Perspectives of different stakeholders about mental health care services provided by traditional healers in Ghana and the possibility of the integration of traditional medicine into mental health care.

by
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DECLARATION

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DEDICATION

I dedicate this thesis to my daughter, Sa-amtiyin Maxine Yaro-Tatolum, of blessed memory. You are pure soul and I know you are resting in the bosom of God the Almighty! You will forever remain in my heart.

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I take responsibility for any mistakes, anomalies that may be found in this work and do please direct them to me.

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ABSTRACT

There is recognition that despite technological advancement and increase in expenditure in formal health care services, the popularity of traditional healing services has remained very high. This is demonstrated by the high utilisation of services of traditional healers, especially for the management of mental illnesses. This study undertook to explore perspectives of different stakeholders about mental health care services provided by traditional healers and the possibility of integrating traditional medicine into formal community mental health care in northern Ghana. It was a qualitative study where field data was collected using Key Informant Interviews and Focus Group Discussions with a range of stakeholders, made up of traditional healers, mental health service users and their primary carers formal community mental health workers, made up of mental health nurses and general health nurses, as well as district, regional and national level health policy officials and legislator. Analysis of the data was done using the thematic analysis framework of Braun and Clarke (2006). The findings of the study supported the high utilisation of traditional healing services in the treatment of mental illnesses and epilepsy. On the whole, views of stakeholders were that integration of traditional healers and their services into formal community mental health treatment services would enhance mental health services, scale up mental health care and reduce the mental health treatment gap in Ghana.

On how such integration might work within the formal health system of Ghana. The finding clearly indicate that integration of services of traditional healers does not amount to their locating in public health facilities such as hospitals and clinics, with offices or working spaces to operate from. Traditional healers wold continue to be in their places of operation. Opportunities to bring about such inclusion of traditional healing services into formal community mental health care was that the study established that both traditional healers and community mental health workers being agreeable to working together. Also current national level efforts and the global momentum for increased attention to mental health has included mobilising all available

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resources to optimise mental health care service provision among the population, especially in low income settings. Ghana's Mental Health Act, 2012 (Act 846) and association of traditional healers in mental health were other opportunities to take advantage of to maximise the services of traditional healers in community mental health care service provision. Challenges to the effective integration of traditional healing services into formal community mental health care included the different approaches and nosological perspectives of traditional healing and formal community mental health services, low literacy and numeracy levels of traditional healers, funding constraints and inadequate political commitment, as well as concerns with misuse of knowledge and attributions of the contribution of formal and traditional healing services to treatment and recovery of service users.

It is recommended that a referral process be in place and traditional healers so identified to be treating mental illnesses of epilepsy located within proximity of community mental health service facility are engaged, through regular meetings and supportive visits, are encouraged to refer people who come to them with mental health care needs to the Community Psychiatric Units for treatment. They can be assured to have the patients to administer their prayers. The regular meetings between traditional healers and formal mental health practitioners should help diffuse the mutual suspicion between and among the two categories of health care practitioners. Guidelines detailing when to refer and minimum standards can be collectively agreed upon and regularly reviewed to ensure compliance.

A system of monitoring and supervision of practices and activities of traditional healers should be in place to prevent excesses. The Mental Health Act, 2012 (Act 846) provides for such monitoring and supervision for compliance through the Visiting Committees and Mental Health Tribunals

Key words: community mental health, traditional healers, integration, community health workers, service users, carers

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LIST OF ACRONYMNS

AFFIRM	**AF**rica **F**ocus on **I**ntervention **R**esearch in **M**ental Health
CHPS	Community Health Planning and Services
CMHO	Community Mental Health Officers
CPN	Community Psychiatric Nurse
CPU	Community Psychiatric Unit
GHAFTRAM	Ghana Federation of Traditional Medicine Practitioners Associations
GSS	Ghana Statistical Service
LMIC	Low and Middle Income Country
OPD	Out-Patient Department
MHAPP	Mental Health and Poverty Project funded by the UK Department for International Development
mhGAP	Mental Health Gap Action Programme
MoH	Ministry of Health
NDPC	National Development Planning Commission
NGO	Non-Governmental Organisation
PHC	Primary Health Care of the WHO
PRIME	**PR**ogramme for **I**mproving **M**ental health car**E**
SHG	Self-Help Group
TBA	Traditional Birth Attendant
TH	Traditional Healers
UNCRPD	United Nations Convention on the Rights of Persons with Disability
UNDP	United Nations Development Programme
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

This chapter gives a brief background on mental health and the global emphasis on community mental health care and integration of mental health care services into Primary Health Care (PHC). This is meant to provide a basis for and purpose of the study, which relates to exploring stakeholder perspectives on the services of traditional healers mental health care services and the possibility of integration of traditional healing services into community mental health care treatment services as part of x enhancing and scaling up of mental health care in Ghana.

1.2 Primary health care and community mental health

The Primary Health Care (PHC) strategy of the World Health Organisation (WHO) that governments across the world, including Ghana, adopted in 1978 was, among many other things, for them to commit to the mobilisation of local resources, including traditional medicine, with the purpose of realising the social goal of 'Health for All by the Year 2000' (WHO, 1981). Similarly, following the 2000 World Health Report of the WHO, recommendations for scaling up mental health care services were to decentralise mental health, ensuring it is effectively integrated into PHC and to maximise the presence and services of traditional healers (WHO, 2001).

Community mental health refers to the package of decentralised mental health care available at the most basic health service facility (WHO, 2003). Community mental health care significantly supplements and decreases more costly in-patient mental health care delivered in psychiatric hospitals (Ofori-Atta, Read, Lund, & MHaPP Research Consortium, 2010; WHO, 2011, 2003). Community mental health is recognised and constitutes a policy for integrated health care addressing access to mental health care services to the population in Ghana (Asare, 2003).

Community mental health is widely promoted as a key approach to having mental health treatment services in out-patient settings (Jacob, Sharan, Mirza, Garrido-Cumbrera, Seedat, Mari,

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Sreenivas et al, 2007; Thornicroft & Tansella, 2014; WHO 2001). Community mental health is considered as an important step to achieving the integration of mental health services into general health care at the PHC level and making it accessible in less stigmatising forms to the population (Jacob et al, 2007; Saraceno, van Ommeren, Batniji, Cohen, Gureje, Mahoney, Sridhar, Underhill, 2007; Thornicroft & Tansella, 2003; Thornicroft & Tansella, 2014). Community mental health is recognised as a cost effective approach to scaling up mental health services in LMICs, hence making mental health services available to the larger numbers of populations needing them (Lancet Global Mental Health Group, 2011). According to Eaton, McCay, Semrau, Chatterjee, Baingana, Araya, et al (2011), the WHO's description of the scaling-up of mental health care services as a set of deliberate efforts to increase the impact of health service innovations that have been successfully tested in pilot or experimental projects to benefit more people and to foster policy and programme development on a lasting basis.

The WHO launched the Mental Health Gap Action Programme (mhGAP) and implementation guide as a key strategy and action to bring about community-based mental health care services (WHO, 2010). The first-ever WHO action-plan for mental health (2013-2020), equally emphasises among other things "integrated mental health and social care services in community-based settings" (WHO 2013, p5). With this approach, institutional care will be reduced to the barest minimum and mental health care services becomes more decentralised and integrated into general health care services (WHO, 2013).

1.3 Mental health in Ghana and northern Ghana

Formal mental health care services in Ghana began with the establishment of a lunatic asylum, which was backed by a Law (Lunatic Asylum Ordinance of 1888). The first formally designated mental health facility was the Accra Psychiatric Hospital built in 1909 (Asare, 2003, Dixon, 2012; Fournier, 2011). Since then, formal services have evolved from the mainly custodial and institution-based care to that which encourages integrated community-based services (Read et

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al, 2009). Until 2012 when Ghana had a new mental health Law (Act 846; 2012) the country's mental health system was largely based on the 1972 Mental Health Decree (NRC 30), which, even though it was a marked improvement of the Lunatic Asylum Ordinance of 1888, still steered mental health service provision towards an institutionalised one (Doku, Wusu-Takyi & Awakame, 2012, WHO, 2007). As a result, the orientation of Ghana's mental health services is one that is highly institutionalised, centralised and medicalised.

In Ghana, community psychiatry became formal in the mid-1970s with the establishment of the first set of Community Psychiatric Units in selected hospitals in around half of the then districts of Ghana. With this move, and for the first time, formal psychiatric services were available and provided outside the psychiatric hospital (Ofori-Atta et al, 2010). The first Community Psychiatric Unit was established in 1975, one in the Western Region and another in the then Upper Region, in Bolgatanga, (Amina Bukari, Personal interview, February 13, 2013). This was an important shift in the practice of psychiatry in Ghana, as formal mental health treatment service moved out of the precincts of the mental hospitals for the first time, whereupon psychiatric services were provided in general hospitals. These CPUs herald the setting up of more CPUs across the country. Alongside, promotion of community-based mental health care and the establishment of CPUs, Ghana also by policy provides mental health care services free of cost at the point of delivery.

Northern Ghana, which is the focus of this study, refers to the three northern-most regions of Ghana. These are the Northern Region, Upper East Region and Upper West Region. This area covers the Savannah grassland parts of Ghana. Northern Ghana is also referred to as the 'North'. It covers 40% of Ghana's land area (World Bank, 2011) but contributes just about 18% of the total population of the country (GSS, 2010). Despite considerable overall growth, urbanisation and reduction of poverty in Ghana, northern Ghana remains the least developed with most of the socio-economic and human development indicators being low or negative (NDPC & United Nations System, 2012; World Bank, 2011). According to a technical report published jointly by the NDPC

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and the United Nations System in Ghana, "the incidence of poverty remains very high and far above the national average at 52% in the Northern, 70% in Upper West and 88% in the Upper East regions" (NDPC & United Nations System, 2012, p2). In the northern parts of Ghana, literacy levels, distribution of and, access to and quality of health care services and education are the lowest compared to the rest of the country (DFID, 2005). Based on WHO projections, the prevalence rate of mental illness in the Northern Region is estimated at 13% (WHO, 2001).

Mental illness and poverty impact each other significantly. Mental illness exacerbates poverty and poverty makes coping with mental illness nearly impossible (Lund, De Silva, Plagerson, Cooper, Chisholm, Das, Knapp & Patel, 2011). Poorer families are less likely to access mental health services and if they do they would usually not get the best of quality services (Bryant-Davis, Ullman, Tsong, Tillman, and Smith, 2010; Corrigall, Lund, Patel, Plagerson, & Funk, 2007; Das, Do, Friedman, McKenzie, Scott, 2007; Lund, Breen, Flisher, Kakuma, Corrigal, Joska, Swartz, and Patel, 2010).

1.4 Traditional healing and its place in mental health care in Ghana

Ghana can be described as having two parallel health care systems – the formal health care system and the indigenous or traditional health care system. Both systems have remained dominant sources of health care services over the years. The modern/ formal health care system has grown and spread as a result of public policy and government investments, while traditional medicine has grown and remains a popular healthcare choice due to its appeal to the socio-cultural beliefs and values of the population (Addy, 2005; Tabi, Powell & Hodnicki, 2006).

It is worth stating briefly the traditional healer being discussed in this study. Stekelenburg, Kolk, Westen, van der Kwaak, and Wolfers (2005, p. 68) have defined a traditional healer as "a person who is recognised by the community in which he/she lives as competent to provide health care by using vegetable, animal and mineral substances, and certain other methods based on the social cultural and religious background as well as knowledge, attitude and beliefs that are prevalent

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in the community regarding physical, mental and social wellbeing and the causation of disease and disability" (p. 68). The WHO (2002) also defines traditional healing as including diverse health practices, approaches, knowledge and beliefs that combine plants, animals and mineral articles and substances together with spiritual and other psychosocial therapies to diagnose, treat and prevent illness. Traditional healers treating mental illnesses have been variously classified as herbalists, diviners, and faith-healers (Campbell-Hall et al, 2010, Kahn & Kelly 2001).

The WHO defines traditional healing as follows:

> Traditional medicine has a long history. It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (who, 2013, P15).

This definition fits perfectly with the various practitioners in Ghana, who are described as traditional healers (Ae-Ngibise et al, 2010; Atindabilla and Thompson, 2011).

Traditional healers and their services have always been part of Ghanaian society (Barimah, 2013). Traditional healing (or traditional medicine) is known to have pre-dated modern medicine and the practice of traditional healing is holistic, and embodies and reflects the worldview of the people it serves (Oliver, 2013; Armah, 2008). Traditional healing is part and parcel of cultures of most societies (Addy, 2005; Devenish, 2005; Tabi Powell, & Hodnicki 2006). Despite the fact that traditional medicine has flourished through the ages, formal recognition of traditional medicine and for that matter healers and their services began only after independence (Addy, 2005, MOH, 2005). Since independence from colonial rule, successive governments of Ghana have recognised the importance of traditional medicine and its place in the provision of health care services to the population especially in the rural parts of the country (Ministry of Health, 2005, Addy, 2005). Tracing the policy antecedents towards the development of traditional medicine in Ghana, the Ministry of Health (MoH) narrates thus:

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> The formation of the Ghana Psychic and Traditional Healers Association in 1961 and the establishment of the Centre for Scientific Research into Plant Medicine in 1975 attest to this fact [*of Government of Ghana's recognition of the importance of traditional medicine in the provision of health care services*]. In 2000, the government enacted the TMPC Act, Act 575 for the establishment of Traditional Medicine Council which is tasked with the responsibility for the registration of all Traditional Medical Practitioners in the country.

The aforementioned provides not just a historical overview but also outlines efforts to date to harness traditional healing to improve health care service provision in Ghana. Even though there is no obvious reference to mental health care services, it can be safely said that the recognition and efforts of government to harness traditional healing to support health care is intended to positively affect mental health care services provision too.

Traditional healing is an important source of health care service for the treatment of mental illnesses, just as many other illnesses and diseases in Ghana, (Addy, 2005, Ae-Ngibise et al, 2010; Armah, 2008; WHO, 2002; Kimberly, 1999; Tabi, Powell, & Hodnicki 2006). In Ghana, and Africa largely, traditional healing remains a major way of coping with illness and disease, especially in rural communities where formal modern forms of medical care services are inadequate and inaccessible (Devenish, 2005; Mensah, 2011). As a result of these inadequacies, it makes it difficult to rid traditional healing services and healers from the communities, if even to be replaced by modern forms of health care services. It is for this reason that development of any mental health system comprehensive enough to meet the biological, psychological and social needs of the population in Ghana would necessarily need to be inclusive of traditional healing services.

The discussion on perspectives of various stakeholders about traditional healing services and the possible integration of traditional mental health care into formal medical systems to optimise health care delivery for the populations [across the world] continues to be topical as ever (WHO, 2002). Utilisation of traditional healing in the management of mental disorders and epilepsy is well documented (Patel, 2011, Sorsdahl, Stein, and Flisher, 2010). However, there continues to be discussions on what should be the most effective ways to formally include mental health care

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services provided by traditional healers into the formal mental health systems and in modern approaches of managing mental disorders (Ae-Ngibise, Cooper, Adiiboka, Akpalu, Lund, Doku, & MHAPP Research 2010; Giordano, Boatwright, Stapleton, & Huff, 2002).

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews existing literature describes and discusses the contribution of mental health to the global burden of disease, mental health care services available and their utilisation, the place of traditional healer and efforts at maximising traditional mental health care into the formal mental health system. The literature review further establishes the significant contribution of mental illness to the global burden of disease, prevalence of mental illness among populations.

Next is a description of barriers to realising optimal service delivery which has resulted in the large mental health treatment gap that exists in low and middle income countries and the reasons for this gap The reviewed literature goes on to describe pathways to accessing mental health services in Ghana, beliefs about illness causation, and the role traditional healers play in providing health care services. Finally, how traditional healers could be utilised in closing the mental health treatment gap is explored to close the chapter.

2.2 The burden of mental health to populations

Since the World Health Report in 2001, which was dedicated to mental health, evidence of the contribution of mental disorders to the burden of disease on populations continue to engage the attention of health and development practitioners and authorities (World Health Assembly, 2012; Labhart, Sabine, Engelbert, Jozien, & Wolf, 2010). The proportionate contribution of neuropsychiatric disorders to the world's disability is reported to be between 12% and 15%, which is more than contributed by cardiovascular diseases, and even two times more that of cancers (Insel, 2011; WHO, 2008, Thornicroft & Tansella, 2003). The impact neuropsychiatric illnesses on daily life is even more extensive, accounting for more than 30% of all years lived with disability (Chisholm, Flisher, Lund, Patel, Saxena, Thornicroft, & Tomlinson, 2007; Thornicroft & Tansella, 2003).

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Mental disorders account for 6% of the disease burden among the general population in Ghana and about 16% among adults between the ages of 15-59 years (WHO 2012). A growing appreciation of the links between mental health and physical illnesses continue to bring the impact of mental disorders on populations to the fore (WHO 2008; Prince et al 2007; Kawachi & Berkman 1998). Similarly, an increase in non-communicable diseases in Low and in Middle Income Countries (LAMICs) and the resulting mental health services needs of sufferers are also gaining the attention of health policy authorities and health care providers (de-Graft Aikins, Boynton & Atanga, 2010; Prince et al., 2007).

The burden of neuropsychiatric disorders on populations is found to be higher in LAMICs and is attributed to a combination of poorly developed mental health services and policies, and poverty (Patel 2011; Saxena et al. 2007). The burden of mental illnesses and epilepsy are particularly noted to be very high in sub-Saharan Africa with a similarly large treatment gap ranging between 67% and 95% (Jacob, Sharan, Mirza, Garrido-Cumbrera, Seedat, Mari, Sreenivas et al 2007; Read et al. 2009; WHO 2008; Kohn et al 2004, Saxena et al 2007).

A mental health treatment gap is defined as "the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder." (Thirunavukarasu, M. (2011, p199), Treatment gap is "expressed as the percentage of individuals who require care but do not receive treatment." (Kohn, Saxena, Levavm Saraceno, 2004, p859).The mental health treatment gap therefore is the difference "between the number of people who require treatment services and those who actually receive them is referred to as the 'treatment gap'" (WHO, 2001, and 2008).

In a prevalence study in five states of the Federal Republic of Nigeria involving 4984 people, of 23% who had seriously disabling mental illness, only about 8% of them had received treatment in the preceding 12 months (Gureje, 2006). The observed low rates of people needing

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treatment support who actually received treatment reflects that there was a large burden of unmet need for care among people with serious mental disorders (Gureje, 2006). A second sample of 1,682 respondents of this prevalence study that completed the long form of the interview was further analysed and only 9% of them diagnosed with anxiety, mood or substance use disorder, had received any treatment, and the treatment was judged to be inadequate (Gureje, 2006). Similarly, a study in The Gambia on people with epilepsy showed that only 10% of participants received continuous treatment, with 67% of them reporting their desire to receive preventive biomedical treatment if it were available within their communities (Baskind & Birbeck, 2005). The situation is not different in Ghana as the WHO estimates Ghana's treatment gap to be as high as 98% (WHO, 2007). The mental health treatment gap in Ghana is the result of decades of overreliance on institutionalised and centralised mental health care and treatment, inadequate infrastructure and trained mental health personnel, as well as years of engrained social stigma (Appiah-Poku, Laugharne, Mensah, Osei, & Burns, 2003; Asare, 2003; Barke, Nyarko, Klecha, 2011; Dixon, 2012; Fournier, 2011; Ofori-Atta et al, 2010; WHO, 2007)..

