**Research Article**

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# Collaboratively developing mental health education materials with champions in faith communities in Ghana: A pilot study

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## Abstract

Collaboration with faith communities has been identified as a promising approach to addressing the huge mental health treatment gap in low- and middle-income countries. These collaborations can provide opportunities to develop mental health education materials and interventions in local forms. In this study, we identified champions (N=10) in Christian and Muslim communities in Ghana and co-developed mental health education materials focusing on mental illness myths, presentations of depression, anxiety, bipolar, and schizophrenia in lay terms. We also provided information on how to support people with mental health conditions. We subsequently supported the champions to use the co-developed materials within their faith communities. The champions found the materials both useful and easy to apply. They created opportunities and facilitated conversations around mental health with different groups, including both youth and adults, within their faith communities. Observations and interviews with the champions suggest that it is feasible to co-develop mental health education materials in partnership with faith community members in Ghana.

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## Introduction

Collaboration with faith-based organisations has been identified as a potential strategy to address the huge mental health treatment gap in Low- and Middle-Income Countries (LMICs) (Galvin et al., 2020; Javadi et al., 2017). This approach has the added advantage of making it possible to provide culturally acceptable models of care. Limited research has focused on how such collaborations might work, and the potential barriers, particularly in Ghana. Mental health education is an area that has received relatively little attention in LMICs, including Ghana.

In Ghana, human resources for mental health are inadequate; and there are challenges with stigma and acceptability (Arthur et al., 2022; Roberts et al., 2014). Nevertheless, community assets can be mobilised to improve mental health promotion and prevention efforts (Campbell et al., 2007; November, 2014; Tomalin et al., 2019). Engaging with faith communities is one possible way. Faith communities have the potential to act as resources for mental health promotion (Shidhaye et al., 2017; Sidibe, 2017). Studies have been conducted on mental health promotion interventions involving faith communities (Bopp et al., 2012; Perez et al., 2025). However, studies focusing on LMICs in Africa are few and tend to focus on physical health (Musyimi et al., 2017; Tagai et al., 2018); and those involving Muslims are even fewer (Abanilla et al., 2011; Galvin & Byansi, 2020; Sidibe, 2017).

Religious participation is high in Ghana (Arthur & Andoh-Quainoo, 2024; Koduah, 2019). While mental health services are organised primarily by the Ghana Mental Health Authority, private agencies, NGOs, and faith communities also play an active (Osei-Tutu & Affram, 2024; Osei-Tutu et al., 2019, 2020). Studies have found positive associations between religiosity with stigmatizing attitudes toward mental illness in Ghana (Adu et al., 2021). Although Ghanaians adopt biomedical and social explanations for mental illness, spiritual explanations are predominant (Opare-Henaku & Utsey, 2017; Osafo et al., 2015; Salifu Yendork et al., 2018) influencing treatment and care of people living with mental illness (Read et al., 2009). Further, mental health literacy is low in Ghana, with many people having difficulty recognizing common mental health conditions such as depression and schizophrenia (Adu et al., 2021; Arthur et al., 2022).

Faith communities are already involved in mental health services and have expressed interest in partnering mental health professionals (Arias et al., 2016; Osafo, 2016; Osei-Tutu & Dzokoto, 2018). Therefore, this study examined the feasibility of collaborating with faith communities in Ghana to develop mental health education materials. Specifically, the study aimed to: (1) identify stakeholders in Christian and Muslim communities in Ghana; (2) co-develop mental health education materials; and (3) support these stakeholders to use the materials to increase education and reduce stigma associated with mental illness.

The study aligns with the WHO Mental Health Gap Action Programme (mhGAP) aimed at utilising resources within communities to promote mental health. It has the

potential to enhance understanding of what works in faith communities within LMICs and contribute to achieving the UN Sustainable Development Goal 3 (SDG 3): promoting mental health and well-being.

## Conceptual framework

The study employed a task-sharing approach (Hoeft et al., 2018; Padmanathan & De Silva, 2013) by bringing together trained mental health professionals and volunteers from faith communities with no specialized mental health training. This collaboration aimed to develop mental health education materials that can spark conversations about mental health within faith communities. A key challenge in task-sharing is ensuring the availability of a capable workforce (Padmanathan & De Silva, 2013). To address this, we prioritized engaging faith communities that demonstrated both readiness and the capacity to recruit volunteers. Additionally, we incorporated elements of Boyd et al.'s (2012) co-design framework by establishing partnerships, developing the materials, and piloting them collaboratively.

