they now respect the rights of patients once they became aware of the existence of laws protecting the rights of patients. Although there are laws to protect the right of people with mental illness, their implementation at rural areas is always a challenge (Read et al., 2009). The constitution, public health act and mental health act clearly articulate the need to respect and protect human rights of all citizen despite that human right abuses have been documented among patients seeking treatment for mental condition (Dako-Gyeke & Asumang, 2013; Read et al., 2009). This change in attitude will positively affect mental health care in Ghana.

Improving mental health care: passing of LI for mental health act and increase funding indispensable

Participants in this study clearly indicated that it appears government has little attention for mental health care. Shortage of psychotropic medications in health facilities was one such area that was used to buttress the seeming neglect for mental health care in Ghana. The shortage of the medication compelled some traditional healers to use expired medications on patients. Use of expired drugs has adverse effects on the body. Medicines typically contain one or more active ingredients accompanied by excipients and additives (Taft, 2009). All of these things are chemicals that after a specific period of time could degrade into other chemicals. When the drug is expired, the excipients degrade or undergo some chemical reactions to get converted into other chemical compounds that lead to toxicity (Taylor & Grabovich, 2009). These call for sensitization of traditional and spiritual healers on the need to stop using expired medication. These drugs do not only become ineffective but may also lead drug toxicity.

Increasing funding for mental health care is as essential as providing resources for infectious diseases and chronic conditions such as diabetes, hypertension and cancers. An earlier study has found that economic costs of mental illness are as high as those caused by infections and chronic somatic conditions (Trautmann et al., 2016). An economic model developed from a study estimated that for every US$1 spent on treating depression, production would be restored by the equivalent of US$2.50 (Meredith, 2018).

Mental health care is underfunded across the continent compared to other health concerns. According to the WHO (2005), 70% of African countries spend less than 1% of their health budgets on mental health. In Ghana, government spending as percentage of gross domestic product (GDP) is below the threshold of 14% with respect to the Abuja Declaration of 2000 (The Global Fund, 2014). Given the potential economic benefit the government can make from the estimates above, it would be important for the mental health authority to lobby for the increase in health expensive and the difference used to fund mental health activities.

Conclusion

The training increased the traditional and spiritual healers on mental illness and has fostered collaboration between CPNs and spiritual and traditional healers. This collaboration has resulted in quick recovery of patients who seek health care at traditional and spiritual healers. The training has also lead to abolition of chaining and use of shackles by traditional and spiritual healers with more attention given to respect of human rights of patients. Shortage of psychotropic medication is undermining biomedical care of mentally ill patients.

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Authors' contribution

P.B.Y., E.A., P.T.-N.T. and S.A.A. conceived and designed the study. P.T.-N.T., S.S.A., A.Y.D. and F.A.N. performed the data collection. E.A., P.T.-N.T. and P.B.Y. analyzed the data. P.B.Y., E.A. and P.T.-N.T. contributed reagents/ materials/analysis tools. E.A., P.T.-N.T. and P.B.Y. wrote the paper. All authors read and approved the final manuscript.

Availability of data and materials

The data sets during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Conflict of interest

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Ethical approval

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References

Bernard, H. R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches. Library* (Vol. 4). Rowman & Littlefield.

Borneman, T., & Brown-Saltzman, K. (2016). Meaning in illness. In B. R. Ferrell (Ed.), *Spiritual, religious, and cultural aspects of care* (pp. 71–90). Oxford University Press.

Bowling, A. (2014). *Research methods in health: Investigating health and health service* (4th ed). Open University Press.

Cofie, R., & Liu, A. (2014). Knowledge, myths and misconceptions of Ghanaians about tuberculosis. *International Journal of Advanced Physiology and Allied Sciences*, *2*(1), 24–30.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. SAGE.

Creswell, J. W., & Clark, P. V. L. (2007). Designing and conducting mixed methods research. *Australian and New Zealand Journal of Public Health*, *31*(4), 388. https://doi.org/10.1111/j.1753-6405.2007.00096.x

Dahlberg, L., & Krug, E. (2002). Violence-a global public health problem. In E. Krug, L. Dahlberg, J. Mercy, A. Zwi & R. Lozano (Eds.), *World report on violence and health* (pp. 1–56). World Health Organization.

