SCIREA Journal of Sociology

http://www.scirea.org/journal/Sociology

October 7, 2023

Volume 7, Issue 5, October 2023

https://doi.org/10.54647/sociology841063

The Socio-Economic Challenges of the Covid-19 Pandemic: Qualitative Contributions from the Mentally Ill Population in the Greater Accra and Eastern Regions

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ABSTRACT

New and unforeseen socioeconomic challenges related to the COVID-19 crisis have disrupted the mentally ill population of Ghana's livelihood support and general access to psychiatric treatments. This research looks critically at the pandemic's impact on the mentally ill population to determine whether the crisis has changed the mentally ill population's social support networks, financial opportunities as well as essential access to care. The discussion is based on a qualitative study that is designed to explore the direct and indirect socioeconomic challenges and healthcare limitations related to the COVID-19 epidemic among Ghana's mentally ill population in the Greater Accra and Eastern regions. The study examines four reoccurring themes including medication, familial obligations, community support, unemployment, and relapses among the mentally ill population regions using both phsychiatric and divine healing options in the Greater Accra and Easter regions. First, it considers the role that belief systems and socioeconomic difficulties have played in influencing mental healthcare treatment preferences in the wake of the pandemic. Second, the

paper introduces the research methods, settings, and sample size of the qualitative study. Third, the study's findings are explored concerning the relationship between the Corona Virus and the lived experiences of mentally ill person's socioeconomic challenges. COVID-19 furthered challenges of preexisting stigma, job loss, and limited psychiatric services options. This qualitative study explores the underlying economic and cultural contexts defining mental healthcare treatment preferences during the pandemic to shed light on new challenges.

Introduction

Mentally ill persons in Ghana are regularly facing economic difficulties, healthcare limitations, social stigma, and discrimination (Mehta and Thornicroft 2013). These challenges are linked to long-term socioeconomic issues that increased during the 2019-2020 COVID-19 pandemic. The lack of socioeconomic protection that mentally ill persons experienced during the crisis spurred forth limited access to not only community support systems but healthcare options thereby cascading into larger areas (Aduhene, 2020). This qualitative study explored the underlying economic and cultural contexts defining mental healthcare treatment preferences during the pandemic to shed light on new challenges.

The Socioeconomic Challenges of the Covid-19 Crisis

Ghana's mentally ill population remains highly susceptible to the indirect and secondary socio-economic impact of the COVID-19 pandemic because of preexisting stigma, strained psychiatric service systems, and new household income declines (Babuna et al. 2020; Aduhene, 2021; WHO, 2022). From the loss of employment to community support issues among Ghana's mentally ill population, the coronavirus pandemic unleashed new and unforeseen economic challenges for persons suffering mental illness. Limited research is available on the general socioeconomic challenges and mental healthcare limitations of Ghana's mentally ill population. Notably, those suffering from mental illnesses are unable to care for themselves let alone their families. As a result, families have experienced undocumented difficulties of financial challenges and social suffering. There is a pressing need for further information on this matter in the wake of the pandemic, especially as foreign researchers and development project collaborators seek to improve Ghana's mental healthcare system.

Mental Health Act 846 (2012) establishes protocols for collaborative ventures between medical providers and faith-based healers to improve quality care for mentally ill persons (Walker et al. 2017). Thus, governmental authorities and researchers have undertaken a systemized effort to integrate prayer camps with public sector mental health services (Tracy 2020; Edwards 2014; Ae-Ngibise, et al. 2010; Walker et al. 2017; Ofori-Atta et al. 2017; Ofori-Atta et al. 2018). Collaborative efforts have been unsuccessful because of a lack of knowledge on the faith-healing practices of prayer camps. Moreover, western researchers generally lack the appropriate knowledge, and they rely on foreign lenses to interpret forms of healing, which prevents clear understandings and inhibits collaboration. This study responds to the above challenges by offering insight into the treatment preferences.

In many cases, those living with mental health conditions were driven into financial hardships during the COVID-19 period. Many were generally at risk for further disadvantages of limited mental healthcare and social support options. Namely, the travel bans, economic declines, closure of schools, ban on public gatherings, and general anxiety caused severe problems of an increase in mental healthcare systems (Quarshie et al., 2021). Additionally, adverse conditions linked to the pandemic led to relapses or enhanced symptoms of mental illness. According to the WHO (2022), individual's suffering from severe mental disorders without mental healthcare services "particularly are at risk" of death or long-term hospitalization.

This qualitative study examines the socioeconomic challenges that the mentally ill population faced during the COVID-19 pandemic to provide insight into said issues because it faced a lack of baseline data. This broader scope is particularly relevant to understanding options for furthering the future livelihood, financial systems, and social support structures of mentally ill persons.

Economic Challenges

Ghana is in the middle of an economic recession, along with low- and high-income countries across the world (The World Bank 2020). The tourist attraction sector of the country, for example, lost 171 million dollars alone in the first three months of the partial lockdowns (Aduhene, 2021). The pandemic devastatingly impacted the livelihood of many Ghanaian citizens. The mentally ill population especially faced limited access to jobs and community support as the economic downturn persisted (Aduhene, 2020).

The socio-economic challenges for the mentally ill population are severe, in general (Quarshie et al., 2021). The WHO (2003), for example, discussed the burdens that come with mental

illness in Ghana by emphasizing concerns related to livelihood: "the costs for individuals, families and societies [is]staggering." Those suffering from mentally ill conditions are highly susceptible to the primary and secondary effects of the pandemic because of preexisting stigma, household income declines, strained service systems, and limited psychiatric service options (Babuna et al. 2020). For a large majority of persons suffering from mental illness, these challenges have likely worsened during the pandemic. Furthermore, financial difficulties increased in lower-income communities during the crisis.

Many of those suffering from mental illness experienced severe socio-economic challenges due to the increase in loss of employment. Employment provides opportunities for improving the livelihood of mentally ill persons. Teachers lost their jobs, for example, following the closure of schools. Schools closed in May (2019) but reopened around the 15th of January 2021. Jobs also offer routine and structure to daily lives with opportunities to socialize as well as support the development of social networks. The pandemic presented restrictive measures of public gathering bans, economic declines, and closure of schools thereby enhancing anxiety as well as increasing socioeconomic instability for vulnerable groups across Ghana.