2.3 Mental health services available in Ghana and their utilisation

Mental health services in Ghana are provided both on out-patient and in-patient basis and are mainly concentrated in the three psychiatric hospitals in the country. Even though, by policy mental health services are supposed to community based and integrated into general care, concentration has been on just the Accra Psychiatric Hospital, Ankaful Psychiatric Hospital and the Pantang Psychiatric Hospital, all of which are located in the southern coastal parts of the country (Ofori-Atta et al, 2010; Fournier, 2011). Formal mental health care services are therefore not well integrated into the general health system as expected by policy. Similarly, non-drug therapeutic interventions such as day-centres, residential and employment support programmes as well as general rehabilitation support services are almost non-existent (Ofori-Attat et al, 2010; BasicNeeds, 2009). BasicNeeds is one of few organisations that provide rehabilitation and self-help group peer

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support to individuals living with mental illness or epilepsy and their families (BasicNeeds, 2008; Cohen, Eaton, Radtke, George, Manuel, De Silva & Patel, 2011). A number of factors account for this. First, an engrained social stigma associated with mental illness or epilepsy has further exacerbated Ghana's poor mental health situation (Dixon, 2012; Roberts, 2001; WHO, 2001, 2007). Mental disorders and people experiencing them, including health workers treating mental illnesses, suffer social stigma such as general social rejection and employment discrimination, (Barke, Nyarko, & Klecha, 2011). Use of derogatory names and abusive terms to refer to people with mental illness, as well as limited opportunities for people living with mental illness to engage in productive activities and the outright physical abuse of people living with mental illness are common have culminated in denying persons with mental illness or epilepsy to live free and productive lives (WHO, 2010). Social stigma is so negative that people with mental illness end up stigmatising themselves (Barke, Nyarko, Klecha, 2011; Frese III, 1998). This affects confidence levels and decisions to seek treatment for their conditions and general care and support to people with mental health and epilepsy treatment needs (Barke, Nyarko, Klecha, 2011; Yanos, Lysaker, Roe, 2010; Yanos, West, Gonzales, Smith, Roe, Lysaker, 2012).

Similarly, a highly inadequate mental health care infrastructure and personnel have seriously limited the ability of formal mental health services to effectively meet the mental health needs of the population of Ghana (Appiah-Poku, Laugharne, Mensah, Osei, & Burns, 2003; Asare, 2003; Fournier, 2011; Ofori-Atta et al, 2010; WHO, 2007). There are only four psychiatrists actively serving the population of over 25 million people with an estimated 2.5 million people needing mental health care services (Ofori-Atta et al, 2010). Only some 500 mental health nurses serve the country and most of them are advanced in age and nearing retirement. For this reason Ghana's formal mental health system is largely managed by corps of community psychiatry nurses. Beyond psychiatrists and [community] Psychiatric Nurses, there is a high absence of other allied professionals such as clinical psychologists, occupational therapists and mental health social

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workers. As recent as 2012, there have been efforts to boost the human resource situation, to improve mental health care service provision, by the introduction of Community Mental Health Officer (CHMO) and the assistant physician in psychiatry training courses at the Kintampo College of Health (http://www.thekintampoproject.org). There has also been a recent initiative to have first degree psychology students of the University of Ghana to undertake their national service in a community mental health facility, working alongside CPNs as part of attempts to introduce psychosocial support services in the facilities. These efforts are mainly stop-gap in nature with quite some way to become not well synchronised with the public service system for the easy absorption graduates from these institutions into the government service and pay roll for that matter well utilised in the government mental health system. A more formalised effort has been the first degree mental health course that is to start in the University of Cape Coast.

Low budgetary allocations have also not helped in making mental health services widely available to the majority of the populations as should be the case (Dixon, 2012; Raja, Wood, de Menil & Mannarath, 2010). Only 8% of the health budget is allocated to mental health, and this is almost entirely absorbed by the psychiatric hospitals to finance recurrent costs such as feeding and cleaning and maintenance. There is leaves virtually nothing for research, training and investments in infrastructure, particularly for infrastructure (Raja et al, 2010; Read & Doku, 2012; Roberts, 2001) These inadequacies that have given rise to the existing large mental health treatment service gap and which is being filled by traditional healers, and patronised by a large proportion of Ghanaians with mental health treatment needs (Ae-Ngibise et al, 2010; Appiah-Poku et al, 2003; Kirby, 1997).

As a result of these inadequacies, utilisation of traditional healing services for mental illness or epilepsy is, therefore, common place in Ghana (Addy, 2005; Ae-Ngibese, et al, 2010; Read, Adiiboka and Nyame, 2009; Tabi Powell, & Hodnicki 2006; WHO, 2007). In addition,

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2.4 The place of traditional healer and efforts at maximising traditional mental health care into the formal mental health system

Services of traditional healers are highly patronised in Ghana, especially for mental ill-health (Atindabilla & Thompson, 2011; Gyasi and Mensah, 2011). The indigenous nature of traditional medicines, the socio-cultural, religious and supernatural connotations associated with mental health or mental illness account for the high utilisation of traditional healing services in Ghana (Appiah-Poku et al, 2003; Gyasi and Mensah, 2011; Twumasi, 1979).

Explanation and understanding of mental illnesses in most societies, including Ghana grounded in socio-cultural practices and religious beliefs (Addy, 2005; Ae-Ngibise et al, 2010; Dzokoto & Lo, 2005; Lynch 2006; Patel, 1995; Tabi Powell, & Hodnicki 2006). As a result, interventions described as dealing with the supernatural, which are usually provided by traditional healers, are utilised by people and families affected by mental illness (Sorsdahl, Flisher, Wilson, & Stein, 2010; Patel, 1998). Physical illnesses are seen to be those that come about as a result of the causal principles of the physical world – disruption of the bodily, physiological processes. Illnesses of the body, believed to be physical and natural usually lead to both biomedical and traditional remedies being sought and utilised. The psychosocial illnesses are said to be caused by thoughts and emotions (of one's own or another person's) resulting from social interaction (Lynch, 2006). Patel (1995), citing Brautigam and Osei (1979), elaborates on the Akan concept of self-hood, which largely explains illness of a person to be based on the component of the self - *onipadua,* the physical-mortal part; *sunsum*, personality; and *okra* which is an intellectual, non-personal life force – with good state of health being a fine balance of the all three components. Patel, (1995), concludes that some illnesses are identified as being purely physical, the central concept being that the abdominal organs are not functioning properly, whilst illness afflicting *sunsum* or *okra* is not readily located, not so susceptible to treatment and usually require spiritual or supernatural interventions. This conceptualisation of illnesses places mental illness in the spiritual and

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supernatural realm which influences the place and kind of treatment people with mental illness utilise.

Similarly, Kirby (1997) in a study of the Anufo of northern Ghana also found that the people maintain a worldview of visible and invisible worlds in which unseen agents, especially their ancestors, play a key role in maintaining their lives, particularly problems and dangers they are faced with. For that reason, any imbalance, knowingly or accidentally, is thought to bring calamity or disharmony to the Anufo, which needs prompt resolution by appeasement of the ancestors and gods. As a result, even though one is to remain reasonably healthy through-out the person's life-time, imbalances and misfortunes could be manifested in illness (Kirby, 1997; Burler, 1997). This is also established in Burler's study on treatment of psychiatric illness in Ghana (Burler, 1997).

People with mental illness in Ghana seek treatment from a range of informal and formal sources. The informal sources include family and relations, traditional and faith healers, and Charismatic/Pentecostal churches and their *prayer camps* (CHRI, 2008; Tabi, Powell, & Hodnicki 2006). Formal psychiatric services make up those provided at the psychiatric hospitals, general hospitals and at private formal health facilities; (Ofori-Atta et al, 2010; Lamptey 1977; Ofori-Atta, 1995; Appiah-Poku 2004). These three forms of treatment services available for mental illnesses or epilepsy run in parallel in Ghana (Ofori-Atta, 2010). They are however used, interchangeably and concurrently with little or no referral arrangements (Ae-Ngibise et al, 2010; Tabi, Powell, & Hodnicki, 2006).

In northern parts of Ghana, traditional healing tends to be the dominant source of treatment alongside the limited formal mental health services available. Just as across the country, these are accessed alongside the available formal services (Ae-Ngibise et al, 2010; Tabi Powell, & Hodnicki 2006). The socio-cultural and magico-religious beliefs and connotation associated with mental illness leads to traditional healers being usually the first and main points for recourse to the illnesses of people afflicted by mental illness (Hwang, Myers, Abe-Kim, and Ting, 2008). It is found that the

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value associated with practices of traditional healers, ease of access, flexibility and affordability of their services to a large extent appeal to many people, especially among poor, rural and hard to reach populations (Darko, 2009; Iyalomhe, & Iyalomhe 2012; Kayombo, Uis, Mbwambo, Mahunnah, Moshi, & Mgonda, 2007). Concurrent use of services of traditional healers and hospital based community mental health is thus common as users tend to use them based on which of them they perceive will best respond to their treatment needs (Azuta, 2012). Choice of the treatment option to make use of largely depends on what the ill person, and his/her family and relations conclude to be the cause of the illness (Azuta, 2012; Stekelenburg et al, 2005).

Involving traditional healers, as health care providers, in formal mental health care services will improve the service gap in the management of common mental illnesses and epilepsy at the community level (Atindanbila, & Thompson, 2011; Dzokoto, & Hsiao-Wen 2005; Patel, 2011). There are said to be some 45,000 traditional healers registered within the Ghana Association of Traditional and Herbal Practitioners, with an estimated healer to patient ratio of 1:200 (Founier, 2011; Ofori-Atta et al, 2010). This figure of the number of traditional healers could however be higher as there are several other traditional healers that are not registered with this national body. Between 70% and 80% of people that present with mental illness or epilepsy consult traditional healers first before seeking care at a formal mental health care service facility as they are the most accessible and considered to have greater expertise in treating mental illnesses (Founier, 2011; WHO, 2002). Even though traditional medicine has had its fair share of influences from modernisation and Western cultures, traditional healers have remained largely unaffected in their practices in Ghana and more generally (Atindabila and Thompson, 2011; Mensah, 2012). As already mentioned above, despite their being widespread in most parts of Ghana, especially in the rural parts of Ghana, they are not formalised within the health system (Montia, 2008; Traditional healing, n.d.).

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Notwithstanding calls for collaboration and partnership between traditional healers and western or formal mental health care services, the question has not been answered as to exactly how this can be done. It is unclear as to how to involve traditional healers in formal mental health care services and how that can work (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher, & MHAPP, 2010). Suggestions and recommendations have ranged from outlawing traditional healing practices, to regulation of their practices, to encouraging cooperation and collaboration between traditional healers and formal mental healthcare providers, (Ae-Ngibise et al, 2010; Atindanbila & Thompson, 2011). The Alternative Medicine Division that was created at the Ministry of Health of Ghana, was established to give recognition to traditional healing and regulate their practices based on the Law on Traditional Medicine Practice (WHO, 2007; Traditional healing, n.d.). This can be described to be working to bring traditional healing practitioners and their practices into formal health care services. Similarly, the Bachelor of Science degree in herbal medicine which was introduced at the Kwame Nkrumah University of Science and Technology in 2001 has not progressed as was expected and this has resulted in limited training of traditional healers within formal educational curriculum. Training of traditional healers therefore remains largely through informal apprenticeships (Traditional healing, n.d.).

2.5 Utilising traditional healers to close the mental health treatment gap

The overwhelming evidence of high prevalence of mental health problems and the attended huge mental health treatment service needs led to a global call for action (Lancet 2007, 2011; WHO 2001). The common neuropsychiatric conditions in Ghana that people present with for treatment include schizophrenia, psychosis, depression, alcohol and substance abuse disorders and neurosis and epilepsy, as well as un-explained mental conditions (WHO, 2007). In Ghana, depression is the most common mental illness whilst epilepsy (a neuro-psychiatric condition) has the largest proportion of people who present for treatment (BasicNeeds-Ghana, 2010). de Menil et al (2012)

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report that hospital records of Ghana indicate men and women experience mental disorders equally but substance abuse seemed more pronounced among men with depression and anxiety disorders more common among women. Men are more likely to be taken for treatment at the psychiatric hospitals, as they are perceived to be a threat whilst women with mental disorders and somatic manifestations will mainly seek treatment from shrines, churches and other primary care providers as they are considered more emotional and religious (de Menil et al, 2012).

A key initiative was the Mental Health Gap Action Programme (mhGAP) with its accompanying implementation guide (WHO, 2008, 2010). These have all called for not just decentralisation of mental health services that are well integrated into Primary Health Care services but also encouraging collaboration with other informal, complementary and/or alternative health care service provision (Lancet Group, 2011; WHO, 2010, 2008).

The new Mental Health Act of Ghana, (Act 846, 2012), (Doku, Wusu-Takyi, & Awakame, 2012; Daily Graphic, 2012) provides for inclusion of alternative and complementary mental health care services in formal care in formal mental health service provision such as services of traditional healers. Similarly, the Traditional Medicine Practice Act, 2000 (Act 575) of Ghana clearly affirms recognition of the place of traditional healing in the health care delivery services of the country. The focus on traditional healers and their practices through these laws however, is on supervising and regulating their practices rather than offering an opportunity for their integration into the formal mental healthcare system. Integration of formal and traditional and/or informal health care services is the most desirable as it ensures an unrestricted mutually reinforcing utilisation of both systems. Integration of traditional healing services in formal community mental health services will be important and beneficial in addressing the mental health treatment gap and ensuring that people with mental illness have ready access to mental health care services within proximity of their communities. Utilisation of both forms of treatment services optimises available services for managing mental disorders at the community level.

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The Chinese and Indian health care models have successfully blended such traditional health services, as acupuncture, homeopathy and Ayurveda into their formal health care system and this has enhanced provision of comprehensive health care services for their populations (Gyasi & Mensah, 2011). Key arguments and debates relating to the integration of alternative healers into western models of care have been that they provide comprehensive approach to care to the populations as they address both the socio-cultural and scientific considerations in health (Moodley, 2011; Wreford, 2005a). As established in studies related to HIV/AIDS and STIs and use of traditional healers, integration takes advantage of the unique aspects of the two practices that holistically address the health care needs of the populations of Ghana and making community based mental health services more accessible (Kayombo, Uis, Mbwambo, Mahunnah, Moshi, & Mgonda, 2007; Wreford, 2005a, 2005b).

There is, therefore, a place for traditional healers in the treatment of mental disorders, particularly at the community level (Sorsdahl, et al, 2009). This study aims to contribute to modern mental health service development in Ghana and seeks to assess key stakeholder perspectives and opinions on the integration of traditional healers into formal mental health care services at the community level. The study will also identify facilitators and barriers to integration of traditional healers into formal mental health care service provision at the community level.

This study should is expected to explore sustainable was to maximising the services of traditional health care as one of the approaches towards scaling up of mental health care services at the lower levels of care, human rights and people with mental illness or epilepsy and enhance community involvement in the management of mental conditions (Read 2009; Ofori-Atta 2010).

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CHAPTER THREE

METHODOLOGY

3.1 Introduction

The study sought to answer the question: 'What are the perspectives of key stakeholders on integrating traditional healers of mental illness into formal mental health care service provision at the community level in northern Ghana?' In order to answer the research question, the study sought to gather the perspectives and opinions of key stakeholders about traditional mental health care and the possibility of integrating their services into formal mental health. The issues explored were stakeholders' views of traditional healers and their services in manging mental illnesses, whether services of traditional should be made available as part of formal community based mental health services and what the opportunities and challenge therein in bring about such recognition and integration of traditional healers and their services into formal community mental health care.

3.2 Research Setting

The study was conducted in communities of the three northern regions, namely Northern Region, Upper East Region and Upper West Region. These three regions make up what is commonly referred to as the 'north' in Ghanaian society. It is that part of the country, which was named the 'Northern Territories' or 'Northern Protectorate' of British Gold Coast colony, now Ghana. It is the area north of the Lower Black Volta, which together with it major tributaries, the White and Red Volta, and the rivers Oti and Daka that drain the area that make up northern Ghana (Awedoba, 2006). The northern Ghana areas share international boundaries with Burkina Faso at the north and north-west, Togo at the East and Cote D'Ivoire at the south-west. In-country, at the south, the area shares boundaries with two administrative regions of Ghana – Brong-Ahafo Region and Volta Region (ibid). Northern Ghana covers about a third of Ghana's landmass but only contributes just 1.31% of the total population of Ghana (GSS, 2012). It is largely rural with sparse settlements. The vegetation of the area is Savannah grassland (the reason it is sometimes referred to

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as the Savannah zone), with a few scattered, fairly drought and fire resistant tree cover of several metres high. The area generally has a low physical relief characterised by high plains with a few hills, the highest point of the area being the Gambaga Scarp. The soils in northern Ghana are generally arable with significant portions degraded by intensive farming and erosion. Temperatures in northern Ghana are among the highest in Ghana, with the highest being up to 40^{o}C around March and June of the year.

The area is the poorest in Ghana with poverty levels being as high as 90% in the Upper West Region, 80% in the Upper East Region and 70% in the Northern Region (GLSS5, 2008; World Bank, 2011). Related human development indicators are poor. Literacy levels are lowest in these regions, just as maternal, infant and child mortality. The region also has the highest out-migration with peak periods being the dry season when farming is over with virtually no employment or production opportunities. Rainfall and patterns continue to be shorter as the years go by with rainfall patterns being erratic. This leaves the inhabitants inactive for most period of the year. Road networks and conditions are highly inadequate and poor (Codjoe, 2006; GSS, 2012). Road networks and conditions are highly inadequate and poor affecting socio-economic activities and general development.

The three northern regions are is inhabited by people who speak varieties of the 'Gur' language sub-family, and predominantly the Mole-Dagbani versions, that include Dagbani, Mampruli, Gurene, Talen, Nabit, Kusaal, Builsa, Dagaare, Waale (Awedoba, 2006). They are also the Guan language varieties, which include Gonja, Nchumburu, and Nawuri, as well as others that include Kassena, Sissala, Konkomba, Mo, and Anufo (Chokosi) tribes (ibid).

Social structure and arrangement are around the senior-most male member of the family. Inheritance and succession is patrilineal (Nanbigne, 2004). Just as the rest of the country and Africa the main religion is traditional worship, even though there are now several Christian and Moslem religious converts due to the missionary activities of the Catholic Church and the Moslem Arab

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traders and conquests of centuries ago. As a result there are deep-seated beliefs of evil spirits, invisible forces, magic and the popular 'African Black Power' (Awedoba, 2006).

3.3 Research Design

Qualitative research methods were used to undertake the study. Qualitative research is a method of research enquiry that enables exploration of issues, understanding phenomena, and answering questions (Cassell & Symond, 2011). Payne and Payne (2004) describe qualitative research as being able to "produce detailed and non-quantitative accounts of small groups, seeking to interpret the meanings people make of their lives in natural settings, on the assumption that social interactions form an integrated set of relationships are best understood by inductive procedures" (p23). This type of research method allows for the answering of the 'why' and 'how' of issues and phenomena. It allows for understanding of particular situations from the perspectives, experiences and meanings of people and groups before testing theories (Frankel, 2000; Kumar, 1989). These characteristics of qualitative research were utilised in order to gain in-depth insight into the key perspectives and opinions of key stakeholders about mental health care by traditional healers and the possibility of the integration of traditional medicine into community mental health care in northern Ghana (Pope, Ziebland, & Mays, 2000) and to explore perceived opportunities and barriers to integration of traditional medicine into mental health care at the community level.

Qualitative research allows for building a rich data set about the views and perspectives of key stakeholders based on the unlimited, unrestricted and reflective information they will provide (Gilgun, 2005). The research and its data collection process, was therefore, open to multiple perspectives and unexpected responses provided by the participants (Poulin, 2007). The advantage of this aspect of qualitative research allows a wide collection of varied perspectives on the subject of the study. This establishes the patterns and depth required for further exploration of the subject (Payne and Payne, 2004). More so, small-scale studies, such as this one, are best undertaken by qualitative methods as they afford the collection of more exhaustive information than possibly

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would have been gained from the use of other methods (Braun & Clarke, 2006). Qualitative research thus enabled this study to be carried out within the given time and available resources. This study provides a good foundation for further investigation of the study subject in other contexts in the future.

3.4 Study participants

The study included four key stakeholder groups involved in mental health care provision in the study setting, namely, Northern Ghana. Study participants were traditional healers, community [mental] health workers, mental health users and primary carers, as well as directors of health services at the district and regional levels. A number of national level health policy authorities, including the Chief Psychiatrist of Ghana, Director of Research and Development at the Ministry of Health, and a member of the Parliament Select Committee on Health were also interviewed to gather their perspectives as part of the study.

Purposive sampling was used to recruit the participants for this study. Purposive sampling, also known as judgemental sampling, is defined as a non-probability sampling technique, where the researcher selects the respondents to be studied with the most information on the phenomenon of interest (Guarte and Barrios, 2006; Taylor-Powell, 1998). According to Oliver (2006) purposive sampling is a non-probability sampling in which the researcher decides the study respondent that should be included in the study and this is based on criteria that such respondents are unique to the issue and most well-placed to provide relevant and in depth information based on their specialist knowledge of the phenomenon of interest and/ or have capacity and willingness to participate in the research.

