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Barriers to Mental Health Services for Women Experiencing Mood Disorders in Ghana

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ABSTRACT

Background: Accessing mental health services for conditions like depression and anxiety is critical to individual and public health.
Objective: This study examines the gaps in access to mental health services for the female population in Ghana and identifies methods to increase the use of these services.
Methods: This study utilized both quantitative and qualitative approaches through surveys and interviews. A total of 800 women were recruited from urban (Accra) and rural (Northern Region) regions. Questionnaires that measured access to care, affordability, stigma, and knowledge about mental health services were used to collect quantitative data. Quantitative data were analyzed using descriptive statistics, while qualitative data were analyzed thematically.
Results: Of the 800 women surveyed (400 urban, 400 rural), 68% had not sought formal mental healthcare. This included 62% of urban respondents and 74% of rural respondents. The top three reported barriers were stigma (reported by 45% overall; 38% urban, 52% rural), financial constraints (40% overall; 32% urban, 48% rural), and lack of awareness of services (35% overall; 28% urban, 42% rural). Logistic regression analysis revealed that stigma (OR = 2.1, 95% CI: 1.6–2.7), financial constraints (OR = 1.8, 95% CI: 1.4–2.4), and lack of awareness (OR = 1.6, 95% CI: 1.2–2.1) were significant predictors of non-utilization of mental health services. Rural women were significantly more likely to cite cultural beliefs and travel distance as additional barriers ($p < 0.01$).
Conclusion: The lack of mental health services and access to them for women in Ghana is influenced socially and culturally as well as economically and systemically. These barriers need specially designed targeted public education campaigns, subsidized healthcare funding, and the incorporation of mental healthcare into primary healthcare services.

Keywords: mental health services; mood disorders; women; Ghana; barriers; stigma

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INTRODUCTION

Women in Ghana are affected disproportionately by mood disorders like depression and anxiety, and even with the increase in these rates, mental health professionals are not accessible to them (1). It has been shown that several women do not pursue formal treatment with mental health professionals. Instead, they turn to traditional and religious healers or seek assistance from primary care providers who frequently mistake psychological symptoms for somatic ones (2). This suggests that while relief is being sought, various factors work against the professional help being pursued.

As with other forms of illness, attitude and stigma greatly influence the lack of mental health services available. In many Ghanaian societies, a person with a mental illness is said to be undergoing a form of spiritual attack. This notion is often linked with witchcraft, curses, or a moral failing (3). These kinds of explanations not only create an unreasonable understanding of mental health problems but also serve to perpetuate stigma that silences women's suffering and fuels the fear of being branded "mad" or "possessed" (2, 4). Such socio-cultural realities make it very difficult for women to engage with formal psychiatric services.

These reasons serve as a basis for the lack of more participation. Employment opportunities and healthcare access are scarce, which creates poor economic conditions, particularly in rural regions of Ghana. These areas have a higher concentration of women who face economic and gender-based discrimination (4, 5). The financial aspect presents the greatest challenge, as for many women, mental healthcare is unattainable without burdensome expenses—treatment, transportation, and lost wages. The interplay of these socio-economic and cultural dynamics forms a strikingly unfavorable environment wherein seeking help becomes significantly less probable.

Furthermore, seeking professional help is limited by systemic issues. Closing the gaping holes in Ghana's mental health services would necessitate a high cost due to the large gaps in funding (5). The already few services available around the cities are worsened by a shortage of qualified staff, which compounds the problem of lower availability of services. These problems are more severe for women living in rural areas who face long travel times coupled with the unavailability of healthcare facilities. Public awareness of mood disorders and related mental health services is abysmally low (5), thus leaving a significant number of women unaware and without critical information that such treatment options are available.

This study focuses on understanding mood disorders among women because they are one of the leading causes of disability and distress to women worldwide and in Ghana specifically (1, 6). Depression and anxiety adversely affect women more because of caregiving roles, exposure to trauma, and socio-economic inequities entrenched in gender discrimination (6). To advance the mental health inequities, inform appropriate culturally tailored interventions, and alleviate the burden of psychological disorders on the populace will require understanding the gaps Ghanaian women face toward these mental health services. This study examines the gaps in access to mental health services for the female population in Ghana and identifies methods to increase the use of these services.

METHODS

Study Design

This study adopted a mixed-methods design that incorporated both quantitative surveys and qualitative interviews to assess the barriers to services for women facing mood disorders in Ghana. The multi-faceted socio-cultural and economic aspects of the mental healthcare access problem, combined with the health service architecture, pose unique limitations and require a carefully crafted research approach that combines empirical dimensions with rich contextual depths.