The Covid-19 restrictions furthered financial challenges due to many businesses closing or workers experiencing reduced salary limitations. A large majority of the population's daily work schedule was outlawed during these lockdown measures. An estimated 42,000 people lost their jobs in the first two months of the pandemic (Aduhene, 2021; Quarshie et al., 2021). The WHO (2022) cited mental healthcare challenges related to the pandemic restrictions as especially taxing for the 80% of Ghanaians working in the informal sectors (Tabi 2006; Ae-Ngibise, 2010; Boateng, 2022).

Familial Concerns

For a large majority of family members from vulnerable groups, including children with disabilities, school closures caused unforeseen challenges. Social isolation protocols have increased children's vulnerability to violence, illnesses, and abuse. According to a report about Covid-19: "[b]etween March and June 2020, the share of Ghanaian children exposed to physical punishments in their households reportedly rose from 18% to 26%" (UNICEF, 2021). Moreover, in low-income communities, school closures resulted in high drop-out rates (UNICEF, 2021). More than nine million students between pre-primary and secondary school levels returned home following the nationwide school closures.

School closures impacted the well-being of parents and their children, especially for those in vulnerable groups. According to a study conducted by UNICEF, for example, more than 1.6 million children from primary schools in poverty-stricken districts of Ghana lost access to school meals (2021). For parents in lower-income settings grappling with mental illness, the COVID-19 trials have led to a series of issues. Specifically, parents experienced financial and illness related difficulties thereby children did not return to school in order to contribute to the household by joining the workforce. Caregivers also experienced difficulties providing healthcare and support for family members suffering mental illness following reduction in salaries or job loss due to the pandemic.

Ghanaian Mental Healthcare Preferences

According to the WHO (2021), 98% of Ghana's mental healthcare population receives treatments from one or more faith-based sectors of evangelical or indigenous healing traditions. Roughly 80% of the mentally ill population use the services of prayer camp sanitariums (Ae-Ngibise, et al. 2010). Prayer camps have emerged as a widely used alternative to psychiatric hospitals. There is an urgent demand during Ghana's current period of mental healthcare reform to address widespread religious beliefs about treatments for mental illness while improving healthcare conditions at prayer camp sanitariums (Walker et al. 2017; Ofori-Atta et al. 2010; Ofori-Atta et al. 2014).

In the last decade, many prayer camps have engaged partnerships with local medical organizations to distribute psychiatric services in tandem with divine healing practices. The patients at the prayer camps sanitarium of Mount Horeb generally did not claim a formal diagnosis, and the prayer camp generally administered a treatment of Olanzapine through a medical program that is sponsored by Basic-Needs. In this program, a nurse dispenses a shot of Olanzapine to people suffering from mental illness. Olanzapine is meant to replace one's daily medication and the effects can last for up to two months. BasicNeeds-Ghana also regularly offered donations of medication during the lockdown.

In some cases, severally mentally ill people who seek the services of prayer camps are referred to hospitals, especially if the sufferer cannot break a fever or presents a life-threatening preexisting condition. One prayer camp is cited by Benyah (2022) as piloting a project in collaboration with a psychiatric hospital involving a regular transfer of patients to the hospital for further treatments. Furthermore, mental healthcare providers are known to refer mentally ill individuals to prayer camps in certain cases (Taylor 2016; Ofori-Atta, et al.

2014; Benyah 2022). Determining how prayer camps identify healing as well as dispense medical and divine healing treatments presents new insights for misunderstood areas to connect and interact with larger healthcare agendas.

Limited Mental Healthcare Access

Along with new and preexisting financial challenges in poverty-stricken areas, this vulnerable group faces extraordinary difficulties accessing treatments and care. Socioeconomic difficulties are enhanced for those already experiencing limited mental healthcare options as a mere 2.8% of Ghana's mentally ill population have access to biomedical treatments while the remaining 97.2 % have limited mental healthcare options (Ajzenman et al., 2020; WHO, 2021). Many cannot afford pharmaceutical medication. Due to financial limitations and geographical barriers, a large majority of Ghanaians are unable to access psychiatric hospitals.

To date, there are only three public psychiatric hospitals in Ghana. Two of the hospitals are in the capital city of Accra (Accra Psychiatric Hospital and Anakaful Hospital), and the other resides in Ghana's Central Region (Pantang hospital). The public health researcher, Lauren Taylor, emphasized Ghana's issues of inadequate mental healthcare resources by stating that out of the public psychiatric hospitals there "are 1,350 beds available to serve an estimated 650,000 people living with severe mental illness" (Taylor 2016). There is also an alarmingly short number of mental healthcare professionals in the country. Around 38 psychiatrists (or, 1 per 1.5 million of the population) are mainly based in private hospitals in Accra (Tetteh Dela et al., 2020; Harvard Global Health Institute, 2020). Due to Ghana's limited mental healthcare system a large majority of Ghanaians suffering from mental illnesses seek care from other healing sources, predominantly, prayer camp sanitariums.

Prayer Camps

Prayer camps are usually comprised of an assortment of facilities including worship centers as well as a sanitarium on-site wherein patients are administered faith-healing treatments (Arias et al. 2016). Prayer camps regularly diagnose disorders as a spiritual-based phenomenon caused by supernatural forces such as evil spirits or witches (Read 2012; Arias et al. 2016).

Sanitarium patients usually demonstrate symptoms that psychiatric physicians would diagnose as mental illness namely, clinical depression, bipolar, and schizophrenia (Taylor 2016; Ofori-Atta et al. 2018). In other cases, residents at prayer camp sanitariums are suffering from epilepsy or substance abuse (Ofori-Atta et al. 2018; Benyah, 2021). People with epilepsy or drug addictions do not fall under the umbrella of mental illness. Yet, patients admitted to the

Mount Horeb prayer camp sanitarium for substance abuse or epileptic seizures were assessed by the psychiatric nurse as presenting symptoms of mental illness and were treated in the same manner as individuals with mental illness. All three disorders are usually treated in the same manner at prayer camp sanitariums because many Ghanaians do not distinguish between mental illness, substance abuse, and epilepsy (Benyah, 2022). All three are categorized as spiritually caused illnesses. The sanitarium population at prayer camps are treated using faith-healing practices consisting of a combination of prayer, biblical teachings, and forced fasting (Ae-Ngibise et al. 2010; Arias et al. 2016).