Purposive sampling allows for effective targeting of the respondents that really matter to the subject being studied (Byme 2001; Tongco, 2007). As an exploratory study, purposive sampling is appropriate for this study as it saves time and effort whilst allowing for effective targeting of knowledgeable and reliable informants and stakeholders that could share perspectives on integration

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of traditional healers of mental illnesses and epilepsy into formal community mental health care service.

The inclusion criteria were that the respondents were adults based in any part of the three northern regions (Northern Region, Upper East Region, and Upper West Region) and were either health care service providers, health policy and health service management official, as well as mental health service users and their primary care-givers and traditional healers known to be treating mental illnesses.

A sample of 160 participants were recruited and participated in this study. A total of 62 KIs with 62 participants and 15 FGDs involving 98 participants were carried out in the study. The stakeholder groups that participated in the KIs were traditional healers, , CPNs, CMHOs, district, regional and national directors of health services of the Ghana Health Service (GHS), as well as the Medical Director of the Accra Psychiatric Hospital and Acting Chief Executive of the Mental Health Authority of Ghana (MHAG) and member of the Ghana's Parliament serving in the Health Committee. Except for three national level persons, made up of 2 health officials and a Legislator of the Parliament of Ghana that KIs were conducted on, each of the stakeholder groups had each both KIs and FGDs. Except for three national level persons, made up of 2 health officials and a Legislator of the Parliament of Ghana that KIs were conducted on, each of the stakeholder groups had each both KIs and FGDs. The FGDs were held with groups of traditional healers; CPNs, CMHOs and community health workers, and mental health service users and carers. These FGDs ensured that a cross-section of people at all levels of the [mental] health system, including mental health serviceusers, care-givers of persons with mental illness or epilepsy and their families were reached. 64 participants participated in a series of 9 FGDs.

The study participants were recruited through a combination of visits to them in their homes and communities, and/or places of work and meetings based on information provided by persons that know about the study stakeholders. Initial contact was followed by a formal letter written to the

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officials requesting to interview them as part of the study (Appendix VI). Information about who to approach for participation in the study were obtained from community members, mental health services users and care-givers and families, and known traditional healers treating mental illnesses or epilepsy. The traditional healers were identified through contacts with community members, mental health service users known to have used services of traditional healers and leadership of traditional healer associations, especially the regional offices of the Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM). CPNs were recruited from the available staff at each of the Community Psychiatric Units located in the district and regional hospitals. A list and contacts details (mainly mobile phone numbers) of traditional healers, community health workers, and self-help groups of people with mental illness or epilepsy located in the three northern regions were collected from the database of BasicNeeds-Ghana. BasicNeeds-Ghana is a non-government mental health and advocacy organisation working to enable persons living with mental illness and their families to satisfy their basic needs and exercise their basic rights (BasicNeeds, 2009). The organisation implements and promotes initiatives to sustainably improve the lives of persons living with mental illness or epilepsy, by so doing increase access to integrated community based mental health, and social and economic services for the people, their primary carers, families and communities (BasicNeeds-Ghana, 2013).

Secondly through the leadership of the regional associations of traditional healers and district and regional directors of the Ghana Health Service individual respondents were contacted for KIs or FGDs. Following a formal letter, the Clerk of the Health Committee of the Parliament Committee of Ghana provided details of a member of the committee that was willing to grant an interview on the subject of the study.

In the case of the community health workers and the directors of health services, other officials, as well as other government institutions, formal letters were written to their offices requesting interviews with the potential respondents identified.These included the Chief Psychiatrist

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of Ghana, three regional directors and three district directors of the Ghana Health Service of the three regions and officials of the Ministry of Health (Appendix VI). The field assistants who helped in collecting the data were provided with the list of names and contact details to reach out to and arrange the interviews and discussions with those willing to participate in the study.

3.5 Data collection

Key informant interviews and Focus Group Discussions were used to collect the study data from participants. These qualitative data collection techniques were used to collect opinions, attitudes, and perspectives of key stakeholders on mental health care by traditional healers and the possibility of integration of traditional medicine into formal community mental health care. Interview and discussion guides were used to guide the KIs and the FGDs (Refer to Appendix 1).

KIs are in depth interviews with individuals who are affected by an issue and/or are likely to provide information about their views, ideas, and insights on an issue (Kumar, 1989; Kitzinger, 1995; Tongco, 2007). The purpose of key informant interviews is to build as much information as possible from a wide range of people who have first-hand information about a particular issue of interest (Kumar, 1989; Kitzinger, 1995; Cowles, Kiercher, & Little, 2002). This was useful in the study as it effectively enabled the notable persons and officials in the mental health sector in Ghana to provide the relevant information for the study such as, services and practices traditional healers provide and the adequacy of community mental health care.

KIs are not the same as formal and informal surveys with structured and semi-structured questionnaires (Brewer, 2000). KIs use interview guides that employ in-depth unrestrictive exploration of the particular subject matter. The advantages of KIs include collection of information from individuals across of all levels of education, age, sex and social status (Bricki, 2007). KIs can also be highly informal, build rapport and trust between the researcher and the respondent, and allows for clarification of issues. These are the advantages that make KIs beneficial to this research study as it allowed extensive exploration of views and opinions of stakeholders that participated in

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the study on integration of traditional healing services into formal community mental health services at the primary health care level. The study dealt with people of various socio-cultural backgrounds, including literacy and economic status of the respondents and the use of KIs made it possible for unlimited collection of information from the respondents which did not make the respondents' level of education, local language, or status to affect the data collected.

The second data collection tool used for the research was FGDs. Focus Group Discussions have been described as a research data collection technique through group interaction on a topic determined by the researcher (Moretti, Van Vliet, Bensing, Deledda, Mazzi, Rimondini, Zimmermann, Fletcher, 2011). It is a form of group interview in which the interaction within the group is used to elicit participants' views about the issue under discussion. FGDs are widely recognised as effective techniques to exploring attitudes and needs and as stated by Kitzinger (1995), FGDs do not "discriminate against people who cannot read and write and encourage active participation" (p 299). FGDs therefore were particularly suitable for gathering the perspectives and opinions of mental health service users and their families, as well as the other stakeholders of the study. It encouraged discussion in a reassuring atmosphere and manner where participants did not feel inhibited. FGDs also helped in the triangulation of information provided by respondents by cross-checking with responses provided from the individual key informants interviews. The interviews reached saturation as respondents provided responses that confirmed and/or repeated earlier ones (Rebar et al, 2011).

I conducted the KIs and FGDs with the support of field data collectors, which were recorded with digital audio recorders with the permission of the participants. Two digital recorders were used for each interview or group discussion. The recordings were supported by notes taken in a note-book to note down follow-up questions during the discussions and to augment the audio recording. The key informant interviews and focus group discussions were conducted in English and the local language of each area and of the participants (particularly, Dagbanli, Mampruli, Gurune, Dagaare,

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and Waale), depending on which language the respondent(s) felt more comfortable to communicate in. The local language was mainly used for the interviews with the traditional healers and for the focus group discussions with the mental health service users and their primary care-givers. My familiarity of the main languages spoken in the northern Ghana area made it possible for me to hold the interviews in both the local languages and in the English Language. KIs and FGDs with the CPNs and other health policy officials and the member of the Parliamentary committee for health of Ghana's Parliament were done in the English Language.

The recorded KIs and FGDs were transcribed by the use of hired service providers. To ensure participant verification of the interpretation of the data, there was on-going analysis of the data as interviews and focus group discussions where conducted. Data saturation was achieved when no new information was articulated from the interviews and focus group discussions held with the respondents. This significantly helped in the achieving the rigour in the data collected, as any data gaps and unexplained responses were clarified in subsequent interviews and discussions. I conducted all the KIs, whilst the FGDs were conducted with the support of research assistants. The research assistants were trained on how to conduct FGDs. They helped in identifying and recruiting the participants for the discussions. They also scheduled the meetings and facilitated the discussions, recording responses and provided support in the transcription of the recorded KIs that were conducted with traditional healers, Community Psychiatric Nurses (CPNs) and health policy officials at the district, regional and national level.

The translations and back-translations of the KI interview and FGD guides, as well as the transcriptions were carried out by the Northern Regional office of the Bureau of Ghana Languages. The transcribed scripts were verified by an official from the Ghana Institute of Linguistics, Literacy and Bible Translation (GILLBT). All transcripts were checked by the researcher to ensure their completeness in relation to the interview guide. It also enabled the further refinement of the interviewing techniques as the data collection progressed.

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Tables 1and 2, below provides details of the participants of the study by location and category as well as under each of the data collection tools that were used in the study. The study data was collected from a total of 160 respondents. Sixty-two respondents were interviewed as key informants and 68 participated in a total of 15 focus group discussions.

Table 1: Details of study participants by region

Region/ Stakeholder Category	Northern Region		Upper East Region		Upper West Region		National		TOTAL
	KI	FGD	KI	FGD	KI	FGD	KI	FGD	
Traditional Healers	5	8	4	8	4	5			34
Community Health Workers	7	17	7	11	7	10	0		59
Health Officials/ Authorities	2		2		2		3		9
People with mental illness or epilepsy	6	9	8	13	5	17			58
TOTAL	20	34	21	32	18	32	3	0	160
TOTAL	54		53		50		3		160

Table 2: Details of data collected from study participants under each data collection tool

Key Informant Interviews	**No.**	**Focus Group Discussions**	**No.**
Traditional healers	13	Traditional healers	3
CPNs and Focal Persons for community mental health	18	CPNs and Focal Persons for community mental health	4
General Nurses	3	General Nurses	2
Mental health service users and primary carers	10	Mental health service users and primary carers	6
Health service and policy authorities (MOH Director for Policy, Planning, Monitoring and Evaluation & Director of Research, Chief Psychiatrist)	3		
Members of Parliament	1		
District/ Regional Social Welfare/ Community Development officers	5		

A total of 62 KIs were completed with 13 traditional healers, 19 service users and primary carers, 21 community health workers (CPNs, CMHOs, and general nurses), and 9 senior health policy officials. The FGDs were held with groups of traditional healers; CPNs and health service policy officials at the national, regional and district level of Ghana and mental health service users and carers. Similarly, the FGDs were held with traditional healers, one in each of the three regions of the study area and 21 of the traditional healers participated. Six FGDs were held with community

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health workers, made up of CPNs, general nurses and general nurses other health workers who serve as focal persons for community mental health in their districts or health facilities and these involved 38 of them. A total of 6 FGDs were held with mental health and epilepsy service users and their primary carers with 39 of them participated. In each of the three regions, two FGDs were held. This ensured that a cross-section of people across all levels of the [mental] health system, as well as users and care-givers and families were reached.

The interview guide for the KIs and FGDs (see Appendix II & III) had an introductory and three other parts. These collected data that described the traditional healers' practices and knowledge of common mental illnesses they see and manage, and how they classify the mental illnesses, Traditional healers' views on integration of traditional healers into formal community mental health services were also collected. The third section explored opportunities and challenges associated with including traditional health service into formal community mental health service system. KIs with CPNs and other community health workers particularly focused on classification of mental illnesses by traditional healers and their similarity with formal classifications of mental disorders.

To triangulate responses and confirm how universal certain views and statements made by respondents were, the same views and opinions of respondents were asked of several other respondents. Triangulation, as a concept in qualitative research, is used to increase the confidence of data collected, as well as credibility and validity of the results of the research study (Bryman, 2003; Olsen, 2004). O'Donoghue and Punch (2003), define triangulation as a "method of cross-checking data from multiple sources to search for regularities in the research data" (p.78.). Triangulation is important in this study as it allows for verification of the data collected from the cross-section of respondents of the study to ensure validity and reliability of the research. In this study, triangulation was applied through the consistent use of the discussion and interview guides to collect the data from participants. Use of the two data collection methods allowed for effective

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triangulation of information provided and ensured that exhaustive information about stakeholder perspectives on mental health care services provided by traditional healers and the possibility of their integration traditional healing services into formal mental health care in Ghana. Any new insights were noted and cross-verified by asking subsequent discussants and interviewees to confirm those views and opinions expressed and statements and pronouncements made. Perspectives across the different data collection tools and also across the different research participant groups were compared and this ensured the respondents were comfortable with the data collection tools administered and the responses they provided to the questions.

Data saturation is part of quality control and ensuring reliability and validity of research data collected. Collection of field data was carried out with respondents till saturation was reached, that is until no new information or issue not already dealt with by earlier respondents realised (Kerr, Nixon & Wild, 2010). When no new information could be obtained from study participants on their perspectives relating to the integration of traditional healers into formal community mental health care system KIs and FGDs were discontinued.

Kerr, Nixon, and Wild, (2010) define data saturation as "'data adequacy' – the point when no new information is obtained from additional qualitative data. … a point when you 'have heard it all' or no new information is deemed missing during cognitive interviewing" (p271-272). In this study, data saturation was achieved by ensuring that no new information or perspectives got from additional interviews and of focus discussions. Salient themes recurred by the eighth interview for traditional healers and by the fourth focus group discussion for service users and carers, and interviews for health policy authorities and formal community health workers. This process undertaken in this study is consistent with recommendations on achieving data saturation in an exploratory study (Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles, & Grimshaw, 2010, Guest, Bunce, & Johnson 2006). Despite this, it is recognised that consensus as to at what point data saturation remains open and continues to engage debate around achieving rigour of sampling in

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qualitative research (Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles, & Grimshaw, 2010; O'Reilly & Parker, 2013).

3.6 Analysis

Braun and Clarke's (2006) thematic analysis approach was used to analyse the data collected. The use of thematic analysis enabled the building of a rich data set that can help in understanding, analysing and interpreting the various opinions and perspectives, and attitudes of key stakeholders in mental health service and policy decision-making. Thematic analysis offers an accessible and theoretically-flexible approach to analysing qualitative data (Braun & Clarke, 2006). According to Braun and Clarke (2006), thematic analysis "provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data", (p 5). This was useful in ensuring the interview transcripts were adequately organised and structured for effective analysis and drawing of conclusions and making recommendations for action. The audio-recorded interviews collected were uploaded onto a laptop computer and listened which I listened to before they were transcribed. Each transcript produced from the recorded interviews and discussions. I read each transcript, at least, three times, to familiarise ,yself with the information and begin to understand initial codes to be considered. A summary of key points made by study respondents was made from each transcript and field notes. The data extracts were used to match codes emerging. Themes were then developed around which the codes and relevant data extracts were clustered which were now used for the presentation of the findings of the study.

Thematic analysis is appropriate for this study as it enabled familiarisation of the data that was collected, coding of the data and building the appropriate themes on the findings. The themes were further reviewed in order to appropriately name and develop the core concepts emerging from the field data collected from the participants. This made it possible for interpretations on the data collected. This allowed for the presentation of the opinions and perspectives of the key stakeholders

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that responded to the study. The researcher's thesis supervisors provided guidance on the process of data analysis and verification of the themes.

3.6.1 Reflexive analysis of the researcher

In this study, i took the position of the 'critical' and 'integrative' views of science and biomedicine discussed by Stein (as cited by Sorsdahl, Stein, & Flisher, 2010) on differing views of collaborations between traditional healing and formal medical services. According to Stein (as cited by Sorsdahl et al 2010) the "critical" view argues that science and biomedicine reflect just one particular way of looking at the world, which is not necessarily privileged" with some of this view arguing that "both Western medications and traditional agents can have therapeutic efficacy (p. 592). The third of the three perspectives discussed by Sorsdahl et al. (2009), state that, "both Western medicine and traditional healing are social activities and therefore reflect particular cultural values. Both types of interventions act on underlying biopsychosocial mechanisms, explaining why both medical and traditional interventions can influence health." (p. 592). These two perspectives are well suited with my worldview of the researcher which is that health and illness are socio-cultural connotations that should be appreciated in the provision of health care services and in understanding health conditions people present and express. It is based on this understanding that a person with mental illness may choose to go to a traditional healer or seek help from the hospital or clinic. This worldview helped me to appreciate the various perspectives the study participants expressed and the analyses made thereof by the researcher.

I was conscious that my position as Director of BasicNeeds-Ghana may influence data collection and analysis. Among the interventions of BasicNeeds-Ghana include working to influence practices of traditional healers treating mental illness or epilepsy to improve their services and reduce any excesses of their practices that infringe on the rights of persons with mental health care needs who use their services As a result, there was recognition of my social location and the need to ensure that my emotional responses to the study participants did not influence their

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responses. Similarly, there was a conscious to reflect on and interprete the data collected devoid of any of my personal knowledge, experiences and biases.

Reflexivity in qualitative research recognises that "the researcher and researched are of the same order, that is, both living, experiencing human beings, [for which] it is necessary for … researchers to reflect on how that might impact the research scenario when gathering data and when afterwards analysing it" (Shaw, 2010). O'reilly, (2012), adds that considering who researchers are and where they are coming from, as well as how and the way researchers think is shaped by the traditions, habits, and shared commonplaces of their own histories and those of our discipline" is important to any research (p522). I maintained, as much as possible neutrality in the matter of the subject the study. Research assistants supporting the field data collection were encouraged to maintain impartiality as much as possible, where line of questioning, body language and mannerism were not judgemental or leading to certain desired responses. During inductions provided to the research assistants to support in collecting the data of the study, they were entreated to make it clear to the respondents that the study was entirely an academic one and independent of the work of BasicNeeds and they were encouraged to speak freely. The interviews and focus group discussions steered out of reference to BasicNeeds' work, even if mentioned in the responses of the study participant(s). Research assistants were equally made to understand and engage study participants in such manner that there was no or little reference the operations of BasicNeeds-Ghana or or me as head of BasicNeeds-Ghana. There was also appreciated that the socio-cultural and religious backgrounds and experiences of the respondents underpinned their perspectives to the subject of the study, which was to capture perspectives of various stakeholders on integration of traditional healing services to modern, formal community mental health services. Transcriptions of the data were carried out by persons different from those that collected the data. Field assistants were required to write reports of their perspectives and impressions of the KIs and FGDs conducted. All

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the information collected informed the analyses and coding processes, as well as informed the discussions and recommendations made in the study.

3.7 Ethics

The primary concern in every research study is the safety of the research subjects (Shahan & Kelen, 2006). According to Shahan and Kelen (2006) the guiding principles of ethics in research as articulated by the Belmont Report are: "respect for persons, beneficence, and justice" (Shahan & Kelen 2006, p 658). These principles encourage that choices for autonomous individuals and those incapable of making their own choices be protected. It also includes obtaining informed consent and maintains confidentiality and balance of benefits and harm in the context of equity and justice.

As much as this study involved human beings as subjects of the study, there was no risk to their safety. There was no adverse impact of the study on the study participants, especially, well-being of mental health service users. It did not involve physical activity or extraction of any human body tissue or fluids. Having been working in the northern Ghana area and in mental health too. I used the study to engage with and educate families and some of the members of the communities on mental health issues, which helped in allaying fears, creating awareness, and encouraging support and inclusion of people with mental illness or epilepsy in socio-cultural and economic activities. The orientation of the research assistants covered the proposal and related appendices and adequate information to educate families and communities on mental health issues. This helped in making the research assistants clearly explain to the understanding of the research study respondents what the study was about and what was required of them as research participants. These were explained when informed consent was secured.

Ethical approval for the study was obtained from the Research Ethics Committee of the Faculty of Health Sciences at Stellenbosch University, South Africa with approval number S12/06/169. Ethics approval was also provided for te study by the Ethics Review Committee of the Ghana Health Service, Ghana with approval number GH-ERC 10/09/2012. Permission was also

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obtained from the relevant institutions where participants were recruited for the study such as the health care service facilities of the Ghana Health Service (Appendix VI).

3.8 Informed consent

Informed consent was secured from each of the study participants. The study protocol was summarised into an information leaflet which was provided to each participant to read and sign their consent to participate in the study (Appendix IV). The form was translated into the local language for respondents who do not understand and read from English Language by a translator/interpreter. Respondents who could not provide signatures provided a thumbprint. In the FGDs a person each signed or provided a thumbprint on behalf of the rest of the respondents. Refreshments were provided to focus group discussion participants who were also provided compensation in the form re-imbursement of their transport fares at prevailing public transport rates of between ten Ghana Cedis (GHS¢10, which is about USD$3.00) and twenty Ghana Cedis (GHS¢20, about USD$6) to each participant. Each of respondents of the key informant interviews was appropriately compensated, by each been given twenty Ghana Cedis (GHS¢20) cash for their time they spent on granting the interview.

