DEVELOPING MENTAL HEALTH LAWS IN GHANA, KENYA, AND ZAMBIA

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Mental health has become a national health priority in the West; however, it is still an overlooked issue in most African countries. Sixty-four percent of African countries do not have any mental health legislations or fail to adequately promote the rights of people diagnosed with mental illnesses (Mental Health and Poverty Project & World Health Organization, n.d). As a direct consequence, individuals with mental illnesses in African nations often do not receive adequate treatment. This review evaluates the barriers of appropriate development and implementation of mental health laws in Ghana, Kenya, and Zambia. Legislative actions that have been taken in these three countries will be examined in an effort to improve mental health laws, via an analysis of strengths and areas of improvement. Through these analyses, the author hopes to raise awareness about legislations in Africa regarding mental health issues, build a stronger path towards comprehensive mental health laws, and work towards the effective provision of treatment for people with mental health issues in Ghana, Kenya, Zambia, and the rest of the African continent.

STATEMENT OF THE PROBLEM

Most African countries appear to adopt a similar attitude towards the issue: mental illness is stigmatized, and little legislation exists to provide improved mental health care services (Omar, et al., 2010; Bartlett, et al., 2011; Faydi, et al., 2011). An estimated 76% - 99% of people with serious mental illnesses in Africa do not receive adequate services for their conditions, due in part to this pervasive stigma (Faydi, et al., 2011; Mental Disability Advocacy Center [MDAC] & Mental Health Users Network of Zambia [MHUNZA], 2014). It is clear that laws and policies are crucial elements in forming priorities for political agendas, obtaining funding, and acknowledging the rights of a particular group of people (MHaPP & WHO, n.d.; Omar, et al.; 2010; Bartlett, et al., 2011; Faydi, et al., 2011). In the context of mental health, laws and policies are of critical importance, as it allows for the rights of individuals with mental illnesses to be protected and can direct the government to provide funding for effective services. Laws and policies embody a clear, written government commitment to work towards the improvement of mental health services (Faydi, et al., 2011).

By 2005, half of all African countries had mental health policies, compared to the early 1990s when only 23% of member states of the African Region of the World Health Organization (WHO) were reported to have mental health laws (Okasha, 2002; Omar, et al.; 2010; Faydi, et al., 2011). This sudden increase might be due to the diverse projects initiated by international non-profit organizations advocating for improvement in mental health laws (Faydi, et al., 2011). Despite the significant increase, there are still serious challenges in terms of implementation and dissemination of mental health legislations in countries where these policies have been created.

All of the African mental health laws drafted prior 2005 promoted involuntary treatment without consideration of the rights of individuals with mental illnesses (MHaPP & WHO, n.d.; Okasha, 2002; Omar, et al.; 2010; Faydi, et al., 2011). Many of these laws did not value informed consent, assuming individuals with mental illnesses did not have the capacity to understand or make decisions for themselves (MHaPP & WHO, n.d.; Bartlett, et al., 2011; Faydi, et al., 2011). Such legislations often failed to consider the dignity, respect, autonomy, and need for protection against discrimination of people with mental illness (MHaPP & WHO, n.d; Bartlett, et al., 2011). These legislations also failed to include guidelines against abuse, specifically with regards to involuntary admission and treatment in psychiatric hospitals (MHaPP & WHO, n.d; Bartlett, et al., 2011).

Currently, mental health services available in most African countries are mainly accessible through government funded psychiatric institutions (MHaPP & WHO, n.d; Omar, et al., 2010; MDAC & MHUNZA, 2014; Walker, 2015). Most often these psychiatric institutions are overcrowded and run by one psychiatrist assisted by two or three nurses. Bartlett, et al. (2011) found that roughly one psychiatrist is available per million people in Africa. The lack of trained mental health providers inevitably leads to poor quality of care, as it is impossible for one psychiatrist to properly serve patients in an overcrowded institution. Compounding the problem, the psychiatric hospitals examined are dominated by pharmacologic treatments (MDAC & MHUNZA, 2014). Moreover, patients are often overmedicated (Bartlett, et al., 2011; Faydi, et al., 2011). Training in evidence-based interventions such as Cognitive Behavioral Therapy (CBT) is limited, mainly because such interventions require continuous supervision in order to be properly implemented (Bartlett, et al., 2011).

In addition to involuntary treatment and lack of trained staff, geography has also been a challenge. Psychiatric hospitals and mental health providers are mainly concentrated in urban areas (Bartlett, et al., 2011). The concentration of mental health professionals in the major cities makes it difficult for patients in rural areas to access care.