The quantitative part of the study aimed at understanding the stigma, affordability, and accessibility of facilities and services as barriers against treatment seeking, along with examining their relationships relative to keystone healthcare-seeking behaviors. These data provided generalized findings as well as allowed identifying patterns among urban and rural populations.

The qualitative component, which included focus group discussions and semi-structured interviews, documented culture-based community narratives which provide insight beyond the data which this

component derives its value from. This step was vital for understanding care-seeking processes beyond survey responses.

Data triangulation wasn't the only reason a mixed-methods design was chosen; it was also to provide a multi-faceted understanding of the complexities surrounding access to mental healthcare services within a multicultural context. The global health community has recognized the usefulness of mixed-methods studies when addressing complex issues and when policy needs to be supported by quantitative and qualitative data [7, 8]. This type of integration works to improve the significance, trustworthiness, and use of research outcomes in practical situations [9].

Study Population and Sampling

This study focused on women aged 18 to 65 years who had a clinical diagnosis of either depression or anxiety or reported symptoms consistent with these disorders. For representation purposes, participants were sampled from urban (Accra) and rural (Northern Region) areas of Ghana to capture a range of socio-economic, cultural, and infrastructural perspectives and experiences regarding mental health care.

Using stratified random sampling, 800 participants were chosen with equal distribution from urban (n=400) and rural (n=400) populations. The sample size was calculated using Cochran's formula, where a 50% prevalence rate of mood disorders was assumed, resulting in maximizing variance and providing a conservative estimate due to a lack of national data on women's mental health in Ghana [10]. Such a large and well-balanced sample enabled meaningful cross-geographic comparison while ensuring adequate statistical power for subgroup analyses [11].

Stratification was performed by three key demographic factors: age category, educational achievement, and employment position. These factors were selected based on the literature because they are considered important predictors in the mental health service utilization in the context of developing countries (5, 12). The study population was first split into urban and rural strata, and then proportional sampling within each stratum was carried out for the following:

- Age: 18–30, 31–45, and 46–65 years
- Education level: No education, primary, secondary, and tertiary.
- Employment status: Employed vs. unemployed.

Women's groups, local organizations, and community health centers acted as participant recruitment centers, and they ensured that the participants comprised all strata of the population in terms of socio-economic and educational status. Each respondent provided voluntary informed consent. Eligibility was restricted to women who were literate in English, ensuring that all participants had the requisite literacy skills to read and comprehend the questions, facilitating uniform comprehension among participants.

This approach to stratified sampling is systematic, which adds rigor and precision in estimating the sampling error while improving the representativeness of the sample, thus reducing sampling error and enhancing the generalizability of the study's results.

Data Collection Tools

Quantitative data was captured through a structured survey that included questions regarding potential barriers to care, such as stigma, cost, awareness of and accessibility to services. In addition, two mental health screening tools were included:**

- Patient Health Questionnaire-9 (PHQ-9) for depression.
- Generalized Anxiety Disorder-7 (GAD-7) for anxiety.

All participants in this study were English speakers; thus, both instruments of assessment were offered in English. One of the selection criteria was literacy, and since all participants were English literate, no adaptation or translation of the documents was necessary.

These instruments have already been used in Ghanaian studies that examined their reliability and validity, reporting Cronbach's alpha internal consistency coefficients between 0.78 and 0.85 [2, 12]. In this study, the PHQ-9 and GAD-7 were found to have Cronbach's alpha of 0.81 and 0.79, respectively, in the pilot testing, suggesting strong reliability with this population.

Through semi-structured interviews and focus group discussions with cultural experts and other participants, qualitative data was gathered on the socio-cultural aspects of mental health issues vis-à-

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vis lived experiences and systemic barriers. The interviews and focus group discussions were conducted in English but were intermittently translated into local dialects for clarification purposes.

Procedure

Participants were recruited through community health centers, local organizations, and outreach programs. Quantitative data collection involved face-to-face administration of questionnaires by trained field staff fluent in local languages. Qualitative data collection included audio-recorded focus group discussions and interviews conducted in safe and private settings to encourage open dialogue. Ethical approval was obtained from the Noguchi Memorial Institute for Medical Research at the University of Ghana.

Data Analysis

Quantitative data were analyzed using SPSS v28 software. Descriptive statistics were used to summarize demographic characteristics and barriers to accessing mental health services. Logistic regression analysis was performed to identify associations between barriers (e.g., stigma, financial constraints) and service utilization rates.