Certain treatment methods of prayer camp sanitariums are regarded as inhumane by international and domestic human rights advocates, religious authorities, and researchers (Tracy, 2020; Human Rights Watch 2012; Barriga 2014; Benedict 2018; Carey 2015; Edwards 2014). Principal among the ethical concerns is the practice of chaining patients to an immovable object for the duration of their admission (Human Right Watch 2012). Despite human rights concerns about the poor conditions of patients at these sanitariums, prayer camps provide divine services that Ghanaians rely upon (Read 2012; Onyinah 2002; Taylor 2016; Ofori-Atta 2014).

The healing processes at prayer camps are vastly different from psychiatric hospitals. For example, many believe that medication is unnecessary at prayer camps because these centers present a complete cure thus removing the potential for a relapse altogether. General conceptions about relapses and medication depend on one's health-seeking behaviors and views about healing mental illnesses. A principal source of appeal for prayer camps stems from their ability to provide more accessible and less expensive services. The cost of medication is around 200-400 cedis a month for those regularly taking pills. The monthly cost of a psychiatric hospital is usually from 1,000 to 2,000 Ghanaian cedis.

Mental Healthcare Seeking Behaviors

Ghana is recognized as one of the most religious nations in the world (Gallup 2013). In Ghana's most recent census 71% of the population identified as Christian and 12% as indigenous traditional (Governmental Census 2010). Pentecostalism has become the largest religious institution in the nation (Nations Encyclopaedia 2020). This religiosity plays a prominent role in determining Ghanaians' choice to use the divine healing traditions of prayer camp sanitariums. Prayer camps are one of Ghana's more prominent mental healthcare

systems because they meet the spiritual and medical needs of many by engaging the religious and cultural needs of Ghanaian society.

Prayer camps allow congregants a bridge to access their indigenous beliefs while remaining within Christian boundaries. These centers provide leadership guidance as well as the spiritual environment and resources for Ghanaian Christians to remain within Charismatic-Pentecostal frameworks while still upholding their indigenous belief systems. A large majority of Ghanaians look to the spiritual world for understanding illnesses that are believed to have spiritual-based causes (Read 2012; Ofori-Atta 2014; Arias et al. 2016). The widely shared opinion that illnesses may be caused by spiritual forces, such as witches or ancestral curses, has ideological origins in indigenous traditions (Salifu 2018; Arias et al. 2016; Ofori-Atta 2014; Gaba 1969; Onyinah 2002). Moreover, divine healing treatments are generally regarded as essential for overcoming illnesses viewed as religiously based (Arias et al. 2016). Prayer camps have emerged as a widely used alternative to psychiatric hospitals primarily because their services align with widespread socio-religious beliefs about healing, cures, and healthcare (Taylor 2016; Ofori-Atta, et al. 2014; Benyah, 2022).

In Ghanaian contexts, chronic illnesses like epilepsy and mental illness are often understood as caused by spiritual ailments that cannot be explained or cured by modern medicine. Amid psychiatric treatments negative outcomes such as relapses and adverse side effects often lead patients to the religious belief that symptoms have spiritual causes (Read 2012). Furthermore, negative treatment outcomes are viewed as representative of modern medicine’s failure to provide cures (Read 2012; Ofori-Atta et al. 2014). In many cases, prayer camps are the preferred treatment option for mental illness because modern medicine is considered ineffective for treating spiritually based illnesses (Wyllie 1983; Read 2012; Kpobi 2018).

Stigma and Mental Illness in Ghana

Ghana’s mental healthcare population is generally treated as subhuman by their local communities and alas, even by family members (Read 2018). The Barke et al (2011) ethnographic study, for example, examined Ghanaian attitudes toward mental illness and found that patients often live in social isolation due to extreme stigma. Bark holds that the mentally ill are unable to contribute to society because many cannot secure schooling or jobs due to heightened degrees of stigma (Barke et al. 2011). Furthermore, mental illness can impact the social standing and financial capacity of families because disabilities are regularly viewed as an ailment capable of spreading within families, either throughout generations

(similar to genetic mutations) or within a household (more like a germ). This level of stigma not only engenders the mentally ill's isolated role as outsiders in Ghanaian society, but it sets the stage for unethical treatment practices. The journalist, Tracy McVeigh (2020) summarizes the severe repercussions of mental health stigma in Ghana: "[t]he stigma of mental illness is a poison that mutates those contaminated…from a whole and usual person into a tainted, discounted one."

Resource limitations are a major problem for prayer camps and psychiatric hospitals. Prayer camps continually have a shortage of funds for maintaining the sanitarium as well as attend to a persistently stagnant patient population (Taylor 2016, Read 2018). Relatives that use the services of prayer camps and psychiatric hospitals rarely return. Following the admittance of patients to prayer camps, some caregivers leave falsified contact information with the intention of not returning. Similar issues have long plagued Ghana's formal psychiatric sector requiring the head psychiatrist of one hospital to hire a school bus to return dischargeable patients to their homes (Gifford 2004). Even if the logistics of providing care could be managed, in many of these circumstances, families refuse to administer care at home because of the stigma associated with mental illness (Read 2018).

Prayer Camps and COVID-19

Overall, Ghanaians at prayer camps upheld Covid-19 protocols of wearing face masks and maintaining social distancing because of the view that the Corona Virus is not a spiritual illness. After the COVID-19 protocols were enforced in March 2020, many prayer camps did not enroll new patients during a seven-month period. 126 patients were enrolled at the prayer camp sanitarium of Mount Horeb in April 2022. The prayer camp canceled all church services for 6 months beginning in March 2020. In 2020, there were 95 patients at the prayer camp and 101 in 2021. The caretakers reported that the patients experienced severe financial setbacks during this period as many of the relatives of patients experienced severe financial burdens related to the COVID-19 crisis. Consequently, a large majority of sanitarium residents were unable to pay for the monthly cost of sanitarium treatment of 300 cedis per month in 2020-21.