Another major challenge that most African countries face is the limited resources dedicated to mental health care. For the past several years, the African Union has encouraged its members to dedicate 15% of their national budgets to health; however, several countries are unable to meet this target. In turn, mental health is only a small part of the overall health budget (Bartlett, et al., 2011; Drew, 2013).

GHANA, KENYA, AND ZAMBIA

Three different countries were analyzed in this review: Ghana, Kenya, and Zambia. These countries were chosen as subjects of this study for various reasons related to convenience and diversity:

1. Accessibility: These three countries all have received increased attention from international non-profit organizations, leading to greater accessibility of data and studies;

2. Language: English is the official language for these three countries. Language was an important factor for the author's ability to revise and fully understand the laws enacted, yet also ease the research process;

3. Large population: These three countries are among the top 10 Anglophone African countries with a large population. The population size was important as the author hoped, to some extent, examine countries that represented significant portions of the African continent population;

4. Geography: These three countries are located in very different parts of the continent (West, East, and South). Considering the diversity of the African continent, the author hoped to choose countries in different parts of Africa to explore the similarities and differences given each country's location.

It is important to note that Nigeria and South Africa fit some of the criteria. However, the goal of this study is to highlight countries that, unlike these two nations, are not often looked at but still have enough information and data available to allow for more detailed analysis.

GHANA

The Republic of Ghana is located in the Western part of the African continent. In 1957, Ghana was the first Sub-Saharan country to become independent from Great Britain (Adjorlolo, Chan, & Agboli, 2016). As of 2015, Ghana has a population of 27,410,000 (WHO, 2016). Out of the 27 million inhabitants of Ghana, it is estimated that 650,000 have a severe mental illness and 2,166,000 suffer from a moderate to mild mental illness (WHO, 2007; Adjorlolo, et al., 2016). About 41% of individuals diagnosed with mental illnesses in Ghana are women, although the majority of patients in psychiatric hospitals are men (Barke, Nyarko, & Klecha, 2011; Awaf, 2016).

ZAMBIA

Zambia is a landlocked country gifted with diverse wildlife in the southern part of Africa. Zambia was colonized by Britain and became independent in 1964 (MDAC & MHUNZA, 2014). In Zambia, the number of individuals with mental illnesses is estimated to be high; however, there are no official records of the exact number (MDAC & MHUNZA, 2014).

KENYA

Kenya is in the eastern part of Africa. It was also colonized by Great Britain and became independent in 1963 (MDAC, 2014). Currently, Kenya has the largest GDP in central and eastern Africa. Like Ghana and Zambia, Kenya also has a large number of untreated individuals who have mental illnesses (MDAC, 2014; Merab, 2016). An estimate shows that about 11.5 million people might one day be diagnosed with a mental health illness in Kenya (WHO, 2007; Merab, 2016).

STIGMA, SERVICES, AND LEGISLATIONS

SOCIAL VIEWS AND STIGMA

Mental illness is stigmatized within families and communities in Ghana, Kenya, and Zambia (MDAC & MHUNZA, 2014; Osman, 2016). Often, people with mental illness are devalued and isolated. In several countries, individuals with mental illness face extreme discrimination when searching for employment. In the three countries examined, mental illness is often perceived as a spiritual curse (Okasha, 2002; Omar, et al., 2010; Barke, et al., 2011; Ame & Mfoafo-M'Carthy, 2016; Awaf, 2016). Individuals with mental illness are often viewed as undesirable, or as receiving divine retribution for sins committed in a prior life. People with mental illness are often hidden indoors by families, kept chained outdoors, neglected, or even physically abused (Barke, et al., 2011; Awaf, 2016; Osman, 2016). In addition, lawmakers and governmental officials are reluctant to address mental health due to the stigma attached (Omar, et al., 2010; Barke, et al., 2011; Drew, 2013). In their study examining the views of Ghanaian patients toward mental illness, Barke et al. (2011) found the southern population of Ghana to have a general belief that people with mental illnesses should not be excluded from communities; however, several respondents stated that the presence of persons suffering from mental illness in residential neighborhoods might cause danger.