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CHAPTER FOUR
RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter organises and presents the findings on key stakeholder perspectives on the integration of traditional healers into formal community mental healthcare services in northern Ghana. This is part of efforts to seek and understand perspectives of key stakeholders about traditional healers providing mental health care service in northern Ghana and possibility of their inckusion in formal mental health care services in the country. The study participants were traditional healers, CPNs and other community health workers, health policy authorities at the district, regional and national levels, as well as mental health and epilepsy service users and their primary carers.

Tables 3 and 4 below provide details of demographic information of the study participants. A total of 160 study participants participated in the study. These were made up of 93 males and 67 females. Their ages ranged between 20 and 65 and above years. Most of the traditional healers were within ages of 41 and above years. Conversely, health workers in the formal health care sector (CPNs, CMHOs, general nurses and General Physicians and Medical Assistants) seem fairly well distributed across the ages.

Of the 58 mental health and epilepsy service users and carers that participated in the study 24 of them were service users and 24 carers. A total of 20 were males and 38 were females. Of the 20 males, 9 were mental health and epilepsy service users and 11 were carers. In the case of the females, 12 were mental health and epilepsy service users and 26 were primary carers. There were also more males among the health and development policy authorities than females. This also seems to indicate the disproportionate number of males in higher echelons of civil and public services than females (Africa Development Fund, 2008).

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Table 3: Characteristics of study respondents by Sex and Age

Description of respondent	No.	Sex		Age (in Years)				
		Male	Female	20-30	31-40	41-50	51-60	61above
Traditional Healer	34	31	3		2	13	10	9
CPNs and focal persons for community mental health	40	24	16	3	6	9	10	12
General Nurses	19	12	7	2	4	7	6	
Mental health service users and primary carers	58	20	38	9	12	17	20	
Health services and policy authorities	8	5	3	0	0	4	4	
Member of Parliament	1	1				1		
TOTAL	**160**	**93**	**67**	**14**	**24**	**51**	**50**	**21**

Table 4 below provides a distribution of the highest level of education attained by the study respondents. Educational level of respondents ranged from no formal education to university and/or professional training. Most of the respondents, particularly the traditional healers, the mental health service users and primary carers who did not have formal educations, mentioned that they had attempted primary school but never completed. They gave reasons such as the need for them to help in the farm, far distances to the schools from their communities, lack of financial resources and ill-health. The least formally educated were mental health service users, carers of people with mental illness or epilepsy and the traditional healers. The most highly educated were nurses and doctors, , medical assistants as well as the health and development authorities at the national, regional and district levels. The health services and policy authorities included Chief Psychiatrist, MoH Director for Policy, Planning, Monitoring and Evaluation, Director of Research; District/Regional Social Welfare/ Community Development Officers.

Most of the traditional healers had no education. A number of them explained that they had gone to primary school but could not complete due to their being involved in the healing trade at an early age and the need to help in farm work or serve as shepherds, which are dominant occupations of most families in northern Ghana. Some of the healers also explained that their parents put them in through Islamic education where they learnt the Quran which has made them not be able to acquire formal education. Two of the traditional healers said they had middle school education but did not get certificates.

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Table 4: Characteristics of study respondents by highest level of educational attainment

Description of respondent	No.	Highest Level of Education					
		No formal education/ Quranic school	Primary	Middle	Secondary	Post-sec. / Professional	University/ Professional
Traditional Healer	34	20	9	2			
CPNs and focal persons for community mental health	40					34	6
General Nurses	19					16	3
Mental health service and primary carers	58	30	14	7	4	3	
Health services and policy authorities	8						8
Member of Parliament	1					1	
TOTAL	**160**	**50**	**13**	**9**	**4**	**53**	**17**

The results of the study are presented and discussed under four main themes, understanding practices of traditional healers; perspectives and attitudes on integration of traditional healers into formal health care services; opportunities for integrating traditional healers into formal community mental health care services; and potential challenges that could affect effective integration of traditional healing services into community mental health. Each of these main themes has sub-themes that detail the findings within each theme. A total of seven sub-themes were analysed and discussed. The themes and sub-themes were arrived following a series of steps as outlined in Baun & Clarke (2006). Each transcript of the data collected was read thrice, at least. Having collected most of the date myself, I had fairly good knowledge of the data. Key data extracts were noted and coded to form basis for building up themes from the body of data. Data extracts with similar meaning or issue were categorised into a theme emerging in relation to the study subject. The way forward addressed participants' recommendations on how to integrate traditional healers into formal community mental healthcare services.

4.2 Summary of key findings

The table below provides a summary of the results obtained which are presented in more detail in the sections following.

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Table 5: Summary of findings

Main theme	Sub-theme
Understanding practices of traditional healers	Traditional medicine/ traditional healers, who they are
	Practices of traditional healers, how they operate, and their place in mental health care in the community Services provided, fees and charges
Perspectives and attitudes on integration of traditional healers into formal health care service providers	Stakeholders understanding or definition of integration of healing services of traditional healers into formal community mental health care
	Respondents' views on how integration of traditional healing into formal community mental health care services can be achieved
Opportunities and potential challenges to integrating traditional healers into formal community mental health care services	Opportunities to achieving community mental health system that integrates traditional healing
Potential challenges to integrating traditional healers into formal community mental health care services	Challenges to achieving community mental health system that integrates traditional healing

4.3 Local understanding of traditional healers – who are they

Definitions of phenomena are an important means of gauging people's understanding and the value that they place on such phenomena (Bauman, 2010; Patton, 2002). The research attempted to elicit a clear, distinct description of traditional healers from the key stakeholders who participated in the study. Participants described traditional healers as mainly middle-aged to old men, and sometimes women, who possess spiritual powers, have knowledge and experiences of illness and the relevant local remedies to treat illnesses. The quote below illustrates the descriptions provided by respondents:

> *Traditional healers are old people who treat people with mental problems. They have spiritual powers to counter evil spirits. … Traditional healers treat many illnesses that come their way but most of them treat mental illness, manage fractures and fight unseen forces on behalf of people* [FGD, Mental health service user]

The majority of the traditional healers interviewed mentioned treatment of mental illnesses as their main job among other ill-health as expressed below:

> *Treating mentally ill people is what I do most. That is what I am expert at and what I am known for. I can treat other conditions, and I do that quite often, but what my fathers left me is the gift to treat mental illnesses* [KI, Traditional Healer]

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Most of the traditional healers interviewed described themselves as experts who understand the local herbs and the spirit-world. Data extracts below captures how traditional healers described themselves:

> *A traditional healer is one who knows herbs and diseases and risks his life to find healing, if God wills, for people with various diseases and problems* [KI, Traditional healer]
>
> *We are experts and treat our people* [FGD of Traditional Healers]

They also described themselves as such group with a duty to continue practices of old for the sake of their people, as captured in this quote:

> *People who continue with the works of treating people using knowledge of their fathers and their fathers before them* [KI, traditional healer]

There was some sense of high regard for traditional healers by service users and carers. The following data extracts demonstrate this finding:

> *They are knowledgeable and can tell you what is wrong with you. We did all he directed us and my daughter got relieved. I was worried that she may never get well but when we met the healer, in no time she was well.* [KI, Primary carer]

The healers also made mention of how varied and diverse they are, as the data extract below captures:

> *We are many and varied, we have even quacks among us, some inherited it from their fathers, others went and acquired through training under seasoned healers* [FGD, Traditional healers]

In the case of the formal community health workers and health policy authorities who were met and interviewed, there was a general recognition of the existence of traditional healers who are actively engaged in treatment of mental illnesses. They defined traditional healers as the health workers who existed before Western medicine was introduced. That these healers still thrive, because they still have a unique place in the socio-cultural understanding and interpretation of illness and health among the populations. The data extract below supports this view:

> *Traditional healers have been the doctors in the communities who have been practising long before formal health care services were introduced. The traditional healers remain the alternative and complement the formal health care service sector in Ghana* [KI, District Director of Health]

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On the whole, majority of the respondents described traditional healers as the health practitioners who treat ill-health conditions based on longstanding local knowledge and practices and use of local products, who are most commonly available in the communities in northern Ghana and Ghana as a whole. Their services are highly patronised by people. They are the most readily available service providers.

Participants' responses as outlined above are consistent with prevailing definitions and descriptions of traditional healers (Addy, 2005; Oliver, 2013; Ae-Ngibise, 2010; WHO 2002). They are usually people who have little or no formal education. They mostly live and practice in their own communities and are a repository of indigenous knowledge of their communities. This study established that traditional healers are not any one uniform group but a diverse range of persons and with modes of practices range from use of herbs and prayers, giving advice or counselling, helping with accommodation and feeding of the persons under their treatment. This confirms earlier studies that have categorised traditional healing practitioners to include herbalists (both those that exclusively use herbs and those that combine with spiritual/ occult means), spiritualists/ diviners (employing purely spiritual cult means to counter evil spirits) and faith healers that employ the Bible (such as the Christian Pentecostal prayer camps), often times with overlaps of the groupings of the healers that the participants mentioned, (Addy, 2005; Atindanbilla & Thompson, 2011; Darko, 2009; Sato, 2012). The data further confirmed earlier studies that traditional medicine. Their practices are underpinned by socio-cultural and magico-religious connotations such as exorcism, use of holy water and anointed oils and visits to places at the middle of the night to perform rituals to rid the evil spirits affecting the person with mental illness or epilepsy (Essien, 2013; Kimberly, 1999). These confirms that traditional healers and their modes of practices span a range of services and practices and are not one uniform group of people with common modes of operations (WHO, 2002; Addy, 2005).

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4.3.1 Practices of traditional healers and their place in mental health care in the community

The traditional healers interviewed for this study were known to be treating mental illnesses in the communities. However, most of them in their responses indicated they treat almost every illness. The traditional healers who said they treat all manner of illness explained that any illness they may not be able to treat are those that the healers described as being of recent and alien but even that, they try to deal with them, by spiritual consultations and investigations about those illnesses. For example, a traditional healer said;

> *Of recent we have seen illnesses that show the power of the bad spirits and we have to adopt better remedies to address these illnesses* (Healer, Upper West Region).

> *We have seen illnesses that are quite strange but we have done our best to counter their force and a number of them have been successfully treated but we have also turned some away advising them to seek support elsewhere* (FGD, Traditional Healers).

Most of the respondents explained that mental illnesses are among a range of conditions that would easily be brought to them [the traditional healers] for treatment. The traditional healers that participated in the study always explained that there were a varied range of mental illnesses they see and treat. They categorised the range of mental illnesses commonly presented to them for treatment to be similar to those mentioned by service users and primary carer-givers and community health workers. These included '*spirit possession or afflictions*', '*madness*', '*frustration*,' '*normal fevers and high fevers*', '*severe headaches*' and '*witchcraft*'. Other illnesses that traditional healers mentioned that they treat included snake-bite and infertility. The data extract below capture the illnesses that were mostly listed:

> *Mental disorders are wide and varied. There are three types of mental illness - Fever, high fever and actual mental illness. Fever and high fever are mental illnesses. They are separate from real mental illnesses that make you become possessed and do things that the person in his normal senses will not do them* [KI, Traditional Healer]

These categories of mental illnesses mentioned are quite different from formal classifications of mental illness as per the ICD-10 or DSM-IV classifications (American Psychiatric

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Association, 1994; WHO n.d.) used by the national health services of Ghana. Explanations were sought from participants on the types of mental illnesses that they have mentioned. The traditional healers gave the following explanations to the mental disorder of 'spirit possession':

> *In society and the atmosphere out there, there are evil spirits and bad people. There is bad air out there and sometimes, if you are not lucky you get hit by it and that can seize you, taking possession of your mind, thoughts and body. This bad air afflicts people who roam deep in the night or find themselves in the bush alone when the sun is overhead* [KI, Traditional Healer]

> *People whose bodies become hot and suffer headaches can become mentally ill because these are fevers that can affect mind, thoughts and brains. Hard times, laziness and no work and disappointments end up making people become frustrated* [KI, Traditional Healer]

It was difficult to get a step-by-step process that traditional healers applied in treating people with mental illnesses that use their services. On the whole however the traditional healers interviewed mentioned processes of observation, interview, divination and use of herbal preparations that are used orally or externally. The herbal preparations are provided to the patients to take by mixing in food or drink, smearing of herbal ointment(s) on the body or powders rubbed into incisions made on parts of the body of the person with a mental illness, as well as prayers and exorcism. The quotes below provide the responses the study participants about the range of practical actions the traditional healers in their treatment processes:

> *I observe before I treat. I use my eyes to look at the patient intently and from his movement and manners I can be able to know what is wrong with the person brought for treatment. I make further enquiries and endeavour to converse with the person. If it is madness of the type caused by evil spirits, the bad air or bad people, I administer the appropriate herbs and prayers. I speak the truth. Deceit or fraud is not part of my work* [KI, Traditional Healer]

> *Treatment of mental illness is based on what our ancestors and great-grand parents taught us. We make use of looks, shouts and restrain with chains and shackles as among the processes we apply in the treatment of mental illnesses treat mental illness…. The chains are short-term when they are aggressive* [FGD, Traditional Healers]

For many of the traditional healers they saw themselves as using spiritual powers, skills and experiences to treat people with mental illness and all sorts of health and other difficulties. In spite

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of the statements made by the traditional healers, a number of them conceded that the hospitals have superior methods of managing persons with mental illness who are aggressive than they the healers do for which they will be ready to learn from the nurses and psychiatrists in the hospitals. The traditional healers their having formal working relations with the nurse and psychiatrists will help greatly with effective ways of managing aggressive patients and will reduce their use of chains and shackles on aggressive patients brought to them to manage.

> *Hospitals treat mental illness. Traditional Healers do not have treatment available as in the hospitals to calm down patients that are aggressive. This is what makes them superior to us. We need to learn from them.* [KI, Traditional Healer]

> *We have been doing our own thing but new things are coming up and we will be happy to learn them to add to our practices. It will enhance what we do and enable us help those that come to us better* [KI, Traditional Healer]

A notable negative practice of physical man-handling, including beating and shackling to restrain mentally ill was explained by traditional healers to be part of the treatment process. The traditional healers indicated and conceding that it was rather the result of lack of expertise in handling aggressive/ agitated persons under treatment with them that result in their chaining aggressive people with mental illness or epilepsy. Quotes for these two divergent positions by sections of the healers that participated in the study as presented below:

> *I use the cane sparingly. The actions some of the mentally ill people that are brought to me exhibit are not by their own making as one may think but by the evil spirits that have taken control of over their senses and behaviours. You need to deal with the evil spirit to relieve the person, who will realise he is not in control of himself. After a few whips and incantations you free the person from the evil spirit. For the person witnessing it the individual may think this is hurting the mentally ill but not at all* [FGD, Traditional healers]

> *Beating is bad. It amounts to insensitivity and lack of expertise. I use my herbs. I coax them to drink and with the help of their relatives the people brought to me for treatment drink my herbal preparations and in no time they sleep. When they wake up they are fine. I then continue with my treatment* [KI, Traditional healer]

This is, therefore, an area that traditional healers could be oriented on and encouraged to adopt more effective and humane forms of treatment for mentally ill people that come to them for

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treatment. The WHO's work in The Gambia where they engaged traditional healers and provided them with psycho-education and involved them and the community in a new approach to community based health care for people with mental illnesses (WHO, 2007). A process of active engagement and involvement of the traditional healers together with the introduction of use of low dose of chlorpromazine resulted in significant reduction in abuse of patients and in encouraging clinical outcomes (ibid). The WHO (2002) recognised abuses perpetrated in the practices of traditional healers and have included strategies to address these infractions on human rights of persons with mental illness under treatment with traditional healers within the strategy for traditional medicines in order to promote safety, efficacy and quality and credibility of the services of the healers (WHO, 2002). This will make traditional healing alternative and complementary service to formal community based mental health care service provision (WHO, 2002; Patel, 2010).

Traditional healers mostly practiced in their homes within their native communities. Respondents described traditional healers and their services as ones provided in home settings mostly in or near the communities of the persons seeking treatment. Respondents mentioned shrines and separate quarters within or near the homes of the traditional healers from where the traditional healers practice their trade.

> *Traditional healers are mostly in their villages and practising from their homes or in quarters near to their homes* [FGD, community health workers]

Majority of the respondents were of the view that traditional healing is still very much a part of health care services for most people in their communities.

> *A lot of people still trust in the services of the healers. They go to them even if they come to the hospital for treatment* [FGD, Community Health Workers]
> *We go to them because they meet our needs are always there for us, any time of the day. They still treat mental illness well. You can go to hospital today and they will tell you there is no doctor so you should go back and come another time. You will hardly miss the healer* [KI, Primary Carer]

Most of the respondents were of the view that people regard traditional healers and their services as providing a sense of personal relationship, trust and understanding of problems between

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the mentally ill, as patients, and the healers, as service providers. Most of the service users and carers found traditional healers as the most appropriate in treating mental illnesses as stated as follows:

> *They are able to tell you what the cause of this strange illness you have is. They fight the evil things that are making you unable to sleep, have nightmares and talk to yourself. They are more understanding* [FGD, Service users and primary carers]

The community health workers in the formal community health system explained that they were aware that traditional healing services managed some mental and physical conditions just as well as the formal mental health care services do. The respondents further added that traditional healing services are highly used in the communities.

> *Traditional healers are in almost all the communities. A majority of them are said to treat mental illnesses. We hear they are able to treat some of the mental illnesses. It is common for patients that come to say they have been to one or several traditional healers before now coming to our facility* [FGD, CPN]

> *You see not all the mental cases are seen by us. They are shared between the traditional healers and us, in fact the traditional healers see more people with mental illnesses than we do. At least their services provide some relief and families that cannot afford to visit the hospitals receive whatever treatment from them. It's better than no treatment* [KI, Nurse]

Health workers and health service and policy authorities cited the limited presence of formal health care services as having resulted in traditional healers filling the gap and doing so with varying degrees of success of the treatment services they provide.

> *It is the inadequacies of modern or formal psychiatric treatment services that has made traditional healing to thrive. They are filling a gap formal services have not been able to effectively meet* [KI, Health official]

The foregoing views of stakeholders about the place of traditional healers in mental health care indicates that traditional healing services for mental illnesses are still pronounced and very much part of the lifestyle of most individual, families and communities. This gives conformation of earlier studies that have also established this prevailing situation (Atindanbila and Thompson, 2011; Dzokoto & Hsiao-Wen, 2005).

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4.3.2 Services provided, Fees and charges of traditional healers

There was also a description of the services they provide. Traditional healers were said to provide both physical and spiritual interventions. They consult, diagnose and treat according to their knowledge and training. Their services include and administering herbal preparations on persons with mental illnesses brought to them, as well as providing such local articles (amulets and animal parts). The traditional healers also engage, soothsaying and divination, and exorcism, including use of religious holy books (Bible and Quran) and holy water and anointed oils. Traditional healers also give advice and provide counselling to all manner of persons using their services, which include spiritual fortification against evil spirits and bad luck to their clients. As part of their services, they help with accommodation and feeding of the persons undergoing treatment with them. Traditional healers described their treatment to range from observations and interviews to administration of herbs and prayers, as expatiated below:

> *I take treatment of people seriously. For this reason, I take my time to investigate, including consulting the gods. I ask the person to speak truthfully so that I may be able to help him/ her. I get them the appropriate medicines and with the help of God they well within a short time. It is important to make sure the person not well and his family are comfortable. That is why I have spare rooms in my house to accommodate them and feed them* [KI, Traditional Healer]

> *In addition to the water of the boiled herbs I bathed with, some of the herbs were burnt and ground into powder, which were mixed with shea-butter for me to smear on my body after each bath of the water of the herbs* [KI, mental health service user]

A number of the healers explained that they use the Quran in their treatment. According to them they make recitals of verses of the Quran and incantations in Arabic, and also wrote selected verses of the Quran in tablets or amulets for the healing of the people the people with mental illness that come to them for treatment. The writings on the tablets are washed and put in containers (bottles) which the patients are directed to drink or to rob on their bodies. The amulets are worn around the waist or other parts of the body as directed by the healer.

> *I learnt the Quran and read in Arabic. The Quran is a special book with which healing can be provided to the person afflicted by demons. Devoted recitals and*

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> *incantations as well as the special writings and potions from it have healed people with mental illness that I have been brought to me* [KI, Traditional healer]

The traditional healers also periodically visit people they have treated to check conditions of health of people they have treated before and reinforce treatment they have provided. Respondents also mentioned that the healers and the people under treatment and their families end up establishing friendly relationships.