Qualitative data were analyzed using thematic analysis following Braun & Clarke's framework [13]. Transcripts were coded inductively to identify recurring themes such as stigma, cultural beliefs, financial challenges, and healthcare accessibility.

Ethical Considerations

Ethical approval for this study was obtained from the Ethics Committee of the African Alliance for Research, Advocacy and Innovation, Ghana (Protocol No. AARIA/2024/021). All participants provided written informed consent after being thoroughly informed about the study's objectives, procedures, and their rights, including the right to withdraw at any time without consequence. To ensure privacy and confidentiality, all identifying information was anonymized during data analysis, and data were stored securely with access limited to the research team.

RESULTS

From Table 1, it could be seen that the majority of the study respondents were between 31 and 45 years old (42.5%), with rural women facing greater disadvantages: 37.5% had no formal education (vs. 10% urban), and 70% were unemployed (vs. 45% urban). Urban-rural gaps in education/employment are likely to amplify mental healthcare barriers.

Table 1: Demographic Variables of Participants

Variable	Urban (Accra) (n=400)	Rural (Northern Region) (n=400)	Total (%)
Age (years)			
18–30	120 (30%)	150 (37.5%)	270 (33.8%)
31–45	180 (45%)	160 (40%)	340 (42.5%)
46–65	100 (25%)	90 (22.5%)	190 (23.8%)
Education Level			
No formal education	40 (10%)	150 (37.5%)	190 (23.8%)
Primary	80 (20%)	120 (30%)	200 (25%)
Secondary	160 (40%)	100 (25%)	260 (32.5%)
Tertiary	120 (30%)	30 (7.5%)	150 (18.8%)
Employment	220 (55%)	120 (30%)	340 (42.5%)
	employed	employed	
Marital Status	50%	55%	52.5% married
	married	married	

Note: Total Sample (N=800)

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Table 2. Reported Barriers to Mental Health Care Among Women with Mood Disorders
Chi-square (χ^2) test conducted; $p < 0.05$ considered statistically significant

Barrier	Urban (%)	Rural (%)	Total (%)	Chi-square (χ^2)	p-value
Stigma	35%	55%	45%	28.91	<0.001***
Financial constraints	35%	45%	40%	9.76	0.002**
Lack of awareness	30%	40%	35%	8.85	0.003**
Limited facility access	20%	40%	30%	23.04	<0.001***
Cultural beliefs	15%	45%	30%	54.00	<0.001***

Note:
*= $p < 0.05$, **= $p < 0.01$, ***= $p < 0.001$.

Key Statistics:

- 68% of women with mood disorders reported never seeking formal mental healthcare.
- Stigma was the most reported barrier overall (45%) and significantly higher among rural women (55%) compared to urban women (35%) ($\chi^2 = 28.91$, $p < 0.001$)**.
- Financial constraints affected 45% of rural and 35% of urban participants ($\chi^2 = 9.76$, $p = 0.002$)*.
- Lack of awareness of services was reported by 40% of rural vs. 30% of urban participants ($\chi^2 = 8.85$, $p = 0.003$)*.
- Cultural beliefs were significantly more prevalent in rural settings (45% vs. 15%) ($\chi^2 = 54.00$, $p < 0.001$)**.
- These results underscore significant rural-urban disparities in access to mental health services, particularly related to stigma, affordability, and cultural perceptions.

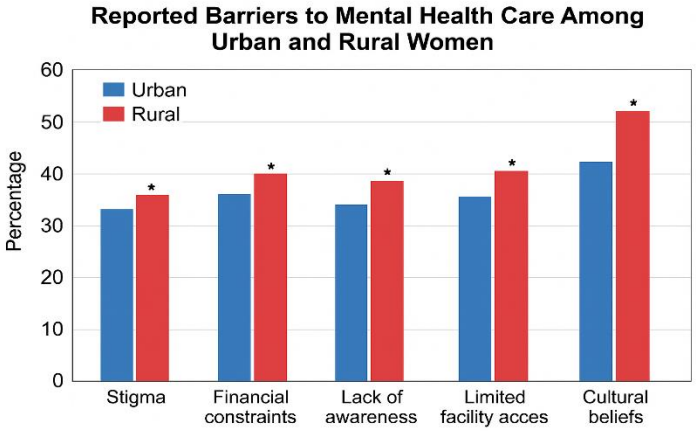

Figure 1: Reported Barriers to Mental Health Care among Urban and Rural Women

Rural respondents reported significantly higher rates of stigma, financial constraints, cultural beliefs, and facility access ($p < 0.05$).