Dako-Gyeke, M., & Asumang, E. S. (2013). Stigmatization and discrimination experiences of persons with mental illness: Insights from a qualitative study in southern Ghana. *Social Work and Society*, *11*(1), 1–14.

Denzin, N. K. (2012). Triangulation 2.0. *Journal of Mixed Methods Research*, *6*, 80–88.

Faydi, E., Funk, M., Kleintjes, S., Ofori-Atta, A., Ssbunnya, J., Mwanza, J., . . . Flisher, A. (2011). An assessment of mental health policy in Ghana, South Africa, Uganda and Zambia. *Health Research Policy and Systems*, *9*, Article 17. https://doi.org/10.1186/1478-4505-9-17

Garbarino, J. (1985). *Adolescent development: An ecological perspective*. C.E. Merrill.

Ghana Statistical Service. (2012). *2010 population and housing census final results*.

The Global Fund. (2014). *Global Fund grants to Ghana*.

Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. SAGE.

Mack, N., Woodsong, C., Macqueen, K. M., Guest, G., & Namely, E. (2005). *Qualitative research methods: A data collector's field guide*. Family Health International.

Meredith, S. (2018). *Treating mental illness could save global economy billions – And it's 'costless'*. https://www.cnbc.com/2018/02/10/treating-mental-illness-could-save-global-economy-billions-study-says.html

Ministry of Health. (2011). *Ghana Human Resources for Health Country Profile*.

Murthy, R., Kumar, K., Chisholm, D., Thomas, T., Sekar, K., & Chandrashekar, C. (2005). Community outreach for untreated schizophrenia in rural India: A follow-up study of symptoms, disability, family burden and costs. *Psychological Medicine*, *35*, 341–351.

Nyonator, F. K., Awoonor-Williams, J. K., Phillips, J. F., Jones, T. C., & Miller, R. A. (2005). The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation. *Health Policy and Planning*, *20*(1), 25–34. https://doi.org/10.1093/heapol/czi003

Omar, M. A., Green, A. T., Bird, P. K., Mirzoev, T., Flisher, A. J., Kigozi, F., & Ofori-Atta, A. L. (2010). Mental health policy process: A comparative study of Ghana, South Africa, Uganda and Zambia. *International Journal of Mental Health Systems*, *4*, Article 24. https://doi.org/10.1186/1752-4458-4-24

Osei, A. (2017). *Mental health situation in Ghana*. https://www.modernghana.com/news/810710/mental-health-ghana-seeks-to-end-chaining-of-mad-people.html

Plummer, K. (1983). *Documents of life: Introduction to the problems and literature of a humanist method*. Allen & Unwin.

Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health*, *5*(13), 1–15.

Roberts, M., Mogan, C., & Asare, J. B. (2014). An overview of Ghana's mental health system: Results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). *International Journal of Mental Health Systems*, *8*(1), Article 16. https://doi.org/10.1186/1752-4458-8-16

Taft, D. R. (2009). Drug excretion. In M. Hacker, W. Messer & K. Bachmann (Eds.), *Pharmacology: Principles and practice* (pp. 175–199). Academic Press. https://doi.org/10.1016/B978-0-12-369521-5.00009-9

Taylor, W. R., & Grabovich, A. (2009). Targeting the cell cycle to kill cancer cells. In M. Hacker, W. Messer & K. Bachmann (Eds.), *Pharmacology: Principles and practice* (pp. 429–453). Academic Press. https://doi.org/10.1016/B978-0-12-369521-5.00017-8

Trautmann, S., Rehm, J., & Wittchen, H. (2016). The economic costs of mental disorders. *EMBO Reports*, *17*(9), 1245–1249. https://doi.org/10.15252/embr.201642951

World Health Organization. (2005). *Mental Health Atlas 2005*.

World Health Organization. (2007). *Ghana a very progressive mental health law: Mental Improvements for Nations Development*.