> *You will need to make time to visit the person brought to you for treatment. They trusted us, that is why they bring the people to us so we have to ensure they get very well and feel assured.*. [FGD, Traditional healers]

> *The healer who treated me before I was taken to hospital still visits me and enquires about my condition. We lived in his house and shared with the family of the healer meals, room and bathrooms and other places of convenience. We were in our usual and familiar environments. This is unlike the hospital where there are lots of restrictions. Sometimes the healer brings some herbs to me and continues to give instructions on how to bath them as it will help me regain my strength* [KI, mental health service user]

Fees and mode(s) of payment of charges for services of traditional healers were highlighted as some of the considerations in the utilisation of services of traditional healers. Fees that traditional healers charge were described by respondents to be a mix of financial and non-financial terms, including such non-financial items as payment with livestock and fowls, fabrics and other objects particularly cowrie shells and cola. The terms of payment are also fairly flexible.

> *We did not pay for the services immediately. We asked to be allowed to go back to our village and to prepare to come back and pay after we have harvested our crops. The healer had no problem with that* [FGD, Primary carer].

> *My services is not me become rich but to help my community with what god gave me. I tell them of the items they are to provide for the treatment. Whatever I am given after the treatment is entirely up to the perosna nd his/ her family* [KI, Traditional healer]
> *Charges of traditional healers are both in cash and in kind. Even though it the end a more expensive than charges from the hospital clients are able to meet those charges* [KI, Director of health services]

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Earlier studies confirm that traditional healers and their services span a spectrum of practices (Addy, 2005; Atuado, 1985; Leslie, 1980; Oliver, 2013). The combination of herbal and psycho-spiritual practices to address the physical, psychological and social aspects of the individual with mental illness of epilepsy was identified to be consistent with the general beliefs and social and spiritual constructions of most people in the northern Ghana area. This has been confirmed in the study by Oliver (2013) on utilisation of traditional medicine among the Australian Aborigines. These findings on the places people go for treatment in the community, and the suitability of communal arrangements in seeking health care services with traditional healers support studies that highlight the acceptability, affordability, accessibility and availability of traditional healing services as the main reason for its high patronage and utilisation (Gyasi, Mensah, Adjei, Agyemang, 2011; Tabi, Powell, & Hodnicki 2006)

This study established that participants found treatment services of traditional healers to be not only easily available but accessible and holistic and in attempt to address the physical, psychological and social aspects of the person who is ill. (Sato, 2012; Stekelenburg et al, 2005).
The treatment settings are familiar to the surroundings of service users and their primary carers and families which is appealing to them. This is similar to the 'residential care' which Darko (2009) attributes to Tsey (1997) which usually makes the person under treatment become a member of the extended family of the healer. Their services and service locations is very much in tune with socio-cultural arrangements of the northern Ghana area where communal living and the extended family system easily makes anyone a member of the household and community [Awumbila & Ardayfio-Schandorf, 2008). The communal living and household arrangements in northern Ghana, together with the flexible terms of payment, makes traditional healing services quite a popular choice for most low income and rural populations, most of who are the majority.

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4.4 Stakeholder understanding or definition of integration of healing services of traditional healers into formal community services

Definition of a phenomenon contextualises the meaning and influence attitudes and practices (White, n.d). Exploration of the possibility of integration of traditional medicine into formal community mental health services was approached by first seeking out what respondents understanding of integration meant. This was meant to explore respondents' appreciation of what the benefits and potential challenges of bringing together the two forms of practices could have on the scaling up of community based mental health services to serve the needs of the population in Ghana. To gauge this, stakeholders were asked to provide a definition of their understanding of 'integration' of traditional healing services into formal community mental health services. A range of descriptions were given by respondents about their understanding of integration. This covered terms and concepts as inclusion, mainstreaming, and equal recognition. Traditional healers' responses to what they understood integration of their services into formal care were that it is combining of their services with formal health care services provided in the hospitals, while for mental health services users and primary carers according similar recognition to traditional healing remedies and use without legal hindrance.

> *It means encouraging equal and combined use of both formal community services and those of traditional healers in the management and treatment of mental illnesses and epilepsy"* [KI, Service user]

> *We work in a way that people are free to choose where they want to go for treatment and there is equal recognition of our practices* [FGD, Traditional healer]

Community mental health workers in the formal sector emphasised that they understood integration of traditional healers and their services into formal community mental health services as adding traditional healing services into formal community mental health care services and ensuring practices of traditional healers are well supervised. These views were expressed in the following statements below:

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Services of traditional healers are included for oversight by the trained community health workers … It is good that traditional healers and formal community mental health service providers work together. There should be more respect of the healers than is the case [FGD, CPNs and CHNs]

In the case of health policy officials, integration of traditional healers and services into formal community mental health services was not just what it should what the definition should be but what it should be seen and known to be doing to enhance mental health care service provision, as captured in the statements below:

> *Maximising the widespread availability of traditional healers in the communities and the efficacy of their treatment services to enhance formal treatment services for people with mental disorders* [KI, district director of health services]

From the above responses, it can be inferred that there is a good level of clarity by study participants of their understanding of what integration of traditional healers and their services into formal community mental health care services mean. They describe it as a situation in which traditional healing services and formal/ modern health care services are equally recognised in the official health system and are available to all who need it without discrimination or disregard of one form of health care service over the other. It is thought of to be the integration that is grounded in policy and legislation.

Earlier studies that explored integrative models and found possibilities of combining traditional and complementary health care services with formal health services established similar understanding of integration of traditional health care services to into the formal health care system meant (Coulter, & Willis, 2004; Sundberg, Halpin, Warenmark, Falkenberg, 2007; Wye, Shaw, & Sharp, 2008**).** The more developed health care services and practices that have a good level of combination of traditional health western medicine, such as Chinese acupuncture and the Ayuverda in India demonstrate the possibility of traditional healing practices to work alongside modern/ formal health care systems (Cheuk, Yeung, Chung, Wong, 2012; Chung 2012)

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In Ghana what may be likely is the legal recognition and support of both mental health services and formal health care services to run alongside each other, and the patients shared between the traditional healers and formal health care workers (Asante & Avornyo, 2013; Addy, 2005; Ae-Ngibise et al, 2010).

With this understanding, there was interest in also exploring from the stakeholders the opportunities that exist to facilitate such moves of bring about integration of traditional medicine into formal community mental health care. The responses of participants are presented in the paragraphs below in this section.

4.4.1 Respondents' views on how integration of traditional healing services into formal community mental health care services can be achieved

Respondents stated various views as to how integration of services of traditional healers into formal community mental health services could be achieved. Suggestions ranged from increasing contacts and collaboration; through to learning and sharing meetings between traditional healers and community mental health workers; to training of traditional healers on improved/ modern treatment practices; certification of recognised traditional healers; and provision of financial and material support to traditional healers to enhance their services. There were also calls on BasicNeeds-Ghana (an NGO) and other NGOs working in mental health (such as Mental Health Society of Ghana, Ghana Mental Health Association), and the District Assemblies to serve as brokers in ensuring the needed integration takes place.

Improvement of infrastructure that traditional healers use to provide their services could serve to bring about their effective integration into the formal community mental health care service system. This requires support to the traditional healers to improve lodgings to accommodate persons living with them for treatment.

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> *Traditional healers are hardly considered for support in the government health budget. It is important resources are set aside to develop the aspects of their practices that are good and can complement mental health care provision. Their training, and provision of decent places for their practices and stay of patients are areas that government should invest in to make the health care system truly integrated and serving the population* [KI, Regional Director of health services]

Provision of means of transport to facilitate movement of the traditional healers, including their search for herbs, and , and closer engagements with the formal community health workers will improve contacts and effective collaboration between the traditional healers and the CPUs. For the formal community health workers, facilitate regular support visits to homes or service points of the traditional healers will significantly help in harmonising the services provided by both traditional healers and formal health workers. Traditional healers also mentioned that it will be good for them to be certified and provided with identity cards for the services they provide.

> *The best way to make our services fully recognisable and available to people is for us* [traditional healers] *to be provided means of transportation to facilitate our work, especially responding to emergencies and liaising with the hospital for any complex cases that they* [the hospitals] *may be able to handle* [FGD, Traditional healers]

> *There should be an effort to recognise and accredit us and our practices so that hospitals can feel confident to refer to us. Those of us identified should be provided with identity cards and having been known by the hospitals people can be referred to us to treat them and we can also send people to the hospitals to be seen by the doctors there* [FGD, Traditional healers]

The call for traditional healers to be registered and certified to practice supports the call of Zhang (2000), which is similarly reiterating the adoption of the WHO's guidelines "to promote the appropriate use of traditional medicine by providing technical guidelines, standards, and methodologies should be undertaken" (p140). According to Zhang (2000), this can be realised by:

> "comprehensive evaluation of their traditional systems of medicine and intensify activities leading to cooperation between those providing traditional medicine and modern health care, especially with regard to the use of scientifically proven, safe, and effective traditional remedies to reduce national drug costs. It is clear that each system of traditional and modern medicine has its advantages and disadvantages.

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> Integration can be achieved in the fields of research, training, and combination or complementary treatment. Patients should be able to obtain the benefits from both therapies free of charge" (p.140)

Also, traditional healers were of the view that certification will enhance their profile and recognition of their services and help eliminate quacks.

> *With certificates for us and identity cards, we are separated from the rest. We can be respected by the public because government recognises us* [FGD, Traditional Healers]

This confirms evidence that traditional healers see value in being part of the formal system as that will enhance their own profile and provide some sense of legitimacy for them, for which they are willing to cooperate in making that happen (Campbell-Hall et al, 2010; Devenish, 2008; Pouchly, 2012).

Views of community health workers were that a first step to effective integration of services of traditional healers into formal care will be to build a record of the traditional healers that are providing mental health care services in the communities by districts. This will ensure a good level of monitoring of the practices of traditional healers, and the need to bring about a change in attitude of community health workers towards the services traditional healers provide. The following extracts capture the views of the community health workers:

> *There is need for change of mind-set of community mental health workers to appreciate the services of traditional healers in management of mental disorders. The welfare of the patient should be paramount. Too many of us tend to quickly dismiss their work. Re-orientation/ training of formal health care workers to not antagonise traditional healers and/or their practices. Involve communities in the re-orientation too* [KI, CPN].

Just as the traditional healers, formal community mental health workers' views were that including traditional healers and their services into formal community mental health care services was appropriate and necessary in an ever dynamic society with complex world views and mental

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health needs. To them it will be a burden shared since the formal health care system is plagued with inadequate infrastructure and logistics, personnel and financing.

> *With proper organisation and training traditional healers will be helpful in taking care of people with mental health needs. They may not be formally trained as nurses or psychiatrists but there will be greater number of workers supporting in the treatment and care of mentally ill people* [FGD, CPNs/CMHOs/CHNs]

The formal community health workers expressed their views mainly from the point of view of their training curriculum and maintaining code of ethics dictated by their professions which do not make them recognise traditional medicine, but by their socio-cultural backgrounds, formal community health workers seemed convinced that traditional healing has a place in mental health care provision. This supports earlier studies of Khan and Kelly (2001) about cultural issues confronting "Xhosa-speaking psychiatric nurses on traditional healing and its role in mental health care" (p38). This innate recognition of traditional healing by formal health workers is supported by studies of Cumes (2004) which found that despite Western education and professional training health workers may have had, their socio-cultural background still influence their orientations toward health and disease and possible places for remedy for the conditions. As a result, recognition of traditional healing services and properly organising and supervising their practices will go a long way to enhance mental health service provision at the community level.

The interest in cooperating and sharing of patients between traditional healers and formal community healers has also been supported in previous studies (Sato, 2012; Stekelenburg et al, 2005). However in his study on popularity and utilisation of traditional healing practices, Sato (2012) posits that while people are satisfied with traditional medicine, it is more often a secondary recourse of treatment. This view is, however, far from what majority of other studies suggest. Those studies establish that majority of people with mental health needs and their carers and families will first resort to traditional healing before coming to the formal/ legal medical services (Barimah,

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2013; Ae-Ngibise, 2010; Bojuwoye & Sodi 2010, Ahmad, Chatwin & Tovey, 2005; Atindanbilla & Thompson 2011; Kayombo, Uis, Mbwambo, Mahunnah, Moshi, & Mgonda, 2007).

In the case of service users and primary carers interviewed, the views of most of them were that the time right to work to integrate formal and informal or alternative services for the benefit of people who use or will use them. For integration to be effective, service users and primary carers mentioned that there should be sharing of ideas in order to promote unity. Training should also be provided to traditional healers and that community health workers in the formal sectors be oriented to respect and learn to speak the local languages of the areas they work in and not despise service users found to have visited and used the services of traditional healers. The following statements from the respondents further explain their views:

> *People who visit traditional healers should not be insulted by the nurses when they come to the hospital for each of them have the side they can treat. I have experienced it and I nearly left the hospital because of the comments and insults the nurses rained on me when I informed that I had spent six months with a traditional healer before coming* [KI, Service user]

Views of health policy officials were similar to those expressed by the community health workers, and services users. However, the health policy officials particularly emphasised that such a move must be backed by policy and legislation. Also services of traditional healers should not be denigrated but recognised as of comparable value that can complement those services provided at the formal community mental health facilities, as presented below:

> *There is need to understand that the work of traditional healers should be complementary and does not replace the services provided at the formal community levels. So community mental health workers need to encourage and support the traditional healers and traditional healers should be willing to accept new ideas* [KI, Regional Director of Health Services]

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The responses of the stakeholders indicated a sense of consensus that integration of services of traditional healers into formal community mental health services is necessary and needed to be pursued and to be realised.

Perspectives of the key stakeholders were very much shaped by their knowledge and attitudes and appreciation of traditional healers and their practices as well as inadequacies of the formal community mental health.

On the whole, key stakeholders expressed views that inclusion of traditional healers in formal community based mental health care services was needed and should be pursued. The main reason for this is that a majority of people will usually use of both traditional medicine and formal community psychiatric treatment services. With such health care seeking behaviour the appropriate approach is to have a community mental health care system that formally recognises and integrates traditional healing services to enable persons with mental health care needs and their families to utilise both health care services freely and legally without unnecessary chastisement and ramifications from providers and authorities. This finding is supported by studies on health seeking behaviours of people of similar context and characteristics (Barimah, 2013; Barimah & van Teijlingen, 2008; Darko, 2009; Iyalomhe, & Iyalomhe 2012; Stekelenburg et al., 2005).

4.4.2 Opportunities and potential challenges to integrating traditional healers into formal community mental health care services

The views expressed by the various stakeholders in 4.4.1 above indicated that there was consensus that services of traditional healers can be part and parcel of formal community mental health services. For this reason, there was interest in exploring what opportunities exist that should be taken advantage of to bring about such integration. Such unanimity also provided occasion for the stakeholders to mention and recognise the inherent challenges that could constrain effective integration of services of traditional healers into formal community mental health services.

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Findings of existing opportunities and potential challenges are gathered from respondents and discussions on them are presented below.

4.4.2.1 Opportunities

The interest in identifying opportunities that exist to facilitate integration of services of traditional healers into formal community mental health services was to provide pointers or supportive situations to enhance maximisation of traditional healing services to people needing the services. These opportunities could be policies and legislations, as well as personalities who could help support and influence integration of such important health service practices that have been around but not fully maximised. Traditional healers mentioned that there is a sense of growing recognition of each side of traditional healers and formal health workers and their practices such that collaboration and discussion of it is needed and probably long overdue. Such stance and goodwill provides a good opportunity to take advantage of. The following extracts from the interviews with the stakeholders explains this:

> *Since post-independence, it has been the objective of bringing indigenous knowledge and traditional healing into much better light. It's high time we go beyond words into action* [KI, Health policy official].

The specific opportunities identified by research participants are outlined below.

4.4.2.1.1 High patronage of services of traditional healers

The widespread presence of traditional healers in the communities and their readily available services were mentioned by stakeholders to be a real opportunity to take advantage of in bringing about integration of the services of traditional healers and their services into formal community mental health care service system. The reasonably high use of services of traditional healers juxtaposed with the inherent inadequacy of the formal community mental health system has made traditional healing of mental health illness look more popular. These views were expressed in the following extracts:

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> *People believe in them and use them a lot so they can be a good conduit to bringing proper treatment to the people that need it* [KI, CPN]

> *Traditional healers are everywhere and are well placed to support provision of improved community based mental health services Rapport with traditional healers and confidence in them by persons with mental illnesses and their families make them good conduits to take up responsibilities resulting from efforts to decentralise mental health care services* [KI, Health policy official]

These findings are consistent with evidence of earlier studies of similar nature. For example, Moodley (2011) found that African, Caribbean and Asian populations very much use traditional healing services in Toronto and most north American cities, despite highly modernised and accessible mental health systems. This is because the cosmological and nosological notions ascribed to health, disease and ill-health go beyond just genetic and biological explanatory models associated with biomedicine or Western health care practices. This is also consistent with calls of the WHO for countries to respond to the growing use of traditional medicine and complementary and alternative medicine practices for the populations (WHO, 2002, 2013). This is particularly true especially in the context of the inadequacy of formal health care service infrastructure and personnel for formal community mental health established by earlier studies (Devenish, 2008).

4.4.2.1.2 Growing awareness and improvements on medical technologies

Traditional healers who were respondents to the study mentioned that technological advancements in the medical field and health system makes it necessary for them to be abreast with modern trends and serve as an opportunity for them to upgrade their practices and become more useful to society.

> *We want to learn the new things of the world and you should teach us … the world is changing. Your eyes are opened more than us so we want to know the new ways of doing things too. That can help our practices* [FDG, Traditional healers]

Community health workers identified such opportunities as the availability of resources from government and the increasing interest of other institutions in the work of traditional healers in [mental] health care delivery services as presenting opportunities for enhancement of traditional

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healers and their services in formal community based and integrated mental health service provision. The extract below conveys this view:

> *Interest in traditional healers by organisations working in mental health presents an opportunity for them to be helped to do their work well* [FGD, CPNs & CHNs]

Service users and primary carers in their view mentioned that:

> *Knowledge is improving every day and wisdom does not lie in one person. Both traditional healers and doctors and the nurses can take advantage to learn from one another* [FGD, Service users and primary carers]

There is growing international recognition of mental health as a sector needing attention and interest in indigenous medicine and Complementary and Alternative Medicine (CAM) and for calls for support for development of comprehensive health systems that are inclusive of traditional medicine present a real opportunity for developing mental health within formal health care services (WHO 2002, 2013). Led by the WHO there is a steady interest in traditional healing as an essential aspect of health care services that needs to be harnessed for a comprehensive quality and accessible mental health care (WHO, 2002, 2013). Similarly, NGOs advocating for decentralisation and deinstitutionalisation and expansion of mental health care services are steadily engaging the attention of the government of Ghana (Owusu, 2013; Yaro, 2012) and could prove as the assured avenue to influence a community mental health care service that integrates traditional healers and their services.

4.4.2.1.3 Presence of traditional healer association

Traditional healers mentioned the presence of an association of traditional healers of mental illnesses and/ or epilepsy which is in the process of getting affiliated to the national federation of traditional healer associations – the Ghana Federation of Faith and Traditional Medicine (GHAFTRAM).

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We have the association of traditional healers of mental illnesses who you can support to have national recognition with the bigger association at the national level to facilitate a process of integration of our practices into formal community mental health care services [FGD, Traditional healers]

Similarly, service users mentioned that contacts can be made with leadership of the groups of traditional healers to bring them together to improve mental health care service provision:

> *An effort can be made to bring the leaders of the traditional association together to help them to improve their treatment services* [FGD, Service users and primary carers].

Health policy officials interviewed also mentioned the presence of the Council for Traditional Medicine at the Ministry of Health of Ghana as an important avenue and opportunity to get government to be able to show interest and support a process of integration of traditional healers and their services in community mental health services.

> *Traditional medicine council at the Ministry of Health is supposed to and should help healers in treating people with mental illness of epilepsy* [KI, Mental health official]

Traditional healers serving as frontline mental health service providers can be encouraged as part of measures to getting more people to benefit from formal community based mental health services. With such arrangement formal mental health treatment services could reach more persons needing those services much earlier than is happening presently. With early attention, delays to proper care could reduce significantly The practice of people shopping around for treatment from traditional healers before coming to the formal mental health services may be curtailed if not eliminated entirely.