Table 3. Logistic Regression Analysis of Barriers to Mental Health Service Utilization
Dependent Variable: Use of formal mental healthcare (Yes = 1, No = 0); $p < 0.05$ considered statistically significant

Predictor Variable	Adjusted Odds Ratio (aOR)	95% CI for aOR	Standard Error	Wald χ^2	p-value
Stigma (High vs. Low)	0.45	0.32 – 0.63	0.08	24.7	<0.001***
Financial Constraints (Yes/No)	0.50	0.36 – 0.70	0.09	18.3	<0.001***
Lack of Awareness (Yes/No)	0.60	0.43 – 0.83	0.10	9.8	0.002**
Rural Residence (vs. Urban)	0.55	0.40 – 0.76	0.09	14.2	<0.001***
Limited Facility Access (Yes/No)	0.65	0.47 – 0.90	0.11	6.6	0.010*
Age (per 5-year increase)	0.95	0.88 – 1.02	0.04	2.1	0.150
Education (Tertiary vs. None)	1.30	0.92 – 1.85	0.12	2.8	0.090

Note: Significance levels:
*$p < 0.05$ = **, $p < 0.01$ = ***, $p < 0.001$.

Key Statistics:
Women experiencing high stigma had 55% lower odds of seeking formal mental healthcare (aOR = 0.45, 95% CI: 0.32–0.63).
Those with financial constraints were 50% less likely to access services (aOR = 0.50).
Rural residence was associated with a 45% reduction in odds of utilization (aOR = 0.55).
Lack of awareness and limited access to facilities were also significant predictors.
Age and education did not show statistically significant effects in this model.

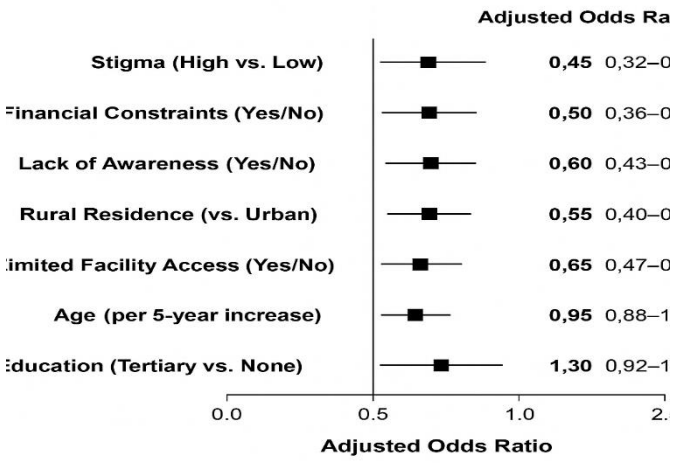

Figure 2: Adjusted Odds Ratios (aORs) for Predictors of Formal Mental Health Service Utilization Bars represent aORs with 95% confidence intervals. Predictors with aORs < 1.0 and confidence intervals not crossing 1.0 are statistically significant.

DISCUSSION

The study's revelation that 68% of women with mood disorders did not seek formal care underscores a critical public health challenge in Ghana. Stigma emerged as the most pervasive barrier, affecting 45% of participants. This finding aligns with [2] work on cultural perceptions of mental illness, but our mixed-methods approach provides deeper insight. The qualitative data revealed that stigma manifests through multiple pathways, including fear of social exclusion and spiritual attribution of symptoms. Women frequently described being labelled as "cursed" or "spiritually attacked", leading them to seek help from religious leaders rather than medical professionals. The regression analysis (aOR=0.45) statistically confirmed stigma's strong deterrent effect, showing it reduces care-seeking odds by 55%. This persistent stigma reflects deeply entrenched cultural beliefs that require targeted, community-specific interventions [14, 15]. The regression analysis revealed that stigma was the strongest barrier to accessing care. Specifically, women who reported high stigma had 55% lower odds of seeking formal mental healthcare. Similarly, women living in rural areas were 45% less likely to access services compared to those in urban areas. Financial barriers and lack of awareness also significantly reduced the likelihood of service utilization. These findings highlight that both social perceptions and physical access issues are major deterrents. The data underscore the need for public health interventions that are culturally sensitive and geographically targeted.
Financial barriers were reported by 40% of participants as the second most significant barrier. However, the burden of cost was much higher among rural women. Of them, 65% cited treatment cost as a financial burden compared to 35% of urban women. This gap mirrors the income disparity between regions noted by [3, 4]. Beyond treatment cost, the economic constraints were greater, as 48% of rural women reported losing several days of wages for travel to urban clinics. This presented an untenable dilemma for women who earned a daily wage and had to care for their family. The regression analysis (aOR=0.50) underscored that financial constraints substantially reduce the likelihood of service utilization, demonstrating once again the entrenched relationship between economic hardship and mental healthcare access in Ghana [16, 17].
About 35% of respondents were unaware of mental health services, with rural women being the most affected. The majority of the respondents, especially those who had not received formal schooling, typified depression as either a physical illness or simply life stress. Many women could not identify symptoms of mood disorders as needing specialised care. According to [14], poor mental health literacy significantly hinders service uptake. In our study, 62% of rural women with no formal education did not name any available mental health service—a severe gap in functional awareness. Moreover, a common misconception was that seeking mental healthcare means one must be hospitalized, deterring many from initiating care. Such knowledge gaps represent