METHODOLOGY

Research Setting

The focus group meeting venues included private areas in schools, hospitals, or neighborhood community spaces. Eight different focus groups with bi-monthly meetings met throughout Ghana's Greater Accra and Eastern regions. Focus groups were conducted at different venues

in the regions of Ledzokuku, Krowor, Ashiaman, Ga West, Ayawaso East and North Municipalities, Ablekumah South and Central, Okaikoi South, Central Municipalities and Asheidu Keteke Sub Metro.

Semi-structured, in-person interviews were conducted with patients in the sanitarium of Mount Horeb Victorious Church Prayer Camp in Mamfe, Ghana. The principal investigator and co-investigators interviewed participants on-site at the prayer camp, Mount Horeb. This research study involved in-person, semi-structured interviews with patients at a prayer camp sanitarium, Mount Horeb. This center is a prominent prayer camp that has attracted public attention locally and internationally. Mount Horeb has a long history of working with researchers and continues to play a significant role in the treatment and care of persons with mental illnesses in Ghana.

In person interviews were undertaken from February 2022 to May 2022 throughout a four-month period, while focus group meetings lasted for three months (February-April 2022). Study participants were recruited because of their use of one or more services of psychiatric healthcare or faith-based healing options. English was the primary language used during the interviews, although a translator was provided for those preferring to speak Twi and Fante.

Sample Size

The study engaged a diverse sample size representative of the general healthcare preferences of Ghana's mentally ill population's choice of either using spiritual healing or biomedical treatments. The interviews were conducted with mentally ill persons while the focus groups engaged Ghanaian community members. The accumulative sample size included roughly 185 individuals seeking mental healthcare services (122 interviewees and 75-85 focus group participants). The focus group participants claimed to use healing methods that involved a combination of services including prayer camps, indigenous traditional healing, and/or psychiatric healthcare.

The participants of the prayer camp and focus groups lived in regions that ranged from Eastern Volta, Togo, Burkina Faso to the central region and as far as the Ashanti region. Study participants of the focus groups represented a variety of geographic locations from diverse areas of Ghana. The prayer camp sample size predominantly lived throughout Ghana's Greater Accra and Eastern regions. Participants at the prayer camps were assigned by the psychiatric nurse who determined whether they met the criteria and healthcare standards to participate in the study. These participants used the healing services of the prayer camp

sanitarium including 47 substance abuse users, 17 individuals with epilepsy, and 58 people experiencing chronic mental health conditions.

A large majority of the prayer camp patients were seeking treatments at the sanitarium for substance abuse issues as well as mental illness. Due to the religious views concerning epilepsy and substance abuse and the indistinguishable treatment methods dispended at prayer camps, this study did not differentiate between the patients at the sanitarium. According to the caretakers and psychiatric nurses, 130 of the patients were at the prayer camp sanitarium during this fieldwork period.

Data Collection

A pilot study from November 2021-February 2022 provided an opportunity to initially identify pertinent questions and themes as well as administer targeted training to the research assistants. During this time, the team designed a discussion guide after engaging in dialogue with the focus group participants as well as analyzing the current literature on relevant topics. This project was piloted in two communities in the Greater Accra area. These meetings were conducted in connection with BasicNeeds self-help group program before the start of the data collection process. The lead investigator visited community mental healthcare group meetings of self-help groups affiliated with BasicNeeds-Ghana to discuss topics related to socio-economic challenges as well as consider issues related to the mentally ill population's response to the pandemic.

The open-ended discussions during the pilot study contributed to the development of the thematic analysis sheet used among data collection. Four areas were consistently relevant to the participant's lived experiences of mental healthcare in 2019-2022 were explored: Medication, community, unemployment, and relapse. The investigators designed a series of questions to research participants concerning their lived experiences related to the Corona Virus by referring to these four themes.

The interviews at the prayer camp were roughly 10 minutes to one hour in length with an average duration of 25 minutes. The focus group meetings lasted between two and three hours. The study documented the biodata of the participants at the prayer camp including gender, age, and length of stay. Each participant received an ID to maintain anonymity.

The semi-structured interview approach offered an ideal format for clarifying themes linked to the Corona Virus. The notes for each interview participant were documented on a hard draft discussion guide to account for a large amount of data. In-person interviews were

documented using the code and count approach. In interview, codes were subsequently assigned to each participant using a pre-coding system of medication (m), community (c), unemployment (j), and relapse (r). The code was recorded if it matched the following criteria: 1) a challenge clearly relevant to the Covid-19 pandemic; and 2) a topic that negatively impacted the participant. Research investigators confirmed direct connections to the pandemic by taking thorough notes. For example, a participant may say that they lost their job selling street cart food while further questions might indicate that their unemployment stemmed from lockdown protocols during the pandemic. The investigator would then mark the discussion guide with a "J" and include a brief description of how the participant's unemployment is connected to the pandemic. This project used a dual moderator focus group model and a thematic approach to classify and organize themes and patterns related to the interview data. The team followed the code and count approach to analyze the in-person interview data and qualitative research by using a deductive approach.

The thematic approach used for the focus group data presented a way to classify and organize patterns related to the interview data. The qualitative data was then assessed using interpretative phenomenological analysis (IPA) gathered from the fieldwork notes and transcript. An audio transcript of the focus groups and interviews were also examined to confirm findings and further explore the code and count themes. Two members of the research team thereby independently assigned these themes and explored the data in depth.

Data Analysis Methods

The code and count method proved useful for a larger sample size and for exploring detailed responses. The responses were categorized into themes related and unrelated to the pandemic including medication, family, community support, unemployment, relapse, and stigma. Shortly thereafter, the notes were handwritten, and audio transcript typewritten. Two members of the research team independently conducted separate line-by-line coding to identify topics that reflected key themes from the interview transcripts and notes.

This study used an interpretative phenomenological analysis of the focus group data and fieldwork notes to conduct a thematic analysis. The major themes and patterns that emerged were analyzed in connection with the study's original questions and theoretical constructs. After the research team examined the handwritten notes of the responses and reviewed the transcript draft, the lead author inputted the data using Excel Spreadsheet software. The research team identified the conceptual findings in the summaries of the thematic networks to

document cohesive points that related to the original questions and the study's theoretical groundings.