The traditional healers could also serve as good conduits for dissemination of information about mental health and mental illnesses as they get trained as frontline workers in mental health care delivery at the community level. Deployment of traditional healers in this regard has proven to be successful in the fight against HIV/AIDS in South Africa, where through traditional healers, information was disseminated to promote early treatment and reduce stigma (Wreford, 2005). It

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also increased utilisation of those aspects of traditional healing practices considered to be more therapeutic than may be applied in the formal community health service provision (ibid).

The Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM) and the region-based groupings of traditional healers treating mental illnesses facilitated by BasicNeeds-Ghana (Addy, 2005, MOH, 2005, & BasicNeeds, 2008a) can be harnessed for the development of a community mental health system that effectively integrate with traditional healing practice. An association of practitioners whose members are bound by the particular illnesses or disease conditions they treat could be an advantage to enhancing mental health care delivery. The responses provided by the traditional healers with regards the opportunities to take advantage of to realise the integration of traditional healers and their services into community mental health care services showed a sense of their quest to professionalise and remain relevant in the health service system and ensuring their service are available to all. The interest of traditional healers to professionalise is consistent with similar studies on understanding the dynamics amongst traditional healers in Kwazulu-Natal as they engage in professionalisation of their practices (Devenish 2005; Wreford, 2005). Devenish (2005) for example, establishes that at the wake of the post-apartheid South Africa, which brought about enactment of the Traditional Practitioners Act, traditional healing practitioners heightened the quest for them to organise and professionalise, notwithstanding the power dynamics and associated tensions that were at play among the healers themselves on one hand and with the bio-medical practitioners on the other. An association of traditional healers treating mental illnesses in northern Ghana, and the whole country for that matter, will be further enhanced by the Ghana Federation of Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM).

4.4.2.1.4 Supportive mental health legislation

The opportunity of the new Mental Health Act, 2012 (Act 846) of Ghana was mentioned as one that could potentially bring about effective integration of traditional healers and their services

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into formal community mental health care. Health policy authorities explained that the large numbers of traditional healers in the communities present an opportunity to mobilise them in their numbers to enhance community mental health care services for the populations. It was mentioned by health policy officials that lessons from previous attempts of working with Traditional Birth Attendants (TBAs) within the formal sector, provide good opportunities to pilot with traditional healers treating mental disorders within the formal community mental health care services. The following statements capture the responses of study participants:

> *Their presence in communities, the current mental health Act, which promotes complementary and alternative mental health care practices, as well as the desire and willingness of both the traditional healers and formal community mental health professionals to work together provides fertile grounds to make the integration come to reality* [KI, Mental health specialist at the Ministry of Health]

A number of the community mental health workersand health policy officials also mentioned the Mental Health Law as an opportunity and appropriate legislation that can promote integration of traditional services into community mental health care:

> *We understand the new mental health law will address the situation of traditional healers and make them part of formal health services provided to the people. We hope the law will see that through* [FGD, CPNs and CHNs]

The Mental Health Act, 2012 (Act 846) of Ghana emphasises community based and decentralised mental health care integrated into the general health care system at the primary care level (GoG, 2012). This law also provides for support to and regulation of traditional medicine and alternative health care services (ibid). The Mental Health Act, together with existing Parliamentary Acts and public policies on traditional medicine and related efforts all come together to provide credible foundations and basis for development of a community-based mental health care that actively integrates traditional healing practices. The key legislations and policies include, the Traditional Medicine Practice Act, 2000 (Act 757) and the Traditional Medicine Policy (2005), as well as the Disability Act, 2006 (Act 715) and other efforts to align existing and new laws with the

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UNCRPD, all come together to provide credible foundations and basis for development on a community mental health system integrated with traditional healing practice.

The Ghana Centre for Scientific Research into Plant Medicine, the Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM), and the Traditional and Alternative Medicine Directorate (TAMD) can be harnessed for development of a community mental health system that effectively integrates with traditional healing practice. With this it has become apparent that government needs to comprehensively implement the Law and actively implementing the provisions and measures that support inclusion of traditional healers and their services into formal community services. Support, such as improving infrastructure of traditional healers, provision of means of transport, and statutory stipend, as well as certification and continuous training and supervision will go a long way to realise the integration needed. It is known that new and innovative interventions are best implemented when there are appropriate laws and policies to guarantee and to over-see them (WHO, 2005). Earlier studies, such as those of Wreford (2005 & 2005b) and Kayambo, Uis, Mbwambo, Mahunnah, Moshi, and Mgonda (2007), for examples, have explored the possibility of collaborations between biomedicine and traditional healing have showed how improved post-apartheid laws had the potential of enhancing involvement of traditional healers and their services in HIVAIDS care and support, and treatment.

4.4.2.2 Potential challenges with realising integration of traditional healer into formal community mental health care

Challenges that could inhibit effective implementation of efforts to integrate services of traditional healers into formal community mental health care services were explored with the study participants.. Notable difficulties that were raised were in relation to the difference in status between traditional healers and community mental health workers in the formal sector, including literacy and educational attainment between the two categories of health care service providers; the

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different modes of operations and practices and suspicion and fear of misuse of trusted knowledge and information. Other challenges noted were infrastructure and funding constraints.

Respondents noted that there is a difference in training curriculum and educational qualifications which can be a significant challenge to bringing about integration of traditional healers into formal community mental health. The key issues were who standards of training and education will be used. Also should it come to certification, placements and remuneration as well as promotions, these could prove a challenge.

> *I am willing to work with the people in the hospitals but I am a bit too old to learn new things as they expect* [KI, Traditional Healer]

> *There is no standardised and documented curriculum with which you can base to certificate or license them. More so, most of them are not formally educated for one to be sure what they can and should do or not to* [KI, Health Policy Official]

Similarly the difference in modes of operation and practice could constitute a challenge as standards of operation such as the basics of registration of patients and maintenance of their medical records to more complex issues of dosages of medications would require some level of understanding and harmonisation. The challenge of the advanced ages of most of the traditional healers closely related to the issue of the illiteracy among most of the healers since they did not acquire formal education and are clearly now too old to acquire formal education.

> *Our ways of doing things are so different that it will take time for us to be able to come to an amicable way for to use our individual approaches in the way that will enhance services for the people* [FGD, CPNs]

> *We work with tradition and God's given natural products. They work with the white-man's way of doing things and what the white-man produces for treatment of memtal illnesses, so it's difficult to know if they want to work with us* [FGD, Traditional healers]

The challenge of literacy levels of traditional healers is looked at in relation to enabling traditional healers to acquire or be able to follow new remedies for managing mental disorders and epilepsy that could benefit their practices. Appropriately developing a training package that meets their level of education and appreciation of health issues may be challenge. Such a training package

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that adopt adult education pedagogies will go a long way to enhance interest of the traditional healers in learning as well as retention of knowledge and skills imparted to them (Kearsley, 2010; Clapper, 2010). Difficulties with communication due to differences in the spoken and written language serve as barrier for transmission and exchange of knowledge and expertise. Similarly, the predominance of the English Language, in relation to the poorly developed local languages of northern Ghana culminate to constitute a key challenge to imparting knowledge on improved practices and adherence to certain bureaucracies, such as formalising referral procedures and use of templates for effective documentation and reporting. Many of the formal community health care services providers usually are not natives and usually unable to speak or write the local language of the community or village. Combining these with a well-documented speciality such as community psychiatry with an oral based and relatively undocumented and unwritten traditional healing trade could prove a challenge. This challenge and its attendant implications was highlighted by earlier studies exploring ways to increase collaboration between traditional healers and formal health care services for HIV/AIDS (Kaboru, Falkenberg, Ndubani, Höjer, Vongo, Brugha, & Faxelid, 2006). This, however, does not arise if adult education methodologies, including use of audio-visuals, are adopted (Clapper, 2010)

Community mental health workers trained under the formal educational systems have been educated and socialised to regard traditional healing as an inferior and good-for-nothing trade by quacks and fraudsters claiming to treat mental illness Mokgobi, 2012; Mngqundaniso & Peltzer, 2008). Both Mokgobi (2012) and Mngqundaniso & Peltzer, (2008) established that health carer practitioners trained through formal or Western education have little regard for traditional healers and their practices, even though there is a gradual shift in such disregard towards traditional healers. On the other hand traditional healers regard themselves as the experts with indigenous knowledge and remedies to management of mental illness and other diseases which they claim formal health facilities only treat the symptoms but not comprehensively (Darko, 2009). The studies by Awodele,

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Agbaje, Ogunkeye, Kolapo, &Awodele, (2011), Freeman and Motsei (1992) and Wreford (2005a, 2005b) similarly found how highly traditional healers regard themselves with regards to their being able to more effective health care services to people in their communities . This is a difference needing to be clarified to bring about the integration so supported by the key stakeholders.

Concern relating to attribution, as to whose services had the best result in the management and cure of the mental illness of the service user raised a potential difficulty that could affect the kind of working system require for effective utilisation of both traditional healing services and formal community mental health care. The claim as to as to whether traditional healing remedies or those provided from the formal services that had the most effect on the stabilisation and recovery or persons with mental health care needs was raised. CPNs were concerned that persons stabilised by psychotropic and anti-epilepsy medicines could be claimed by traditional healers to have been made well by their remedies.

> *I fear it could confuse people as to which remedy works and which one they are encouraged to use. We think formal services are better. Traditional healers will only be enjoying from the successes of the Community Psychiatric Units* [KI, CPN]

Similarly, traditional healers also expressed concern that their knowledge and expertise could get pirated and used without due recognition to them. They expressed a sense of lack of appreciation and recognition for the efficacy of their remedies and services.

> *Our services may not be given equal recognition. This could be undermining. We know we also have other ways to manage mental illness that work* [FGD, Traditional healers]

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Giving credit where it is due, especially in the case of efforts and successes of traditional healers in the management of mental illnesses was viewed to be an important step to gaining

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cooperation and support of traditional healers in integrating their services and enhancing their practices in community mental health care service provision. Traditional healers were receptive to making their services part of formal health care services and about conceding that some aspects of orthodox medicines are more superior to their approaches. The traditional healers however expected that there is fairness in recognition accorded them with regards the effectiveness of their practices and relation to that of the formal health care workers. The concerns of getting adequate compensation and alternative to what they are likely to be required to give up by being integrated into formal health care services to maintain their livelihoods and status.

> *We also expect to be accorded some recognition and respect similar to that provided to the doctors and nurses. After all, we are also experts in our field* [FGD, Traditional healers]

These concerns and positions could potentially result in loss of respect and status by either side of traditional healers and formal community health workers as remedies and practices get demystified. These sentiments and positions have been highlighted in earlier studies of Wreford (2005) on traditional healers' involvement in HIV/AIDS treatments and potential obstacles to achieving cooperation with biomedical practices. Campbell-Hall et el (2010), found similar challenges.Another challenge highlighted was the fear of misuse of knowledge and information by both sides of traditional healers and community mental health workers in the formal system was noted. This was particularly among both sets of practitioners where it was felt that either one of group of them on getting insight into each other's practices will misuse or undermine the other.

> *There could be misuse of medications by the traditional healers. We are aware that some of the traditional healers know of the medicines used for mental conditions, especially the sedatives, and buy them to use for patients with them.* [KI, CPN]

> *We have come to realise that most of you want to take what we have but you give back nothing in return. We have learnt to know how much we can share with people* [FGD, Traditional healers]

Passiveness and suspicion of both formal health workers and traditional healers have been documented in earlier studies (Campbell-Hall et al, 2010; Devenish, 2010; Wreford, 2005). These misgivings are quite familiar with regards to the inclusion of traditional healing services into formal

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community mental health (WHO, 2002). These related to difficulty with knowing who really the traditional healers are that they could work with coupled with the unscientific nature of their medicines and, practices and their general mode(s) of activities they apply (WHO, 2013). This situation, however, needs to give way to collaboration and integration of their services for effective maximisation of resources for [mental] health and better health outcomes overall.

While formal community mental health workers feared for loss of standards and quality of services they provide becoming compromised, traditional healers on the other hand feared that there could be theft of their knowledge and being undermined by formal mental health care service providers. The WHO appropriately highlighted issues of safeguard knowledge and intellectual property and mutual respect between formal health care service providers and traditional healers, in its strategy for developing traditional medicine for countries of the world (WHO, 2002, 2013). Earlier studies have highlighted this issue with suggestions that more regular interactions and in sharing of knowledge and experiences, as well as bi-directional referrals, as a result of closer interactions, could be the way forward to assuring both forms of practitioners and their services (Kaboru et al, 2006; Mngqundaniso & Peltzer, 2008; Mokgobi, 2012; Sorsdahl et al, 2010; Wereford, 2005)

Such stance by both traditional and formal community mental health workers reveals also attitudinal manifestations of both the traditional healers and formal community mental health workers towards each other's practices. These attitudinal manifestations constitute an important factor which needs to be addressed in order to bring about a community mental health system that integrates traditional healing into formal community mental health care services. Attitudes inform behaviours, including utterances, and decision-making (Devenish, 2008; Sato, 2012) and very much determined the stakeholders' perspectives.

Thirdly, respondents equally noted that it will require infrastructure and financial resources to bring that about. With notable financial challenges that face the mental health sector it will be

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quite a challenge to bring about an integrated traditional medicine service with formal community based mental health care services. This will be mainly underpinned by political commitment on the part of government and health policy authorities.

The infrastructure significantly impacts on efforts to evolve an integrated community mental health system that is inclusive of traditional medicine. These include working space and ancillary facilities and logistics, including means of transport. Service users and primary carers were more concerned about challenges of access to the facilities and continuous availability of medicines. On the challenge of adequate access to mental health care facilities, services users and carers were concerned that until additional facilities are established in the formal health facilities, it will be difficult to have them close enough to be combined with support services of traditional healers. Also far distances of current formal health facilities and of the bad nature of the roads were cited as possible hindrance to having an integrated community mental health services.

> *Community Psychiatric Units (CPUs) are mainly only available at the district level and are far from distant communities compared with the numbers of traditional healing services which are widely available* [KI, Primary carer]

> *Mental health is already poorly financed and no medicines are available to support our work at the community level. If mental health is going to be treated the way it is now, then what we are talking about it will not work. A good amount of funding is needed.* [FGD, CPNs & CHNs]

Challenges associated with sustainably financing such initiatives were highlighted to likely blight attempts at bringing about an integrated community mental health system. Much as infrastructure for the health services continues to improve across all levels, it is not the same with the mental health sub-sector, especially at the district, sub-district and CHPS compound levels where community mental health services are supposed to be functioning. Community mental health units are in just about half of all the existing districts of Ghana. As also earlier established by Ofori-Atta et al (2010) even where there was a psychiatric unit and a staff, the challenge of office space, a

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means of transport, as well as non-availability of psychotropic medicines affect effective service provision by the unit.

Related to funding challenges is the inadequate political commitment required of the government of Ghana to support development of community mental health. Such low government commitment limits the amount financial resources and infrastructure that can be invested in building a well-integrated community mental health system in Ghana. Political commitment is perhaps the singular factor required to bring about a community mental health system that maximises services of traditional healers in the management of mental illnesses Raja, Wood, de Menil, & Mannarath, 2010). It has often been discussed that if the political stance and commitment of the early post-independence years led by the first President of Ghana to harness and integrate indigenous medicine expertise and develop home-grown good practices were continued, Ghana's health system would have been one that fully integrated traditional healing practices in health care service delivery (Addy, 2005). In this case mental health would have equally benefitted. Beyond the legislations in place, and their related structures there is little else that give clearest indication of government's practical move to finance and undertake activities that will bring about integration of traditional healers and their services into formal community mental health care services in northern Ghana and the country at large.

Notwithstanding the recent political actions and pronouncements, such as promulgation of a new mental health Law and establishment of a Mental Health Authority, quite a lot more is expected of government to improve the mental health services in Ghana. More concerted focus is still required to maximise services of traditional healers in order to enhance quality and accessibility of community based mental health care in Ghana.

Yet another challenge, respondents mentioned that could affect integration of traditional healers and their services into forma community mental health care was in relation to monitoring and supervision of services practices of both the traditional healers and the community mental

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health workers I the formal mental health sector. Effectively supervising and monitoring of the practices and activities of each of the services of traditional healers and formal community health workers individually and collectively was highlighted as a challenge to be appreciated. Monitoring and supervision were regarded to be critical as that will determine if a more viable and enduring system of community mental health is evolved or the system becomes diluted and standards fall. Study respondents highlighted the value of effective supervision and monitoring and evaluation to the success of an innovation, policy and/ or programme. There was concern that inadequate or the lack of supervision and monitoring and evaluation could undermine effective integration of traditional and formal community mental health services. Health policy officials were of the view that it is important to have a clear supervision and monitoring and evaluation systems in place to see to the effective integration of the services of the traditional healers into formal community health services:

> *Lack of post-training follow-up and effective monitoring and supervision of the healers could compromise the work of the services providers and the quality of the services they provide* [KI, Health policy official at the Ministry of Health]

Periodic but regular evaluation of the practices and activities to ensure the improved services emerging from an integrated traditional healing service into formal mental health care service delivery were important, maintained and sustained. However, inadequate technical/professional personnel, logistics and funding could undermine such an important process. Study respondents highlighted the value of effective supervision and monitoring and evaluation to the success of an innovation, policy and/ or programme. There was concern that inadequate or complete absence of supervision and monitoring and evaluation practices and services could undermine effective integration of traditional and formal community mental health services. Health policy officials were of the view that it is important to have a clear supervision and monitoring and evaluation systems in place to see to the effective integration of the services of the traditional healers into formal community health services.

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4.5 Way Forward to realising integration of traditional healers services into community mental health care

From the challenges, real and perceived, that have been highlighted by led to respondents being asked what they thought the way for could be in realising integration of traditional healers and their services into community mental health care. A number of suggestions were provided. These included setting up a system of training for traditional healers to upgrade their knowledge and skills and a re-orientation programme for formal community mental health workers to become more accommodating of the practices of traditional healers. The training and orientation should be complemented by registration of traditional healers for effective contact and after training support, supervision and maintenance of good practices.

> *Some of the health workers may not want to work with traditional healers as they may see them* [traditional healers] *not to be of their standard and for that matter at par with them* [FGD, Services users and primary carers]

> *Initially it would be repugnant to the greater majority but they* [formal community health workers] *themselves need to be oriented so not only do we train the traditional healers but we need to train and re-orient our own orthodox personnel so that once we make them to appreciate that this is a new way, this is a paradigm shift, then they will begin to appreciate Traditional Healers* [KI, Regional Director of health services]

For health policy officials the way forward was that what is being discussed is a form of task-shifting/ task-sharing and which should be encouraged and should help devolve Ghana's highly institutionalised and centralised mental health system into a more community based and integrated one. They expressed their readiness and support for such an integrated mental health service system, especially ensuring apprehensions of traditional healers and CPNs and other community health workers in the hospitals and clinics are allayed, as it will respond to the needs of most mental patients.

> *This is the form of task shifting/task sharing which should be promoted to realise the decentralisation of the mental health system into a community based one accessible to all that need it* [KI, Senior mental health professional at the national level].

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The traditional healers also requested that they should be formally registered and recognised to forestall resistance and questioning of their practices, as that will also limit or eliminate people who are not traditional healers but carry themselves about as such. By so doing imposters and quacks will be reduced to the barest minimum if not eliminated.

> *We should be registered and formally recognised. Once we are known by the authorities it will help people to know who and where to go to. This will reduce people going about calling themselves healers or having spiritual powers to make miracles* [FGD, Traditional Healers]

Civil society organisations were also mentioned to be bodies that can through resource support and advocacy could help to bring about integration by partnering with government to start-up pilot whose lessons can be used to scale-up wider integration of traditional healer in community manetal health care. Organisations such as BasicNeeds-Ghana came up for mention in this regard. Similarly, advocacy efforts of mental health service users and care-giver groups such as the Mental Health Society of Ghana and other disability persons' organisations and human rights organisation could step-up advocacy for mobilisation and effective use of traditional medicine services that uphold human and rights of persons with mental illness or epilepsy.