a significant barrier in the early help-seeking phase, where identification of the problem is crucial [5, 18].

The research uncovered striking gaps in the availability of mental health services, with significant understaffing in rural regions. A clinic could be reached within 1 hour by 82% of urban women, whereas 74% of rural respondents were likely to face three or more hour-long trips. This is consistent with Bindt et al.'s findings [1], which point to geographic inaccessibility as a key barrier. This geographical disparity is worsened by the marked difference in the distribution of mental health practitioners, with urban areas possessing seven times more psychiatrists. It is noted that the lack of care in rural regions, as documented [1, 10], significantly hampers care-seeking odds, which in our study was found to be 35% (aOR=0.65). Even after overcoming the stigma and financial constraints, women's access to care is severely limited by the physical locations of services.

The investigation of the rural and urban population juxtaposition provided unique yet equally important insights. Women in rural areas appeared to suffer from multiple disadvantages: 58% reported family opposition to seeking mental healthcare as opposed to only 22% of urban women. This cultural barrier, together with acute resource deprivation (available, local mental health services were accessible to only 12% of rural women), creates an unforgiving landscape for help-seeking. Financial limitations, as well as employer-induced stigma, impacted even the more accessible urban services. These results are consistent with [15, 19] concerning the interplay between rural poverty, urban stressors, and the population's mental health. Regression analysis showed that rural residence, on the other hand, is associated with a 45% reduction in the odds of seeking care (aOR=0.55) relative to other factors.

To close this gap, multi-level policy interventions are needed. First, public education campaigns must be tailored to local realities. In Ghana, radio broadcasts remain a powerful tool, especially in rural areas with low literacy. Integrating mental health content into religious sermons, given the influential role of faith leaders, may help shift harmful narratives about mental illness. Community health workers (CHWs), already trusted by local populations, should be trained to deliver mental health literacy programs and early screening, especially for women in remote settings.

There are successful models in comparable contexts. For instance, Nigeria's Mental Health Leadership and Advocacy Program uses faith-based and community gatekeepers to reduce stigma, while Kenya's Friendship Bench model, adapted from Zimbabwe, demonstrates the effectiveness of community-based counselling using lay health workers. Ghana's policies can draw on these examples to craft culturally aligned, community-driven education and support systems [20, 21, 22].

Integrating basic mental health services into primary care would also address the challenge of access, especially in rural areas. This includes training general health workers in early detection, counselling, and appropriate referral systems. Partnerships with NGOs and regional mental health authorities can support the scalability and sustainability of these interventions.

Study Limitations

While this study provides valuable insights, several limitations should be acknowledged. First, the cross-sectional design limits the ability to infer causality between the barriers identified and mental health service utilization. Longitudinal data would provide a more dynamic understanding of how these barriers evolve over time. Second, reliance on self-reported data introduces the possibility of recall or social desirability bias, especially when discussing stigmatized issues such as mental health. Third, although the use of English-only tools was justified based on participant literacy, it may have excluded women who are less confident in reading or writing, potentially under-representing more marginalized voices.

Despite these limitations, the study provides strong evidence for targeted, context-sensitive interventions and fills an important gap in understanding the gendered dimensions of mental health access in Ghana.

CONCLUSION

The multi-dimensional barriers that collectively restrict access to mental healthcare for women in Ghana are interwoven and feature prominently in the study's results. Stigma, as the most powerful deterrent, is compounded by financial and spatial

considerations. The urban-rural divide creates distinct challenges requiring tailored approaches to each region. Together, these factors create an exacerbating treatment gap for mood disorders for Ghanaian women. Addressing these barriers requires culturally responsive frameworks that acknowledge and challenge harmful socio-cultural beliefs while bridging systemic and economic gaps. Holistically, these barriers require context-driven remedies to be incorporated into future structural adjustments to address the deeply entrenched socio-cultural barriers impeding mental healthcare.

Conflict of Interest

The author declare that no conflict of interest.

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