MENTAL HEALTH SERVICE PROVISION

Three types of mental health services were identified over the course of this study: psychiatric institutions, community-based services, and traditional healing. Mental health services are mostly provided through psychiatric hospitals (MHaPP & WHO, n.d; Omar, et al., 2010; MDAC & MHUNZA, 2014; Walker, 2015). At the primary care level, such services are generally non-existent. There are three psychiatric hospitals in Ghana, all located in the southern part of the country: The Accra Psychiatric Hospital, Ankaful, and Pantang (Barke, et al., 2011; Walker, 2015). These three institutions are the only locations for referrals in Ghana. The Accra hospital is burdened with overcrowding: it has 800 beds but often accommodates more than 1200 patients (Barke, et al., 2011; Roberts, et al., 2014). In Zambia, there are eight psychiatric institutions, and

in Kenya there are fourteen (Jenkins, et al., 2010; MDAC & MHUNZA, 2014). Although Zambia and Kenya appear to have more psychiatric institutions, these two countries face challenges similar to those of the psychiatric institutions in Ghana (Jenkins, et al., 2010; Bartlett, et al., 2011). Due to overcrowding in psychiatric units, in all three countries, patients are often overmedicated, which leads to a shortage of essential psychiatric medications (Bartlett, et al., 2011; Faydi, et al., 2011; MDAC & MHUNZA, 2014). In the Ghanaian mental health sector, the doctor-patient ratio is one per 1.7 million (Awaf, 2016). In the Zambian mental health system, there are only five professionals working for a population of more than 13 million (MDAC & MHUNZA, 2014). Kenya has 23 psychiatrists in the public service for a population of 40 million (Jenkins, et al., 2010; Bartlett, et al., 2011). The country produces far fewer mental health providers that are needed.

Community-based services are scarce in most African countries (MHaPP & WHO, n.d; Bartlett, et al., 2011, Faydi, et al., 2011). In Ghana, the term "community-based facilities" refers to residential facilities that are separate from psychiatric hospitals, regional hospitals, and clinics (Roberts, et al., 2014). These facilities are privately funded for the most part, although one was funded by the government. In 2011, there were four community-based facilities in Ghana providing 112 beds for admissions. About 46% of the patients admitted were women, and on average most of them spent approximately a year in these facilities (Roberts, et al., 2014). No information has been collected on the type of treatment provided in these facilities. In Kenya, residents of rural communities volunteer to be "community health workers" (CHWs) and assist health centers in their local area (Jenkins et al., 2010). Health centers employ nurses and non-physician clinicians who often do not have proper mental health training, if any (Jenkins et al., 2010). There has been a push to provide mental health training to CHWs in order to ensure better assistance for the staff in health centers, which are usually the first health care stops before patients are transferred to hospitals (Jenkins et al., 2010). Compared to Ghana and Kenya, mental health community health services appear to be non-existent in Zambia. Pilot community care projects have been initiated, however due to lack of funds they were unable to be continued (MDAC & MHUNZA, 2014; WHO, 2007).

According to Barke et al. (2011), the Ghanaian Ministry of Health reported that 70 to 80% of Ghanaians use traditional healers as their primary care providers, most often in conjunction with modern medicine. Research suggests that the lack of mental health services and finances may result in the use of traditional medicine and churches in most African countries (Jenkins, et al., 2010; Bartlett, et al., 2011; Ame & Mfoafo-M'Carthy, 2016). Approximately 45,000 traditional healers and churches currently treat patients throughout Ghana (Barke, et al., 2011; Walker, 2015). Many Kenyans view mental illness as a spiritual problem rather than a medical one, causing them to turn to religious leaders or traditional healers for a cure (Merab, 2016; Osman, 2016). In Zambia, traditional and spiritual healers have organized and created an association called "Traditional Healers' Association" (MDAC & MHUNZA, 2014). Although traditional healers have attempted to organize and formalize their work, service users have claimed that some of the practices traditional healers use can be physically and mentally harmful. Zambian service users have pleaded with the government to better monitor the traditional treatments used in their country (MDAC & MHUNZA, 2014).