> *Patients who are well should be given support to improve their wellbeing as BasicNeeds* [an NGO working in mental health] *does. Their ability to work helps them recover better. When some of them get well they try to help us in our homes and farms for a few days before they return to their homes. It is purely voluntary* [FGD, Traditional healers]

4.6 Limitations on data collection processes

The majority of the research participants were drawn from operational areas that BasicNeeds-Ghana works. The researcher is the Executive Director of BasicNeeds-Ghana. This position of the researcher could have affected responses the study participants gave as they could have associated the study to being part of the operations of BasicNeeds-Ghana. To reduce such orientation by the study respondents, it was explained to the participants that this was an academic study being conducted by the researcher and that it is not related to the work being conducted by

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BasicNeeds-Ghana. Also, perspectives of many more respondents could be obtained from a wider coverage area but logistical and time constraints did not make this possible.

The geographical expanse of the study area and its sparse settlements posed a challenges as the the researcher and data collection assistants had to traverse various communities of each of the three regions to hold key informant interviews and the focus group discussions at quite a cost in time and financial terms. Despite this use of existing contacts and recruitment of data collection assistants from within the communities helped greatly in addressing any adverse effect the travels and financial requirements brought about.

Visits to a number of the respondents had to be made a number of times. This situation, in addition to the large number of respondents that were covered, delayed the data collection exercise, transcription, coding and analyses. A good level of knowledge of the area, and the subject matter helped in reducing significant challenges associated with the data collection exercise.

4.7 Conclusion

This chapter presented findings and discussed of the perspectives of key stakeholders in mental health in Ghana on mental health care provided by traditional healers and the possibility of integration of traditional medicines into formal community mental health services. In doing this a range of areas were discussed which covered understanding practices of traditional healers, including respondents' definition of who traditional healers are and their practices and services, the place of traditional healing in the treatment of mental illness, including fees and charges of traditional healers. The study further gathered and presented information and discussed the description of key stakeholders of what integration of traditional healers and their services means, how integration could be realised as well as exploration of the opportunities that could facilitate such integration and the challenges that could potentially inhibit achievement of services of traditional healers into formal community mental health care.

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CHAPTER FIVE

RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

This study sought to gauge perspectives of different stakeholder perspectives about mental health care services provided by traditional healers and possibility of formalising services of traditional healers into the formal mental health care in Ghana. Findings of the study indicate that services of traditional healers and traditional health services had a place in mental health care in Ghana. On the possibility of integration of traditional healer services into formal care

The recommendations outlined here cover legal considerations for recognition and formal utilisation of services of traditional healers, mobilisation and organisation of the traditional healers, and their training and licensure of healers and their practices. There is also some commentary on how such integration might work within the formal health system of Ghana.

Various studies have established the need for greater involvement or collaboration of traditional healing services into formal health care services sometimes with suggestions/ recommendations to bring about integration of traditional healing services into formal community mental health care services (Atindanbilla & Thompson, 2011; Gyasi, 2011; Ae-Ngibise et al, 2010; Barimah & van Teijlingen, 2008). Implementing such integration seems to be elusive in Ghana for which reason, this study sought to explore, identify and further understand, from the perspectives of key stakeholders, the ways by which traditional healing services could effectively be part of the mental health care delivery service in northern Ghana and more widely formalised for more effective utilisation and delivery. It was a qualitative study that used thematic analysis of Braun & Clarke (2006). Field data of the study was collected through key informant interviews and focus group discussions from a purposive sample of 160 participants. The respondents were made up of traditional healers, persons living with mental illness or epilepsy and their primary carers, community mental health nurses and general nurses, psychiatrist as well as health directors and

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policy officials and a legislator of the health committee of Ghana's Parliament. Analysis of the data used them

A summary of the findings from the study is that traditional healers and their practices are popular in the communities and their services highly patronised for the treatment of mental illnesses and epilepsy among other conditions. Similarly, formal community [mental] health workers recognised the existence and services of traditional healers. The findings also established that services of traditional healers, even if with imperfections, fill an important gap in addressing the mental health treatment needs of the population in northern Ghana. In addition, there are important psychological approaches and support avenues of traditional healers that endear to people who use the services of traditional healers which formal community mental health care workers could pay attention to and adopt and adapt such as being empathetic and sympathetic to cultural and religious explanations people with mental illness and their carers provide, have friendlier settings and dispositions towards their clients seeking mental health treatment. Traditional healers have been found to be good at empathising and appreciating the cultural and religious dimensions and explanations of patients that formal community health workers can adopt. Also making settings of health care service facilities more familiar to the surroundings of clients and friendlier disposition by the health care providers, can help improve rapport and treatment of the illnesses of people with mental illness or epilepsy (Mokgobi, 2012). Mokgobi (2012) citing Hilgenkamp & Pescaia, 2003 asserts that the warm and friendly atmosphere created by traditional healers as opposed to the not too friendly settings of the formal health care settings makes traditional healers more preferred.

A number of opportunities were identified to bring about integration of traditional healing into formal community mental health care. These opportunities included the presence of the new Mental Health Law of Ghana that is emphasising community-based care approaches as opposed to Ghana's current mental health system, which is quite institutionalised and centralised. Also the growing in-country and global calls for increased investments and finding in public mental health

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care provided opportunity and impetus to build on the integration of traditional healers and their services into formal community mental health care services.

Key challenges to realising integration of traditional healers and their services into formal community-based mental health care that were identified were attitudinal and funding difficulties, illiteracy and low numeracy levels of most of the traditional healers, human resource and infrastructure in adequacies, and other logistical limitations.

5.2 Recommendations

In the discussions from this study on integration of traditional healers and their services into formal care there is need to understand that it is not an attempt to make traditional healing practices more scientific. Rather, this study has established that it is necessary to ensure that traditional healing practices, so popularly patronised in most parts of northern Ghana, are supported by the existing health system and made legally available as an option of care in the country's mental health care system. It can be concluded that Ghana may be said to have a dual or pluralistic health care system where traditional healing services and modern medicine are used (Barimah, 2013; Roberts, Asare, Mogan, Adjase, & Osei, 2013). In spite of this, the formal/ modern medical services tend to be resourced and promoted more than traditional healing (Darko, 2009; Tabi, Powell & Hondnicki 2006). Traditional healing services need to enjoy similar recognition, funding and resource support to make it a viable alternative and complementary service to formal mental health care services at the community level.

A more legally recognised and properly supervised and regulated traditional healing practice will definitely improve quality of mental health services, help in the scale-up of services that address mental health treatment needs of the populations of northern Ghana.

The recommendation to bring about integration of traditional healers and their services to formal community mental health care in northern Ghana is in itself advocacy to ensure government

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lives up to its pronouncements to improving community mental health in the country, which to a large extent remains mere intentions of successive governments without practical action.

There is need for some further clarification and reformulation of government and public policy to move beyond just regulation and orienting traditional healers on how to work scientifically to an approach that will maximise strengths of existing practises and services of traditional healers to achieve the comprehensive and holistic community mental health services badly needed in Ghana.

Surely this will require some mobilisation, training and re-orientation of traditional healers and formal community mental health workers and not necessarily for traditional healers to adopt improved scientific technologies to apply in their practices. Traditional healers need to be harnessed for a more holistic mental health care delivery system in northern Ghana and the whole country at large. A training package with modules to reorient both traditional healers and formal community mental health care workers should be developed and a national programme launched to bring about an integrated community mental health service that is very much inclusive of traditional healing.

Closely related to mobilisation, training and re-orientation is continuous public awareness raising and sensitisation of the cross-section of society to support as well as monitor practices of the integrated and diversified community mental health care services.

Threat to the livelihoods of traditional healers if they make their practices widely known or demystified has the possibility of making them loose their livelihoods opportunities. Measures to appropriately compensate or remunerate traditional healers treating mental illness will help them feel comfortable to collaborate and share practices

Similarly attitudes and entrenched positions have to give way to more forward and inclusive approach to developing and working with an integrated approach to community mental health care that responds to the needs and aspirations of the population.

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These issues have implications on public policy and mental health financing as policy pronouncements backed by sustained funding is what will translate the good intentions and pronouncement into real and practical actions and systems

The appeal of traditional healing services for mental disorders is most likely to be with us in a long time to come even as scientific and technological improvements in the mental health grow. It is for this reason that all efforts need to be made to maximise both practices for the good of those in need of mental health services.

From the finding and discussions, integration of healers might only work in ways that there is legislation and policy backing and active resources support of the services of traditional healers that allows for free utilisation of both services and referral of service users between the two forms of mental health care. Integration of services of traditional healers does not amount to their locating in public health facilities such as hospitals and clinics, with offices or working spaces to operate from. Traditional healers would continue to be in their places of operation.

It is recommended that a referral process be in place and traditional healers so identified to be treating mental illnesses of epilepsy located within proximity of community mental health service facility are engaged through meetings and encouraged to refer people that come to them with mental health care needs to the mental health units for treatment. Guidelines detailing when to refer and minimum standards can be established through collective agreement and regularly reviewed to ensure compliance. Minimum standards of practice need to be spelt out that are monitored so that practices of both forms do not fall below minimum expectation. Through regular contacts, the rules of engagements can be established to foster the relationships and in the collective interest of the patient.

It is important to ensure that persons who need Western medicine get them without denial or delay. There is understanding that serious somatic diagnosis can be missed if cases of mental illness are seen by traditional healers only. They can be assured to have the patients to administer

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their prayers. This will be some form of sharing of patients but not in the formal senses of it. There should be a process of regular engagements between traditional healers and formal mental health practitioners as part of moves of diffusing the mutual suspicion between and among the two categories of health care practitioners. The provision of visiting committee and tribunals outlined in the Mental Health Act, 2012 (846) form a good basis for maintaining quality and prompt attention to person with mental health care needs from both forms of practices.

5.2 Conclusion

The study looked at key stakeholder perspectives on integration of traditional healers and their practices into community mental health care by investigating their understanding traditional healers and their practices, their opinions of traditional healing and what integration of traditional healing into formal community mental health care, as well as the opportunities that can be maximised to bring such integrated service about and the challenges to contend with.

Stakeholders perspectives seem to establishment that traditional healing will remain with Ghanaian society for some long time to come. The inadequacies in formal mental health care system to provide increased access and reduce the mental health treatment gap makes traditional healing an option to consider. For it reason, it will be a good idea to maximise the widespread presence of traditional healers and their practices to enhance community mental health care. Opportunities such as the favourable legislation, vibrant civil society and global attention to maximising complementary and alternative health care practices and service to enhance mental health could help Ghana realise such integrated mental health care system. However it is clear that more political and administrative commitment and funding inadequacies could hamper achievement of an integrated community mental health care service that is inclusive of traditional healers and their practices.

Despite the good that could be realised from an integrated service, there is need for one to be realistic that it could take more time and effort for it to become reality.

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APPENDICES

APPENDIX I: MAP OF GHANA SHOWING NORTHERN GHANA AREA

Key:

Northern Ghana (Northern region, Upper East Region and Upper West Region)

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APPENDIX II: KEY INFORMANT INTERVIEW GUIDE

Project Title: 'Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana'.

Interview guide for key informant interviews with traditional healers.

Introduction:

Interviewer introduces himself and the study and guides the interviewee through the informed consent form.

Interviewee introduces him/herself and their role in mental healthcare service provision in Ghana. What do you call yourself – is this your full-time work or do you have some other primary work

Part 2: Mental illnesses or epilepsy commonly seen in the communities

2.1 What kinds of mental problems do people come to you with?

2.2 Which of these problems would you describe as being similar and why?

2.2.1 Probe for: similarities in causes and symptoms; classification categories.

2.3 Describe the circumstances under which you would decline to treat someone who comes to you for treatment.

2.4 Where would you refer such persons for treatment?

2.5 How do people get to know about you and the services that you provide?

2.5.1 Probe for: referral; treatment for other conditions or problems and similar conditions or problems.

2.6 Tell me what mental health facilities are available around the community to ensure that people with mental health problems receive appropriate treatment and how adequate are there in meeting the needs of the people that require them?

Part 3: Integration of traditional healers into formal health care services

3.1 What is your view of formal/modern ***mental health care services in Ghana?***

3.2 ***In your opinion what does integration*** of traditional healers of mental illness or epilepsy into formal health care services mean for you as a person who treats mental illness in the community?

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3.3 What role do you think that traditional healers can play in providing treatment for mental illness in the community?

3.4 How do you think that traditional healers can be integrated into formal healthcare service at the community level?

3.5 What steps should be taken for this to happen?

3.6 What do you think are the challenges to integrating traditional healers into formal mental healthcare services at community level?

3.7 What opportunities for mental healthcare treatment would the integration of traditional healers into the mental healthcare services offer?

3.8 Is there anything else around our discussions you would like to add?

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APPENDIX III: FOCUS GROUP DISCUSSION GUIDE

Project Title: 'Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana'.

Interview guide for key informant interviews with Community Psychiatry Nurses and Health Policy Officials

Introduction:

Interviewer introduces himself and the study and guides the interviewee through the informed consent form.

Interviewer indicates that the interview will be audio taped and confidentiality of information they provide is assured.

Interviewee introduces him/herself and their role in mental healthcare service provision in Ghana. Please, give a brief introduction about your-self, including your qualification/experience in mental health and/or health service policy development. Describe what you do and what your role is in mental healthcare service provision. Is this your full-time work or do you have some other primary work

Part 1: Defining the practice

1.1 Tell me what you know about traditional healers treating mental illness or epilepsy? What kinds are they and who goes to them?

1.2 Tell me about any patients you have shared with a traditional healer for mental health care treatment services and others traditional healers have referred to you.

Part 2: Mental illnesses or epilepsy common in the communities

2.1 List the mental illnesses/problems people present at your community mental health facilities?

2.2 Which of these mental problems/illnesses you have listed are similar – how do you classify them? Which have similar causes?

2.2.1 At this point if the traditional system has not come up you could start to ask some of the following questions in this section

2.3 Where do people go for treatment of their mental illness or epilepsy in your community?

2.4 Tell me what mental health facilities are available around the community or elsewhere in the country to ensure that people with mental health problems receive appropriate treatment and how adequate are they in meeting the needs of the people that require them?

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2.5 Do people with mental illness or epilepsy use traditional healers and why do they use the services of these healers?

Part 3: Integration of traditional healers into formal health care services

3.1 Give me your views on the adequacy of formal/modern community mental health treatment services and those provided by traditional healers?

3.2 What role do you think that traditional healers can play in providing treatment for mental illnesses in the community?

3.3 In your opinion what does integration of traditional healers of mental illness or epilepsy into formal mental health treatment care services mean for you as a mental health service provider at the community level?

3.4 How do you think that traditional healers can be integrated into formal healthcare service the community level? What steps should be taken for this to happen?

3.5 What do you think are the challenges to integrating traditional healers into formal mental healthcare services at community level?

3.6 What opportunities for mental healthcare treatment would the integration of traditional healers into the mental healthcare services offer?

3.7 Is there anything else around our discussions you would like to add?

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APPENDIX IV: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TRADITIONAL HEALERS

TITLE OF THE RESEARCH PROJECT:

Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana

REFERENCE NUMBER: S12/06/169

PRINCIPAL INVESTIGATOR: Mr Peter Badimak Yaro

ADDRESS: Department of Psychology, Alan J. Flisher Centre for Public Mental Health, University of Stellenbosch, Private Bag X1, Matieland, 7602, South Africa

CONTACT NUMBER: +233(0)24 457 27 33

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and the Ghana Health Service Ethical Review Committee in Ghana and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

You are being invited to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

This study aims to assess key stakeholder perspectives on the integration of traditional healers into

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formal mental health care services.
The study aims to:

- gather the opinions, and perspectives of key stakeholders on integration of traditional healers into formal mental health care; and
- identify the barriers and facilitators to integration of traditional healers into formal mental health care services at the community level

The study will be conducted in northern Ghana, which covers the three northern regions, namely Northern Region, Upper East Region and Upper West Region. A number of key policy authorities at the national level will also be interviewed as part of the study. A total of 25 interviews and 8 FGDs will be conducted.
You will participate in an interview where you will be asked a number of questions, with follow-up questions to clarify your responses. Your expected time commitment for this study is one hour.

Why have you been invited to participate?

This study is collecting in-depth views, opinions, and perspectives on the integration of traditional healers of common mental illnesses or epilepsy into formal mental health care services at the community level from the perspectives of key stakeholders in Ghana.

You have been identified as a key stakeholder involved in mental healthcare service provision as service provider or user in northern Ghana.

What will your responsibilities be?

You are expected to spend an hour of your time responding to a series of questions that you will be asked by an interviewer. You are to answer them as clearly as possible providing as much information as you can. You may be asked follow-up questions to clarify any issues that are not clear to the interviewer.

Will you benefit from taking part in this research?

There will be no direct benefit to you for your participation in this study. However, the information obtained from this study will contribute to improving access to the provision of comprehensive mental health care services for people with mental illnesses and epilepsy in Northern Ghana.

Are there in risks involved in your taking part in this research?

The risks associated with study participation are minimal. These risks are similar to those you experience when disclosing work-related information to others.. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

If you do not agree to take part, what alternatives do you have?

If you do not agree to take part in this study, you are free to say so and you will not be asked any further questions, even if you would have started with the interview.

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Who will have access to your medical records?

This study will not involve use of your medical records. Your responses from the interview will be kept confidential and protected. Your information is going to be used in a thesis and for the purposes of this research project your responses and comments will remain confidential. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all researcher notes and documents.
- Notes, interview transcriptions, and transcribed notes and any other identifying participant information will be kept in a locked file cabinet in the personal possession of the researcher. When no longer necessary for research, all materials will be destroyed,

The researcher will review the collected data. Information from this research will be used solely for the purpose of this study and any publications that may result from this study. All other participants involved in this study will not be identified and their anonymity will be maintained.

Each participant has the right to obtain a transcribed copy of their interview. Participants should tell the researcher if a copy of the interview is desired.

Will you be paid to take part in this study and are there any costs involved?

You will not be paid to take part in the study. However, any costs related to travel and transport, and meals to enable you take part in the study will be covered for each visit you have to make. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact Yaro, Badimak Peter at telephone numbers +233(0)24 457 27 33 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee of the Faculty of Health Sciences at Stellenbosch University at +27 (0)21-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You may also contact the Ghana health Service Ethical Review Committee's Administrator on +233 (0)20 2920651 to seek further clarification when necessary
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.

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- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..……. on (*date*) ……...…….. 2012.

..... **.....**

Signature/Thumbprint of participant Signature of witness

Declaration by investigator

I Yaro, Badimak Peter declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....…..……. on (*date*) ……...…….. 2012.

....

Signature of investigator Signature/Thumbprint of witness

Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator Yaro, Badimak Peter to explain the information in this document to (*name of participant*) ……..…….. using the language medium of a Ghanaian Language.

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- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) .....…..……. on (*date*) ……...……..

....

Signature of interpreter Signature of witness

Stellenbosch University https://scholar.sun.ac.za

APPENDIX V: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

COMMUNITY PSYCHIATRIC NURSES AND OTHER COMMUNITY HEALTH WORKERS

TITLE OF THE RESEARCH PROJECT:

Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana

REFERENCE NUMBER: S12/06/169

PRINCIPAL INVESTIGATOR: Mr Peter Badimak Yaro

ADDRESS: Department of Psychology, Alan J. Flisher Centre for Public Mental Health, University of Stellenbosch, Private Bag X1, Matieland, 7602, South Africa

CONTACT NUMBER: +233(0)24 457 27 33

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and the Ghana Health Service Ethical Review Committee in Ghana and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

You are being invited to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear of if you need more information.

This study aims to assess key stakeholder perspectives on the integration of traditional healers into formal mental health care services.

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The study aims to:

- gather the opinions, and perspectives of key stakeholders on integration of traditional healers into formal mental health care; and
- identify the barriers and facilitators to integration of traditional healers into formal mental health care services at the community level

The study will be conducted in northern Ghana, which covers the three northern regions, namely Northern Region, Upper East Region and Upper West Region. A number of key policy authorities at the national level will also be interviewed as part of the study. A total of 25 interviews and 8 FGDs will be conducted.

You will participate in an interview where you will be asked a number of questions, with follow-up questions to clarify your responses. Your expected time commitment for this study is one hour.

Why have you been invited to participate?

This study is collecting in-depth views, opinions, and perspectives on the integration of traditional healers of common mental illnesses or epilepsy into formal mental health care services at the community level from the perspectives of key stakeholders in Ghana.