Research Findings

Medication

Medication is repeatedly listed as the highest cost to households facing economic burdens of mental illnesses in Ghana (Addo, 2013; Ofori-Atta et al., 2014; Arias et al., 2016). As stated below, loss of employment or a reduction of income due to the pandemic was primarily stated as the cause of socioeconomic challenges by the research participants. A lack of availability and affordability of medication was repeatedly mentioned as an obstacle to accessing mental healthcare services. Respondents admitted the existence of shortages of pharmaceutical resources. Shortages were frequent all year round for some participants while others acknowledged shortages as a seasonal occurrence. Most respondents said that the Corona Virus served as a primary factor responsible for general shortages.

Study participants identified medication as a major expense. Many stated that during the pandemic they could no longer afford pharmaceutical drugs. Many lost the financial means to afford food let alone medication. One participant, for example, reasoned between the option of either buying dinner or medication: "it is so expensive I have to choose between going to a food cart or taking my pills at night." Moreover, participants also mentioned challenges accessing food during the pandemic thus experiencing issues with taking their medication as proscribed with the recommended meal. Consequently, a large majority of the participants claimed that they chose not to take medication because of a lack of options for routine meals: "it [the medication] hurts my stomach and I can't pay for both or find food with no food carts during Corona."

Individuals located in areas that are difficult to access have experienced logistical issues traveling to hospitals to acquire cheaper medication. Certain areas of Ghana were closed to citizens during the pandemic. Travel in urban areas generally required a work permit along with proof of residence. Medication acquired from private pharmacies is usually relatively expensive, while it was considered cheaper to purchase from pharmacies within the hospitals. Nevertheless, many could not use the cheaper hospital pharmacies due to a lack of resources or logistical challenges during the crises. Others attributed the responsibility of shortages to poor governmental funding. Many of the participants mentioned that access to psychiatric medication was limited during the lockdown. Stories of an irregular supply of medication

were repeatedly mentioned by participants: “I traveled two hours to Pantang hospital to only learn that the medication isn’t there because of the Corona Virus times.”

Many stated that due to the inordinate cost of medication and economic challenges during the pandemic their only option was a cheaper source of care namely, divine healing at prayer camps. A large majority of the participants at the sanitarium claimed that they could not afford modern medical services so they resorted to divine healing: “I go the hospital and pay what I would here one month in one night.” During a time of economic instability, prayer camps offered a more appealing option of care due to the less expensive costs. As mentioned above, the prayer camp’s administration of Olanzapine to patients was considered by prayer camp sanitarium participants a substitute for their regular mediational routine. Many also referenced the benefits of both divine healing and phsychiatric care: “God is healing me but I had a shot that started the purity of my health too.” Economic advantages aside, research revealed that many of the patients at the sanitarium benefits from the psychotropic medication being used alongside the faith-based services.

Several of the patients interviewed claimed that they chose to use the services of prayer camp because they were unable to easily access a hospital or medication during the pandemic. One participant, for example, said: “I have no options. I was sick, so I went to the prayer camp because I felt like my neighborhood was on fire during the Corona Virus.” The cumbersome nature of the procurement processes for regular medication was also known to cause relapses, as later discussed.

Unlike psychiatric facilities, prayer camps have reputations for delivering cures for chronic conditions. Consequently, Ghanaians often depend upon the healing services of prayer camp sanitariums because these facilities are believed to deliver fully curative treatments. Many patients at the prayer camp sanitarium claimed to have no need for medication because they were ‘waiting on God.’ One prayer camp sanitarium patient stated that the medication can present a temporary relief but: “Once God heals you, you are better forever.” While the hospitals can only offer treatments in the form of medication and therapy that is expensive and often finite, the prayer camp is believed to provide the Ghanaian with a permanent or ‘absolute cure.’ During a time of economic instability and general crisis, divine healing solutions are an appealing option.

Familial Obligations

Children and their parents experienced ongoing disruptions and changes to their daily routines during the COVID-19 period thus leading to long-term financial challenges. Unemployed parents who are suffering mental illnesses experienced extreme socioeconomic challenges during the pandemic. The study shed light on how single parents suffering from mental illness especially faced challenges related to the pandemic of household income shocks, food insecurity, and economic instability. One participant in the focus group stated: "it is a circle of pain and money troubles; we can't get out of this now." The reference to a 'circle of pain' was a reoccurring theme of the study. In such cases, families face difficulties related to Covid-19 that build upon themselves. With no solutions or answers in sight, a family cannot break from the socioeconomic challenges.

Family relationships were put under further strain during the pandemic for several reasons. Participants mentioned difficulties caring for children as finances were strained while they were experiencing symptoms of mental illness. Participants mentioned that following the closures of schools many of the children chose to not reinstate their education primarily due to financial difficulties at home. In many of these cases, a lack of parental support and investments in family strengthening persisted because the individual suffering from mental illness was unable to afford medication. Consequently, parents with mental illness presented symptoms that furthered challenges at home.

Participants at the sanitarium claimed that their relatives were caring for their children. One lady who had recently given birth to a three-month-old child said: "My mother is taking care of my baby girl. I couldn't help her. I felt so alone, and Corona made that worse." A large majority of the participants who regularly attended the focus group meetings mentioned issues with salary reductions or job loss. Workplaces were closed or held inconsistent hours in 2019-20 thereby limiting mentally ill persons' income stream. Pay decreases likely continue to present a long-term impact on the families of the mentally ill.

Prayer camp sanitarium patients claimed a depletion of savings for their families due to job loss. Sanitarium patients also discussed challenges with relatives paying their fees or bringing supplies to the prayer camp. For example, one participant said no one could pay the bill at the prayer camp for her care: "My mother lost her job during the pandemic and cannot pay for me to stay here anymore." In another instance, a lady mentioned that she no longer receives food supplies from her husband: "Corona took my husband's job selling street food and he cannot

bring me anything anymore." Sanitarium patients such as those mentioned above were left depending on donations from the prayer camp for specialized items like clothing and food.