LEGISLATION

The Ghanaian, Kenyan, and Zambian legal systems are based on English common law traditions (Drew, 2013; MDAC & MHUNZA, 2014; Walker, 2015). Although the mental health laws currently implemented in Ghana, Zambia, and Kenya have improved, more work is still needed (Drew, 2013). First, the revised laws do not present consistent and appropriate language when referencing mental health. Zambia defines mental health conditions with the terms "imbecile" and "idiot", while Ghana does not define them at all (Mental Health Decree of 1972; Drew, 2013). The lack of concrete, objective, and common definitions leads to ambiguity in the implementation of the laws (Drew, 2013). Second, the current mental health laws in Ghana, Kenya, and Zambia do not explicitly address the protection of people with mental illnesses' rights (MHaPP & WHO, n.d.). Ghana and Zambia both implicitly address the cruel treatment and neglect of individuals with mental illnesses, stating that law enforcement authorities will intervene in such cases (MHaPP & WHO, n.d., Ghana's Mental Health Decree, 1972; Zambia's Mental Disorders Act, 1951; Drew, 2013). Lastly, there are no explicit and clear guidelines relating to the competence, capacity, and guardianship of individuals with mental illness, reinforcing the stereotype that individuals with mental illness are incompetent and incapacitated (MHaPP & WHO, n.d.; Ghana's Mental Health Decree, 1972; Zambia's Mental Disorders Act, 1951; Drew, 2013). In 1989, Kenya passed new mental health laws that were insufficiently comprehensive, as the way in which the legislation was written presented challenges for implementation. The issues mainly revolved around funding shortages, which circled the situation back to where it was before: a severe lack of mental health providers and thus the inability to address any mental illness problems in the country (Bartlett, 2011). Historically in Ghana, implementing mental health policies has been challenging for similar reasons (Walker, 2015). During the implementation stage, Ghana often faces bureaucratic barriers, because its legislative process is often time-consuming (Walker, 2015). Furthermore, financial restrictions from the government and international donors often have strict conditions (Walker, 2015). Funds donated are to be used for mandated projects, thus can't be used for other purposes such as infrastructure (Walker, 2015).

CURRENT INITIATIVES

Several grassroots nonprofit organizations in Ghana, Kenya, and Zambia are advocating for more effective mental health laws and services. These organizations often work on both macro and micro levels. In Kenya, a non-governmental organization named Africa Mental Health Foundation (AMHF), founded by Kenyan psychiatrist Dr. David Ndetei, aims to

conduct research to inform policymakers and identify the most cost-effective, best practices for individuals with mental health issues (AMHF, 2017). Initially, Ndetei's objective was to train more psychiatrists in the country. However, he promptly realized that Kenyans in low income and rural areas were not benefitting from the increased number of trained psychiatrists, as many psychiatrists provided services in private practices. In 2002, a national tragedy occurred when sixty-seven students died in a school fire. In response, Ndetei and some of his colleagues organized and provided free mental health services for the families and the school community. Since then, AMFH has been advocating for accessible, appropriate, and affordable mental health services to all Kenyans through research, policy, and direct services.

In Ghana, there are eight well-known grassroots nonprofit organizations. Most were created by international stakeholders (Roberts, et al., 2014). Only one, Mental Health Society of Ghana (MEHSOG), was founded by communities in Ghana (Roberts, et al., 2014). MEHSOG is a membership-based organization advocating for the rights of people with mental health issues in Ghana (Roberts, et al., 2014). MEHSOG offers self-help groups and has an advocacy presence in legislative and legal matters. For instance, in 2015 MEHSOG advocated for Antwi after he made his threat to shoot the former president (Awaf, 2016). Antwi was confirmed to have mental health issues, yet the court convicted him to a 10-year jail sentence. MEHSOG argued that Antwi should be receiving mental health care, not a jail sentence. In August, Antwi's lawyer, with support from MEHSOG, succeeded in having his sentence dismissed. Nevertheless, Antwi was incarcerated until December. Upon his release, Antwi was finally admitted in the Accra Psychiatric Hospital (Awaf, 2016).

In Zambia, grassroots organizations advocating for mental health are less common. In 2011, the membership-based organization Mental Health Users Network of Zambia (MHUNZA) sought help from a United Kingdom-based organization named the Mental Disability Advocacy Center to create the first comprehensive report analyzing mental health in Zambia through a human right perspective (MDAC & MHUNZA, 2014). As per the 2014 report released by MDAC and MHUNZA, MHUNZA's mission is to promote and fundamental rights of individuals with mental illnesses and "to promote respect for their inherent dignity" (MDAC & MHUNZA, 2014). AMFH, MEHSOG and MHUNZA are doing impressive work within their means; however, again, the main obstacle they face is a lack of funding, which minimizes the visible impact they can have.