You have been identified as a key stakeholder involved in mental healthcare service provision as service provider or user in northern Ghana.

What will your responsibilities be?

You are expected to spend an hour of your time responding to a series of questions that you will be asked by an interviewer. You are to answer them as clearly as possible providing as much information as you can. You may be asked follow-up questions to clarify any issues that are not clear to the interviewer.

Will you benefit from taking part in this research?

There will be no direct benefit to you for your participation in this study. However, the information obtained from this study will contribute to improving access to the provision of comprehensive mental health care services for people with mental illnesses and epilepsy in Northern Ghana.

Are there in risks involved in your taking part in this research?

The risks associated with study participation are minimal. These risks are similar to those you experience when disclosing work-related information to others.. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

If you do not agree to take part, what alternatives do you have?

If you do not agree to take part in this study, you are free to say so and you will not be asked any further questions, even if you would have started with the interview.

Who will have access to your medical records?

Stellenbosch University https://scholar.sun.ac.za

This study will not involve use of your medical records. Your responses from the interview will be kept confidential and protected. Your information is going to be used in a thesis and for the purposes of this research project your responses and comments will remain confidential. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all researcher notes and documents.
- Notes, interview transcriptions, and transcribed notes and any other identifying participant information will be kept in a locked file cabinet in the personal possession of the researcher. When no longer necessary for research, all materials will be destroyed,

The researcher will review the collected data. Information from this research will be used solely for the purpose of this study and any publications that may result from this study. All other participants involved in this study will not be identified and their anonymity will be maintained.

Each participant has the right to obtain a transcribed copy of their interview. Participants should tell the researcher if a copy of the interview is desired.

Will you be paid to take part in this study and are there any costs involved?

You will not be paid to take part in the study. However, any costs related to travel and transport, and meals to enable you take part in the study will be covered for each visit you have to make. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact Yaro, Badimak Peter at telephone numbers +233(0)24 457 27 33 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee of the Faculty of Health Sciences at Stellenbosch University at +27 (0)21-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You may also contact the Ghana health Service Ethical Review Committee's Administrator on +233 (0)20 2920651 to seek further clarification when necessary
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.

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- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2012.

....

Signature/Thumbprint of participant Signature of witness

Declaration by investigator

I Yaro, Badimak Peter declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2012.

....

Signature of investigator Signature/Thumbprint of witness

Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator Yaro, Badimak Peter to explain the information in this document to (*name of participant*) ……..…….. using the language medium of a Ghanaian Language.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

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Signed at (*place*) .....…..…….. on (*date*) ……...……..

....

Signature of interpreter **Signature of witness**

Stellenbosch University https://scholar.sun.ac.za

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

HEALTH POLICY AUTHORITIES AND ADMINISTRATORS

TITLE OF THE RESEARCH PROJECT:

Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana

REFERENCE NUMBER: S12/06/169

PRINCIPAL INVESTIGATOR: Mr Peter Badimak Yaro

ADDRESS: Department of Psychology, Alan J. Flisher Centre for Public Mental Health, University of Stellenbosch, Private Bag X1, Matieland, 7602, South Africa

CONTACT NUMBER: +233(0)24 457 27 33

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and the Ghana Health Service Ethical Review Committee in Ghana and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

You are being invited to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear of if you need more information.

This study aims to assess key stakeholder perspectives on the integration of traditional healers into formal mental health care services.
The study aims to:

- gather the opinions, and perspectives of key stakeholders on integration of traditional healers into formal mental health care; and

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- identify the barriers and facilitators to integration of traditional healers into formal mental health care services at the community level

The study will be conducted in northern Ghana, which covers the three northern regions, namely Northern Region, Upper East Region and Upper West Region. A number of key policy authorities at the national level will also be interviewed as part of the study. A total of 25 interviews and 8 FGDs will be conducted.
You will participate in an interview where you will be asked a number of questions, with follow-up questions to clarify your responses. Your expected time commitment for this study is one hour.

Why have you been invited to participate?

This study is collecting in-depth views, opinions, and perspectives on the integration of traditional healers of common mental illnesses or epilepsy into formal mental health care services at the community level from the perspectives of key stakeholders in Ghana.

You have been identified as a key stakeholder involved in mental healthcare service provision as service provider or user in northern Ghana.

What will your responsibilities be?

You are expected to spend an hour of your time responding to a series of questions that you will be asked by an interviewer. You are to answer them as clearly as possible providing as much information as you can. You may be asked follow-up questions to clarify any issues that are not clear to the interviewer.

Will you benefit from taking part in this research?

There will be no direct benefit to you for your participation in this study. However, the information obtained from this study will contribute to improving access to the provision of comprehensive mental health care services for people with mental illnesses and epilepsy in Northern Ghana.

Are there in risks involved in your taking part in this research?

The risks associated with study participation are minimal. These risks are similar to those you experience when disclosing work-related information to others. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

If you do not agree to take part, what alternatives do you have?

If you do not agree to take part in this study, you are free to say so and you will not be asked any further questions, even if you would have started with the interview.

Who will have access to your medical records?

Stellenbosch University https://scholar.sun.ac.za

This study will not involve use of your medical records. Your responses from the interview will be kept confidential and protected. Your information is going to be used in a thesis and for the purposes of this research project your responses and comments will remain confidential. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all researcher notes and documents.
- Notes, interview transcriptions, and transcribed notes and any other identifying participant information will be kept in a locked file cabinet in the personal possession of the researcher. When no longer necessary for research, all materials will be destroyed,

The researcher will review the collected data. Information from this research will be used solely for the purpose of this study and any publications that may result from this study. All other participants involved in this study will not be identified and their anonymity will be maintained.

Each participant has the right to obtain a transcribed copy of their interview. Participants should tell the researcher if a copy of the interview is desired.

Will you be paid to take part in this study and are there any costs involved?

You will not be paid to take part in the study. However, any costs related to travel and transport, and meals to enable you take part in the study will be covered for each visit you have to make. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact Yaro, Badimak Peter at telephone numbers +233(0)24 457 27 33 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee of the Faculty of Health Sciences at Stellenbosch University at +27 (0)21-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You may also contact the Ghana health Service Ethical Review Committee's Administrator on +233 (0)20 2920651 to seek further clarification when necessary
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.

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- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2012.

....

Signature/Thumbprint of participant Signature of witness

Declaration by investigator

I Yaro, Badimak Peter declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2012.

....

Signature of investigator Signature/Thumbprint of witness

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Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator, Yaro, Badimak, Peter to explain the information in this document to (*name of participant*) ……..……., using the language medium of a Ghanaian Language.

- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) .....….....…….. on (*date*) ……...……..

....

Signature of interpreter **Signature of witness**

Stellenbosch University https://scholar.sun.ac.za

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

FOCUS GROUP DISCUSSIONS

TITLE OF THE RESEARCH PROJECT:

Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana

REFERENCE NUMBER: S12/06/169

PRINCIPAL INVESTIGATOR: Mr Peter Badimak Yaro

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CONTACT NUMBER: +233(0)24 4 57 27 33

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Will you benefit from taking part in this research?

There will be no direct benefit to you for your participation in this study. However, the information obtained from this study will contribute to improving access to the provision of comprehensive mental health care services for people with mental illnesses and epilepsy in Northern Ghana.

Are there in risks involved in your taking part in this research?

The risks associated with study participation are minimal. These risks are similar to those you experience when disclosing work-related information to others. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

If you do not agree to take part, what alternatives do you have?

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Stellenbosch University https://scholar.sun.ac.za

Who will have access to your medical records?

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- Notes, interview transcriptions, and transcribed notes and any other identifying participant information will be kept in a locked file cabinet in the personal possession of the researcher. When no longer necessary for research, all materials will be destroyed,

The researcher will review the collected data. Information from this research will be used solely for the purpose of this study and any publications that may result from this study. All other participants involved in this study will not be identified and their anonymity will be maintained.

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Is there anything else that you should know or do?

- You can contact Yaro, Badimak Peter at telephone numbers +233(0)24 457 27 33 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee of the Faculty of Health Sciences at Stellenbosch University at +27 (0)21-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You may also contact the Ghana health Service Ethical Review Committee's Administrator on +233 (0)20 2920651 to seek further clarification when necessary
- You will receive a copy of this information and consent form for your own records.

Declaration by participants

By signing below, we agree to take part in a research study entitled Scaling up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana.

Stellenbosch University https://scholar.sun.ac.za

We declare that:

- We have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- We have had a chance to ask questions and all my questions have been adequately answered.
- We understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- We may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- We may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..……. on (*date*) ……...…….. 2012.

Name	Signature/Thumbprint of each participant
1. ……..	- - - - - - - - - - - - - -
2. ……..	- - - - - - - - - - - - - -
3. ……..	- - - - - - - - - - - - - -
4. ……..	- - - - - - - - - - - - - -
5. ……..	- - - - - - - - - - - - - -
6. ……..	- - - - - - - - - - - - - -
7. ……..	- - - - - - - - - - - - - -
8. ……..	- - - - - - - - - - - - - -
9. ……..	- - - - - - - - - - - - - -
10. ……..	- - - - - - - - - - - - - -
11. ……..	- - - - - - - - - - - - - -
12. ……..	- - - - - - - - - - - - - -

.....

Signature of witness

Stellenbosch University https://scholar.sun.ac.za

Declaration by investigator

I Yaro, Badimak Peter declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....…..……. on (*date*) ……...…….. 2012.

....

Signature of investigator Signature/Thumbprint of witness

Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator Yaro, Badimak Peter to explain the information in this document to (*name of participant*) ……..……..

  using the language medium of a Ghanaian Language.

- We encouraged them to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participants fully understand the content of this informed consent document and have had all their question(s) satisfactorily answered.

Signed at (*place*) .....…..……. on (*date*) ……...……..

....

Signature of interpreter Signature of witness

Stellenbosch University https://scholar.sun.ac.za

APPENDIX VI: LETTERS REQUESTING INTERVIEWS

C/O BasicNeeds-Ghana
P. O. Box TL1140
Tamale NR

Wednesday, August 08, 2012

Regional Director
Regional Health Directorate
Ghana Health Service
Northern Region
Tamale, NR

Dear Sir,

Re: Permission to carry out a research

I write to seek your consent to undertake a qualitative research entitled '*Scaling Up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana*'. This research forms part of an MPhil progamme in Public Mental Health I am pursuing at Stellenbosch University, South Africa, under the **AF**rica **F**ocus on **I**ntervention **R**esearch for **M**ental Health (AFFIRM).

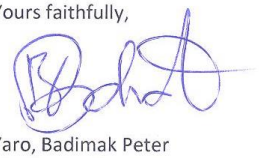
The research question of this study is: What are the perspectives and opinions of key stakeholders on integrating traditional healers into formal mental health care service provision in northern Ghana? In order to address this question, the study seeks to explore key stakeholders' perspectives, opinions and attitudes with regard to integrating traditional healers treating mental disorders in northern Ghana into formal community mental health care service delivery. Among the study subjects will be [mental] health care service providers, including community psychiatric nurses. The study will contribute to mobilising available local resources and practices in mental healthcare services to meet the mental healthcare treatment gap in Ghana.

Observations show a high level of use of services of traditional healers in northern Ghana, and the whole of Ghana for that matter, where traditional healers remain a first point of contact for people seeking treatment for mental health conditions. This is informed by the researcher's observations as he lives and work in Ghana. It also shows that traditional healers are increasingly willing to partner with Western medical health practitioners to provide comprehensive care. Existing policies and attitudes of Western trained medical practitioners who mainly run the mental health services of the country seem not to have a clear consensus and/or model as to how traditional healers can be effectively integrated in mental health services at the community level.

Ethical approval has been provided by the Health Research Ethics Committee of the Faculty of Health Sciences of Stellenbosch University in South Africa. I am attaching the letter granting ethical approval to this correspondence. .

I will be grateful for your written approval to interview health personnel willing to participate in the interviews and data collection to enable me proceed with my research.

Yours faithfully,



Yaro, Badimak Peter
(Researcher)

Stellenbosch University https://scholar.sun.ac.za

C/O BasicNeeds-Ghana
P. O. Box TL1140
Tamale NR

Wednesday, August 08, 2012

President
Mental Health Traditional Healers Association
Tamale NR

Dear Sir,

Re: Permission to carry out a research

I write to seek your consent to undertake a qualitative research entitled '*Scaling Up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana*'. This research forms part of an MPhil progamme in Public Mental Health I am pursuing at Stellenbosch University, South Africa, under the **AF**rica **F**ocus on **I**ntervention **R**esearch for **M**ental Health (AFFIRM).

The research question of this study is: What are the perspectives and opinions of key stakeholders on integrating traditional healers into formal mental health care service provision in northern Ghana? In order to address this question, the study seeks to explore key stakeholders' perspectives, opinions and attitudes with regard to integrating traditional healers treating mental disorders in northern Ghana into formal community mental health care service delivery. Among the study subjects will be traditional healers treating mental disorders, including members of your association. The study will contribute to mobilising available local resources and practices in mental healthcare services to meet the mental healthcare treatment gap in Ghana.

Observations show a high level of use of services of traditional healers in northern Ghana, and the whole of Ghana for that matter, where traditional healers remain a first point of contact for people seeking treatment for mental health conditions. This is informed by the researcher's observations as he lives and work in Ghana. It also shows that traditional healers are increasingly willing to partner with Western medical health practitioners to provide comprehensive care. Existing policies and attitudes of Western trained medical practitioners who mainly run the mental health services of the country seem not to have a clear consensus and/or model as to how traditional healers can be effectively integrated in mental health services at the community level.

Ethical approval has been provided by the Health Research Ethics Committee of the Faculty of Health Sciences of Stellenbosch University in South Africa. I am attaching the letter granting ethical approval to this correspondence. .

I will be grateful for your written approval to interview health personnel willing to participate in the interviews and data collection to enable me proceed with my research.

Yours faithfully,

Yaro, Badimak Peter
(Researcher)

Stellenbosch University https://scholar.sun.ac.za

C/O BasicNeeds-Ghana
P. O. Box TL1140
Tamale NR

Wednesday, August 08, 2012

Regional Director
Regional Health Directorate
Ghana Health Service
Upper East Region
Bolgatanga, UER

Dear Sir,

Re: Permission to carry out a research

I write to seek your consent to undertake a qualitative research entitled '*Scaling Up mental health services in Ghana: Key stakeholder perspectives on the integration of traditional healers into formal mental healthcare services in Northern Ghana*'. This research forms part of an MPhil progamme in Public Mental Health I am pursuing at Stellenbosch University, South Africa, under the **AF**rica **F**ocus on **I**ntervention **R**esearch for **M**ental Health (AFFIRM).

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Observations show a high level of use of services of traditional healers in northern Ghana, and the whole of Ghana for that matter, where traditional healers remain a first point of contact for people seeking treatment for mental health conditions. This is informed by the researcher's observations as he lives and work in Ghana. It also shows that traditional healers are increasingly willing to partner with Western medical health practitioners to provide comprehensive care. Existing policies and attitudes of Western trained medical practitioners who mainly run the mental health services of the country seem not to have a clear consensus and/or model as to how traditional healers can be effectively integrated in mental health services at the community level.

Ethical approval has been provided by the Health Research Ethics Committee of the Faculty of Health Sciences of Stellenbosch University in South Africa. I am attaching the letter granting ethical approval to this correspondence. .

I will be grateful for your written approval to interview health personnel willing to participate in the interviews and data collection to enable me proceed with my research.

Yours faithfully,

Yaro, Badimak Peter
(Researcher)

Stellenbosch University https://scholar.sun.ac.za

C/O BasicNeeds-Ghana
P. O. Box TL1140
Tamale NR

Wednesday, August 08, 2012

Regional Director
Regional Health Directorate
Ghana Health Service
Upper West Region
Wa UWR

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P. O. Box TL1140
Tamale NR

Wednesday, August 08, 2012

Chief Psychiatrist
Accra psychiatric Hospital
Accra

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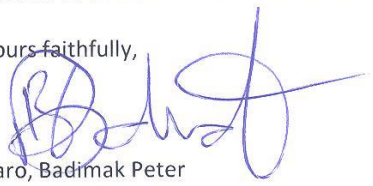

Yaro, Badimak Peter
(Researcher)

Stellenbosch University https://scholar.sun.ac.za

C/O BasicNeeds-Ghana
P. O. Box TL1140
Tamale NR

Wednesday, August 08, 2012

Director
Research Statistics and Information Management
Ministry of Health
Accra

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I will be grateful for your written approval to interview health personnel willing to participate in the interviews and data collection to enable me proceed with my research.

I count on your kind consideration and prompt response.

Yours faithfully,

Yaro, Badimak Peter
(Researcher)

Stellenbosch University https://scholar.sun.ac.za

APPENDIX VII: ETHICAL REVIEW APPROVAL LETTERS

Approval Notice
New Application

02-Aug-2012
Yaro, Badimak Peter
Stellenbosch, WC

Ethics Reference #: S12/06/169

Title: **Scaling up mental health services in Ghana:Key stakeholder perspective on the integration of traditional healers into formal mental healthcare services in Northern Ghana**

Dear Mr Badimak Yaro,

The **New Application** received on **27-Jun-2012**, was reviewed by members of **Health Research Ethics Committee 1** via Expedited review procedures on **01-Aug-2012** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **01-Aug-2012 -01-Aug-2013**

Please remember to use your **protocol number** (**S12/06/169**) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number projects may be selected randomly for an external audit.
Translation of the consent document in the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard REC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further help, please contact the REC office at 0219389657.

Included Documents:
Checklist
Consent Form
Budget
Investigators declaration
Protocol
Synopsis
Application Form

Sincerely,

Stellenbosch University https://scholar.sun.ac.za

Franklin Weber
REC Coordinator
Health Research Ethics Committee 1

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in yourREC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (15) years.

4.Continuing Review. The REC must review and approve all REC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate**any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to the REC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Health Ethics Committee Standard Operating Procedures www.sun025.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package All reportable events should be submitted to the REC using the SAE Report Form.

7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of fifteen years: the REC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Reports to MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you **must** provide a copy of that report to the REC. You may submit the report at the time of continuing REC review.

9.Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognized as research nor the data used in support of research.

10.Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

11.On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

Stellenbosch University https://scholar.sun.ac.za

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

My Ref. :GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: Hannah.Frimpong@ghsmail.org

October 17, 2012

YARO BADIMAK PETER, Principal Investigator
C/O Basic Needs-Ghana
P. O. Box TL. 1140
Tamale
Northern Region

ETHICAL CLEARANCE - ID NO: GHS-ERC: 10/09/2012

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"Scalling Up Mental Health Services in Ghana: Key Stakeholder Perspectives on the Integration of Traditional Healers Into Formal Mental Health Care Services in Northern Ghana"

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification of the project must be submitted to the ERC for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your mother organization before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol

SIGNED.....

PROFESSOR FRED BINKA
(GHS-ERC CHAIRMAN)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Stellenbosch University https://scholar.sun.ac.za

BasicNeeds Ghana
P. O. Box TL 1140
Tamale, Ghana
Tel: +233 (0)3720-23566 (0)3020 - 781217
Tel/Fax: +233 (0)3720-24245, (0)3020-777003
Mobile: +233 (0)24-4572733
Email: info.ghana@basicneeds.org, info@basicneedsghana.org
Website: www.basicneedsghana.org, www.basicneeds.org/ghana

BasicNeeds
BasicRights
Mental Health is a right, not a privilege

BasicNeeds-Ghana

Wednesday, August, 29, 2012

The Chairman
GHS-Ethical Review Committee
P. O. Box MB 190
Accra GHANA

Institutional Support Letter

We confirm that Mr. Badimak Peter Yaro is registered for the Masters in Public Mental Health (course code: 12194 889) at Stellenbosch University (student number: 17459494).

He is undertaking a research project entitled **Scaling Up Mental Health Services in Ghana: Key Stakeholder Perspectives on the Integration of Traditional Healers into Formal Mental Healthcare Services In Northern Ghana,** under the supervision of Ms. Anthea Lesch in the Department of Psychology at Stellenbosch University. He is co-supervised by Dr Lawrence Wissow of the Johns Hopkins Bloomberg School of Public Health, Baltimore, USA.

Peter has our support in the course and the research project he is undertaking.

Please contact us should you require further information.

Yours faithfully,

Matthew Pipio
(Finance and Administration Coordinator)

Stellenbosch University https://scholar.sun.ac.za