Unemployment

The study revealed that with the severe cases of mental illness came about unemployment or loss of job. The sanitarium population was predominantly admitted to the prayer camp for extreme cases of mental illness. Of the 122 residents of the sanitarium population interviewed merely three were employed. Two of these three participants worked for a family business, and one owned property as a business venture. Around 17 participants claimed to be students. In sum, research findings indicated that a large majority of people suffering from mental illness are unemployed.

Unemployment brings about stress and anxiety that can further impact areas of mental health in one's life. Outcomes of relapses regularly coincided with strains on financial prospects following participants job loss or pay decrease. One participant said: "I lost my job—causing me to lose options for sanity." A large majority of the focus group participants generally lost their jobs due to reasons related to the pandemic. Specific reasons ranged from a loss of customers during restrictions, closure of street food carts, students unable to maintain daily routines, and teachers losing their job, among others. For example, one participant claimed:

I sold items on the street, but people would come and stare at me and treat me badly because of my known illness. I started sowing cloths together and putting them on my porch. People would see her items and stop and buy something. I had a trade to contribute. Then, I lost all my customers during the pandemic. I closed my business. I don't have the funds to buy sowing equipment to open my porch store right now.

Many owned businesses which closed during this time and stated issues with finding the funding to reopen. Several of the participants in the sanitariums were teachers who had lost their job during the pandemic. Over fifty participants at the sanitarium claimed that after losing their job they couldn't afford to use the services of a psychiatric hospital. One stated: "the prayer camps is my only option."

Research participants mentioned losing their job because of issues with mental illness. Among the focus group samples, discrimination and stigma played a major role in the topics discussed, especially in relationship with determining job prospects. One lady claimed: "If I have a job people will come and just stare at me." Another man mentioned, in interview: "I am worthless and cannot work." He claimed to feel that way because his job prospects were limited. He

said that community members told him that in response to discriminatory viewpoints. The state of economic decline has likely only increased while job prospects for the mentally ill only decrease. The mentally ill population experienced severe economic difficulties at an enhanced rate during the Covid-19 crisis because job prospects were virtually limited. Over thirty participants mentioned losing their job because companies discharged employees due to limited resources during the economic recession.

A continued theme this research uncovered pointed to challenges that participants experienced during this period involving a lack of customers and supplies at different stores due to the pandemic. For example, one participant mentioned difficulties selling items on the street corner because of her reputation as someone suffering from mental illness. Before the pandemic, she opened a shop selling items on her front porch. Subsequently, she experienced an increase in friends and community support systems while selling items because she had a trade to contribute for a period. During the Covid-19 crisis, however, she was unable to buy the materials needed to create products for her business. Furthermore, there was less foot traffic during the crisis. As a result, she experienced a lack of community support because she was unable to contribute a trade. She said: "if you have nothing to give, you are considered less than others." This participant has yet to open her front porch shop since the challenges incited by the Covid-19 pandemic: "I no longer have the money to keep it or even money for food in putting my finances together."

Research indicated that financial distress following a lack of resources for businesses resulted in a cycle difficult to overcome. Research participants mentioned challenges due to limited supplies or a lack of options for selling. Many who owned businesses that closed due to the limitations of the COVID-19 period ultimately lost the revenue to fund future business ventures. Food vendors particularly experienced less foot traffic. One participant with several children, for example, could no longer sell frozen popsicles because of a broken refrigerator. Similarly, a large majority of participants lost the means and opportunities to fund the reopening of their stores and businesses. The research continued to point to the reality that mentally ill persons with a trade or shop have been forced to return to the first stages of business building due to the pandemic trials.

Relapses

A larger majority of the prayer camp patients mentioned using faith-based services as a final treatment option after experiencing repeated failures from psychiatric services or other forms

of faith-based sectors (i.e., indigenous healers). Research findings indicated that prayer camps are usually a second or third mental healthcare treatment option. 45% of the interviewees claimed to use the services of prayer camps following a relapse, while 15% of participants were using the prayer camp as a first treatment option. A closer look at the number of cases of relapses at the prayer camp sanitariums points to answers about the health seeking behaviors of Ghanaians. Namely, a large majority of people use these faith-based services following relapses.

Few patients claimed to choose to use the services at the initial onset of their mental illness indicating that prayer camps are predominantly used as a final healthcare option. In many cases, prayer camp patients mentioned having previously used different services upon having a relapse. 20% of participants claimed to use the services of another prayer camp without success. On the other hand, many of the substance abuse patients claimed to use the service of prayer camps for the first time.

During interviews, concerns were voiced about medication concerning primary culinary institutions closing. Those that once relied on local delis or grocery stores to buy food to eat with their medication no longer could access their main food source. One participant mentioned difficulties affording food: "I could not buy food to take with my medication. I don't want to take my pills without food because it makes me sick." Another participant asked: 'I didn't know whether to buy medication or food." Mentally ill persons facing financial difficulties were generally unable to afford medications as well as essential nourishment thus resulting in cases of relapses.

Community Support

Many Ghanaians were isolated during the lockdown measures. Less association with neighbors, family, and friends in communities was identified by participants as causing increased stress and anxiety. Additionally, stores and community centers were closed. Several of the interviewed participants mentioned isolation as a triggering factor behind their symptoms of mental illness. Several participants directly attributed the social isolation period as a reason for taking up drug abuse, while many stated that it contributed to their psychosis.

The deployment of military personnel to enforce the pandemic restriction resulting in severe repercussions (APA 2020). Government restrictions persisted to a level that reports called "violent" and "brutal," while police personale imposed measures on civilians accused of breaching the lockdown rules. For example, there exists video footage featuring police

officers who are caning people breaking Covid-19 protocols. In other cases, drivers without permits are being forced to crawl on their knees and other are ordered to “squat and hop,” among other cases (Boateng, 2022).

The lockdown was repeatedly mentioned as a major source of anxiety by research participants. One recalled the strict restrictions: “They [the police] would beat you if you stepped outside; no one was safe.” These cases of police brutality were cited by the sample size as causing extreme anxiety. One research participant mentioned difficulties finding a place to use the restroom. This participant was chased by authorities simply for using an outdoor toilet. Consequently, an increase in fear and anxiety was repeatedly reported by research participants during the pandemic which in some cases led to relapses. For example, one participant mentioned:

I was hungry, but it was scary to find food outside because of the lockdowns and beatings. I didn’t know where to go and I wandered and ran in the streets getting sick.