Initiatives regarding mental health in Africa have also been promoted globally. In December 2006, the General Assembly of the United Nations (UN) passed the Convention on Rights of Persons with Disabilities (CRPD). The Convention aimed to expand mental health community-based service legislations internationally (Bartlett, et al., 2011). The CRPD laid on the principle that individuals with disabilities, including mental illnesses, have the same rights as everyone else and promoted their non-discrimination and inclusion in society (Bartlett, et al., 2011). The CRPD was the first international declaration to include the voices of service users and non-profit organizations ran by service users (Bartlett, et al., 2011; Drew, 2013). The CRPD also included countries from developing regions, and as a result 38 African countries signed, including Ghana, Kenya, and Zambia (Bartlett, et al., 2011). The CRPD holds participating countries accountable by conducting monitoring assessments. The UN has created a committee that will publish public report assessing the compliance of the participating countries to the CRPD standards (Bartlett, et al., 2011). The CRPD hopes that the visibility of these reports will create incentives for participating countries to be adherent to the standards (Bartlett, et al., 2011).

CONCLUSION

This article provided an overview of mental health laws and policies in Ghana, Kenya, and Zambia. Drafting comprehensive mental health laws is crucial for providing effective legal oversight for programs and services that benefit individuals with mental health issues. Understanding the relationship between stigma and policymaking is important for effective strategizing. Efforts cannot focus solely on changing perceptions or on changing policies. Both need to be addressed and properly understood.

Three main changes would address both stigma and policy-making: psychoeducation, collaboration with traditional healers, and proportional government spending.

1. Psychoeducation: Psychoeducation could be an effective way to dismantle stigma towards mental illness. Psychoeducation can help communities become familiar with the causes, reasons, manifestations, symptoms, and treatments for mental health issues (Lukens & McFarlane, 2006). Once communities become educated on mental illness, members may be more willing to interact with, care for, and support individuals diagnosed with mental health issues in their neighborhoods (Ame & Mfoafo-M'Carthy, 2016). Literature shows that psychoeducation results in positive outcomes not only for patients, but for family members as well (Lukens & McFarlane, 2006). One important point to remember is that the culture of communities must be taken into consideration. In Ghana, Kenya, and Zambia, people often believe mental illness is related to spiritual causes (Okasha, 2002; Omar, et al., 2010; Barke, et al., 2011; Ame & Mfoafo-M'Carthy, 2016; Awaf, 2016). For psychoeducation to be effective, a strength-based approach should be adopted, meaning that spiritual beliefs should be valued as a resource and included in mental health education for communities. Existing beliefs should not be shunned, rejected, and treated as unfeasible. Ideally, psychoeducational programs should be designed and run by individuals from the communities.

   One tangible suggestion regarding psychoeducation is for each country to create a government department dedicated to mental health education. This office would be in charge of integrating mental health educational programs in schools. Curricula similar to school sexual health programs can be designed to raise awareness of mental health. To reach adults, there should be a digital platform to help grassroots organizations gain more visibility and offer psychoeducational programs through churches and other community institutions.

2. Collaboration with traditional and spiritual workers: Given the influence of traditional healers and faith-based practitioners in communities, it is important to consider formally integrating traditional healers in the primary health care system. Policies and

regulations should be drafted to address the practices of traditional healers and faith-based practitioners. In Zambia, traditional healers and spiritual workers have founded associations (MDAC & MHUNZA, 2014); the government should encourage these organizations to conduct studies to gather evidence about the effectiveness of traditional practices and ensure that they are beneficial. In addition, developing certification programs could ensure that traditional practitioners are performing healthy methods of treatment. Ideally, mutual respect between traditional healers and mental health providers would evolve, promoting referrals between the two types of health care systems.

3. Proportional government spending: Low government spending on mental health is one of the main weaknesses of the mental health systems analyzed in this study. The amount of the health budget spent on the mental health sector should be proportional to the mental health needs of the population. Many African countries dedicate less than one percent of their health budget to mental health services (Bartlett et al., 2011). In addition, most of the mental health budget is spent on urban psychiatric hospitals (Bartlett et al., 2011). To meet the population's needs, the Ghanaian, Kenyan, and Zambian governments must make an effort to increase the share of the health budget dedicated to mental health services. This a recommendation is in line with the standards of the African Union, which has encouraged its members to allocate 15% of their national health budget to mental health (Bartlett, et al., 2011; Drew, 2013). Perhaps the African Union can provide incentives to countries that are able to meet the standard, such as selecting them as destinations for the yearly African Union summit.

While these recommendations are crucial, not all may be feasible. Further analysis and research are needed. The process of proportionally allocating parts of the health budget to mental health awareness and treatments requires further exploration. Although stigma was identified as one of the main barriers to appropriate government spending towards the mental health system, it might be beneficial to also determine whether there are other obstacles. Once they gain a full understanding of the challenges, financial experts and appropriate officials will be in a better position to assist the government and provide suitable recommendations. Additional research and analysis of the various traditional and spiritual practices available would also be helpful. Further research should examine spiritual practitioners to give them a voice in the way mental health treatment is understood by the people in these countries. As they are often the first to see a person suffering from a mental illness, their inclusion in future research is crucial in helping close the gap between traditional medicine and modern medicine.

REFERENCES

Adjorlolo, S., Chan, H. C. O., & Agboli, J. M. (2016). Adjudicating mentally disordered offenders in Ghana: The criminal and mental health legislations. *International journal of law and psychiatry, 45*, 1-8.

Ame, R., & Mfoafo-M'Carthy, M. (2016). Mental Health Law in Ghana: The Rights of Children with Mental Disorders. *Social Development Issues, 38*(1), 1-14.

Awaf, A.M. (2016). Mental Health Care; Ghana among the worst in Africa. *Graphic Online.* Graphic Communication Group Limited.

Awenva, A. D., Read, U. M., Ofori-Attah, A. L., Doku, V. C. K., Akpalu, B., Osei, A. O., & Flisher, A. J. (2010). From mental health policy development in Ghana to implementation: What are the barriers?. *African Journal of Psychiatry, 13*(3).

Bartlett, P., Jenkins, R., & Kiima, D. (2011). Mental health law in the community: thinking about Africa. *International journal of mental health systems, 5*(1), 1.

Barke, A., Nyarko, S., & Klecha, D. (2011). The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views. *Social psychiatry and psychiatric epidemiology, 46*(11), 1191-1202.

Central Intelligence Agency [CIA] (2016). Ghana country profile. Central Intelligence Agency.

Drew, N., Funk, M., Kim, C., Lund, C., Flisher, A. J., Osei, A., ... & Mayaye, J. (2013). Mental health law in Africa: analysis from a human rights perspective. *Journal of Public Mental Health, 12*(1), 10-20.

Dhadphale, M., & Magu, J. G. (1984). Mental Health Services In Kenya. *Indian journal of psychiatry, 26*(1), 37.

Faydi, E., Funk, M., Kleintjes, S., Ofori-Atta, A., Ssbunnya, J., Mwanza, J., ... & Flisher, A. (2011). An assessment of mental health policy in Ghana, South Africa, Uganda, and Zambia. *Health Research Policy and Systems, 9*(1), 1

Ghana's Mental Health Decree, 1972

Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization, 78*(4), 475-482.

Jenkins, R., Kiima, D., Okonji, M., Njenga, F., Kingora, J., & Lock, S. (2010). Integration of mental health into primary care and community health working in Kenya: context, rationale, coverage and sustainability. *Mental Health in Family Medicine, 7*(1), 37.

Lukens, E. P., & McFarlane, W. R. (2006). Psychoeducation as evidence-based practice. *Foundations of evidence-based social work practice*, 291, 205-25.

Mental Disability Advocacy Center [MDAC] & Mental Health Users Network of Zambia [MHUNZA] (2014). Human rights and mental health in Zambia. Mental Disability Advocacy Center & Mental Health Users Network of Zambia.

Mental Health and Poverty Project [MHaPP] & World Health Organization [WHO]. (n.d). Policy Brief: Developing Effective Mental Health Laws in Africa. World Health Organization.

Merab, E. (2016). Health Experts warns of mental illness crisis. Daily Nation.

Okasha, A. "Mental Health in Africa: The Role of the WPA." *World Psychiatry 1*.1 (2002): 32–35. Print.

Omar, M. A., Green, A. T., Bird, P. K., Mirzoev, T., Flisher, A. J., Kigozi, F., ... & Ofori-Atta, A. L. (2010). Mental health policy process: a comparative study of Ghana, South Africa, Uganda, and Zambia. *International journal of mental health systems, 4*(1), 1.

Osman, M. O. (2016). The Taboo of mental illness in Kenya. Al Jazeera Media Network.

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

Walker, G. H. (2015). Ghana mental health Act 846 2012: a qualitative study of the challenges and priorities for implementation. *Ghana Medical Journal, 49*(4), 266-274.

WHO (2007) Ghana: a very progressive mental health law. The country summary series. http://www.who.int/mental_health/policy/country/GhanaCoutrySummary_Oct2007.pdf
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