Another interviewee mentioned having a serious seizure during this period in response to pandemic related stress. She claimed that no one assisted her when she fell into a ditch convulsing. She attributed the lack of support to stigma: “It was us against them, and I was already an outcast and useless.” Furthermore, she claimed that the pandemic enhanced the negative attitudes of neighbors primarily because people experienced extreme concerns for their personal socioeconomic wellbeing. The state of stress and fear that the pandemic unleashed negatively affected how people responded to their neighbors. In many cases, those with mental illness were cast aside from the social system or altogether abandoned by their community and family.

Participants in the focus group repeatedly pointed to a lack of options for mental health aid from governmental authorities during the pandemic. For instance, a research participant said: “The government brought aid, but we [the psychiatric population] had no physical illnesses to prove our illness.” The focus group members mentioned that government relief did not always reach those in need. In other words, individuals suffering mental illnesses were not seen as worthy of social support primarily because these individuals did not demonstrate physical ailments. In another case, several participants claimed that they were tasked with the responsibility of administering governmental aid to their community and mentioned the purpose and value that this experience offered.

Ethics

The additional research study abided by all policies stipulated in Ghana's Data Protection Act 843 (2012). This project received final ethical review board approval from the Ghana Health Services Committee. The research team asked the participants the same questions throughout the ethnographic journey in an open-ended format to avoid research bias. All participation remained entirely voluntary and confidential.

Mount Horeb Church supported this study. Furthermore, a permission letter of the study site was signed. A community psychiatric nurse facilitated the interviews and determined whether participants met the criteria to participate in the study at the prayer camp sanitarium. All interviewees and focus group participants had the right to omit information or refuse to answer. Additionally, participants gave their informed consent to participate. Furthermore, a data sharing agreement was drafted and signed with the NGO, BasicNeeds-Ghana.

Conclusion

This qualitative study explores the underlying economic and cultural contexts defining mental healthcare treatment preferences during the pandemic to shed light on new and unforeseen challenges. Emerging evidence suggests that mental health-related perspectives, attitudes, and health behaviors of citizens are significantly influenced by community calls to take part in collective actions (Antonakis, 2019; Ajzenman, 2020). To that end, this research area is relevant to informing policy makers, philanthropists, and nonprofit organizations that seek to improve the livelihood of those suffering from mental illness.

The relationship between the COVID-19 pandemic and socioeconomic challenges prevalent among Ghana's mentally ill population have furthered unforeseen disruptions to this vulnerable groups' social services, care networks, familial progress, and essential healthcare networks. The research revealed that socioeconomic disparities related to the pandemic play a prominent role in impacting the areas explored including medication, familial obligations, community support, unemployment, and relapses. Socioeconomic problems have exasperated following the Covid-19 crisis ultimately causing mentally ill persons to experience severe limitations in mental healthcare options. The limited level of social protection for the mentally ill renders it especially difficult for this vulnerable group to access jobs and social security systems during an economic downfall (Aduhene, 2020). The research findings point to a need to understand why Ghana's mentally ill are experiencing challenges in areas of social support systems, relapses, and job loss not only in the wake of the pandemic but on a long-term basis.

The COVID-19 crisis unleashed a degree of stress, uncertainty, and anxiety especially triggering "symptoms for those who [are] already suffering from mental illness," said Ghanaian psychiatrist, Dr. Gyimah (2020). Unemployed mentally ill persons are generally unable to afford medications or psychiatric treatments thereby increasing their chances of relapse. The study uncovered evidence that adverse conditions linked to the pandemic have led to relapses often in tandem with enhanced socioeconomic challenges.

The COVID-19 pandemic and its restrictive measures increased economic uncertainty and paved the way for individuals to experience mentally ill symptoms like anxiety thereby furthering pre-existing issues related to mental health and care. In general, social support systems for Ghanaians mentally ill population are already limited. There are insufficient funds to support Ghana's mental healthcare sector. Moreover, long-term challenges for access to medications persist. Those who suffered from mental illnesses during the pandemic experienced an increase in the likelihood of being able to care for themselves, let alone their families. This study demonstrates that a basic and social need exists for ensuring that Ghana's mentally ill population can receive adequate and regular provisions of quality healthcare. This will not only improve the mental health sector but Ghanaian's quality of life and familial foundations. This research is beneficial to organizations offering livelihood support for lived experiences of mentally ill conditions within and outside of programs affiliated with BasicNeeds-Ghana.

The study shed light on why the socio-economic impact of the COVID-19 pandemic among Ghana's mentally ill persons has resulted in persons preferring to use faith-based treatments options over psychiatric services. Prayer camp sanitariums will likely continue to function as an alternative to psychiatric hospitals primarily because of a combination of issues involving ongoing financial challenges related to the pandemic as well as pre-existing belief systems about the merging roles of faith and healing in Ghanaian culture. From the onset of the pandemic to the emergence of economic challenges, prayer camps offered accessible and affordable services. This research found that those suffering mental illnesses particularly valued this divine healing system during the pandemic while psychiatric facilities were considered the more expensive and less accessible option. During the pandemic, the dependency on prayer camps increased due to socioeconomic reasons thus further establishing these centers as Ghana's unofficial mental healthcare system.

Due to the reoccurring cycle of severe poverty, the link between job loss and relapses likely involves long term implications that deserve clarification. Additional follow-up with this vulnerable group is needed to assess long term implications of the pandemic restrictions and understand the implications of socioeconomic trends. Moreover, further research is needed on the longstanding socioeconomic impact of the COVID-19 pandemic on the mental healthcare options of Ghanaians. Said studies present beneficial knowledge for improving future collaborative efforts between divine healers and biomedical workers. Further research can provide fundamental information needed to advance intersectoral partnerships between medical providers and prayer camp staff. This knowledge opens the door to avenues for improving mental healthcare options for Ghanaians and their community-based services. In taking a step forward in protecting and advancing mental healthcare rights, attention needs to be increased concerning the social and economic challenges that the mentally ill and vulnerable populations face, especially during times of extraordinary crisis.

References

[1] "Primary and Secondary Impacts of The Covid-19 Pandemic On Children in Ghana," UNICEF, 2021. https://www.unicef.org/ghana/media/3486/file/Effects%20of%20COVID-19%20on%20Women%20and%20Children%20in%20Ghana%20(II).pdf.

[2] "The Worst Global Recession Since World War II: Deutsche Bank Just Unveiled a Bleak New Forecast as the Coronavirus Rocks Economies Worldwide." Newstex LLC, 2020. Print.

[3] Addo, R. et al. (2013) Household costs of mental health care in Ghana. The journal of mental health policy and economics. 16 (4), 151–159.

[4] Aduhene, David Tanoh, and Eric Osei-Assibey. "Socio-Economic Impact of COVID-19 on Ghana's Economy: Challenges and Prospects." International journal of social economics 48.4 (2021): 543–556. Web.

[5] Ae-Ngibise K., Cooper S, Adibokah E, Akpalu B, Lund C, Doku V. "'Whether You Like It or Not People with Mental Problems Are Going to Go to Them:' A Qualitative Exploration into the Widespread Use of Traditional and Faith Healers in the Provision of Mental Health Care in Ghana." International Review of Psychiatry. 2010.

[6] Ajzenman, N.; Cavalcanti, T.; Da Mata, D. More than words: Leaders' speech and risky behavior during a pandemic. In Cambridge-INET Working Paper Series; Institute for

New Economic Thinking, Faculty of Economics, University of Cambridge: Cambridge, UK, 2020; pp. 1–48.

[7] Antonakis, J.; d'Adda, G.; Weber, R.; Zehnder, C. Just words? Just speeches? On the economic value of charismatic leadership. NBER Rep. 2019, 4, 1–90. 14.

[8] Arias, D. et al. (2016) Prayer camps and biomedical care in Ghana: Is collaboration in mental health care possible? PloS one. [Online] 11 (9), e0162305–e0162305.

[9] Babuna P, Yang X, Gyilbag A, Awudi DA, Ngmenbelle D, Bian D. The Impact of COVID-19 on the Insurance Industry. Int J Environ Res Public Health. 2020 Aug 10;17(16):5766. doi: 10.3390/ijerph17165766. PMID: 32784978; PMCID: PMC7459729.

[10] Barke, Antonia, Seth Nyarko, and Dorothee Klecha. "The Stigma of Mental Illness in Southern Ghana: Attitudes of the Urban Population and Patients' Views." Social Psychiatry and Psychiatric Epidemiology 46.11 (2011): 1191-202.

[11] Beletsky, Vadim, and Seyed M Mirsattari. "Epilepsy, mental health disorder, or both?" Epilepsy research and treatment vol. 2012 (2012): 163731. doi:10.1155/2012/163731

[12] Benyah, F. (2022) Prayer Camps, Mental Health, and Human Rights Concerns in Ghana. Journal of religion in Africa. [Online] 22 (9), 1–26.

[13] Deborah, Tetteh Dela, Edusei Kwaku Anthony, Eric Badu, Budu-Ainooson Amy, Naomi Gyamfi, Adusei-Nkrumah Josephine, and Maxwell Preprah Opoku. 2020. "The Burden of Caregiving among Mental Health Nurses Providing Services to Consumers with Depression in Ghana." Perspectives in Psychiatric Care 56 (1): 72–80. doi:10.1111/ppc.12377.

[14] Grepperud, Sverre, Per Arne Holman, and Knut Reidar Wangen. "Factors Explaining Priority Setting at Community Mental Health Centres: a Quantitative Analysis of Referral Assessments." BMC health services research 14.1 (2014): 620–620. Web.

[15] Gyimah, Leveana, Mental Health and COVID-19 in Ghana, Asset Health System Strengthening in Sub Saharan Africa. https://healthasset.org/mental-health-and-covid-19-in-ghana/

[16] https://globalhealth.harvard.edu/mindit-mental-health-service-story-ghana/

[17] https://theconversation.com/amp/ghanas-covid-lockdown-why-it-triggered-a-toxic-mix-of-mass-defiance-and-police-violence-176062

[18] https://www.apanews.net/en/news/ghana-deploys-police-army-to-enforce-lockdown

[19] https://www.ifpri.org/blog/how-much-will-global-poverty-increase-because-covid-19

[20] https://www.iol.co.za/news/africa/police-in-ghana-accused-of-using-fan-belts-and-horsewhips-on-journalist-during-covid-19-lockdown-45921503
[21] https://www.sciencedirect.com/science/article/pii/S1875067209000467
[22] https://www.unicef.org/ghana/media/3486/file/Effects%20of%20COVID-19%20on%20Women%20and%20Children%20in%20Ghana%20(II).pdf.
[23] https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide
[24] Hutchinson SA, Wilson ME, Wilson HS. Benefits of participating in research interviews. Image J Nurs Sch. 1994 Summer;26(2):161-4. doi: 10.1111/j.1547-5069. 1994.tb00937.x. PMID: 8063325.
[25] Mark Roberts, et al., "An Overview of Ghana's Mental Health System: Results from an Assessment Using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS)," International Journal of Mental Health Systems, ijmhs.biomedcentral.com/articles/10.1186/1752-4458-8. May 4, 2014.
[26] Ofori-Atta, Angela, Ohene, Sammy. Changing Trends in Mental Health Care and Research in Ghana. Ghana: Sub-Saharan Publishers, 2014.
[27] Taylor, Lauren A. "Reconsidering Samuel: A Mental Health Caretaker at a Ghanaian Prayer Camp." Perspectives in Biology and Medicine 59, no. 2 (2016): 263-75.
[28] Vos R, Martin W, Laborde D. How much will global poverty increase because of COVID-19? International Food Policy Research Institute IFPRI Blog [Internet]. 2020 Mar; Available from: https://www.foodsecurityportal.org/blog/how-much-will-global-poverty-increase-because-covid-19.
[29] Vuilleumier P, Jallon P. Epilepsy and psychiatric disorders: epidemiological data. Revue Neurologique. 1998;154(4):305–317.
[30] World Health Organization. "Ghana." WHO, Accessed February 20, 2021. http://www.who.int/country/gha/en/.