## Methods

Ethical approval was obtained from the Departmental Research and Ethics Committee of the Psychology Department, at the University of Ghana (Protocol number: DREC/009/20-21). The study proceeded across three phases: (1) Identification of champions; (2) Co-development of mental health education materials; and (3) Piloting of the materials.

### *Identification of champions*

The authors approached Christian and Muslim communities in three regional capitals— Accra, Koforidua, and Tamale— to discuss the study and obtain permission. These locations were selected based on convenience. We first approached the heads of faith institutions and discussed our study. If a head expressed interest in participating, we followed up with a formal letter. In the letter, we indicated that we were looking for congregants to serve as mental health champions. A mental health champion is typically a non-professional who takes action to raise mental health awareness among peers or in their community. The heads either nominated themselves or another congregant who had an interest in mental health. All volunteers were consenting adult members of Christian and Muslim communities. A total of 10 were recruited from Christian (n=8) and Muslim (n=2) communities. They had a minimum of secondary level education. Participant details are in Table 1.

**Table 1:** Demographics of the Mental Health Champions

| Participant ID | Gender | Religion | Location |
|---|---|---|---|
| C1 | Male | Muslim | Tamale |
| C2 | Male | Muslim | Tamale |
| C3 | Male | Christian | Koforidua |
| C4 | Male | Christian | Accra |
| C5 | Female | Christian | Accra |
| C6 | Male | Christian | Accra |
| C7 | Male | Christian | Accra |
| C8 | Female | Christian | Accra |
| C9 | Male | Christian | Accra |
| C10 | Female | Christian | Accra |

## *Co-development process*

The purpose of co-developing was to design mental health education materials that people who are not mental health professionals could understand and use to create conversations about mental health. The co-development process involved 3 main steps: 1) needs assessment; 2) co-developing mental health education materials; and 3) piloting the materials.

## *Step 1: Needs assessment*

We used qualitative interviews to assess knowledge on mental health and mental health activities in the selected faith communities. Based on the feedback from this exploration, we outlined three areas of focus: (1) Conceptions of mental illness; (2) Myths about mental illness; and (3) Common mental health disorders.

## *Step 2: Co-developing mental health education materials*

We conducted a total of nine meetings between July and December 2021 to develop mental health education materials. Meetings lasted between 75 and 90 minutes and were conducted via Zoom. Meetings were attended by the champions (N=10) and the authors. The authors included one licensed counselling psychologist and six counselling psychology trainees.

Based on our engagements, we divided the three initial topics into six, namely (1) What is mental illness; (2) Myths about mental illness; (3) What is depression; (4) What is anxiety disorder; (5) What is bipolar disorder; and (6) What is schizophrenia?

Each student author was assigned one of the topics, for which they conducted literature review and developed a one-page presentation to facilitate public education.

We discussed one topic at each meeting, although some topics spanned multiple meetings. The authors took turns leading the meetings. At each meeting, the champions (1) provided feedback on their understanding of the topic; (2) gave suggestions on the choice of words to make the material understandable to people who are not mental health professionals; and (3) sought clarification on sections they did not understand.

During the first meeting, we introduced ourselves, went through consenting processes, and agreed on group norms. We also discussed meeting scheduling. Even though everyone was allowed to speak English or local language of their choice, the meetings ended up being mainly in English. Subsequently, the team, made up of the champions and the authors, reviewed the content of each topic to make sure the information was accurate and that the language was simple enough to be used by non-professionals to initiate conversations around mental illness. The champions helped identify local labels, simple terms, and also provided input on content. For instance, we invited the champions to nominate other myths they might have heard, and we added them to the information. We discussed all the issues and questions raised by the champions. For the section on care and support, the champions discussed their observations of how society treats people with lived experience of mental illness. Suggestions for improving the manual included adding a mental health directory to the manual, clarifying how people can be helped, providing clear guidelines for referrals, as well as clarifying who qualifies as a mental health professional. At the end of the 8 weeks, the team had a complete manual which covered the topics shown in Table 2.

**Table 2:** Topics covered in the co-developed mental health manual

| Topic | Content |
|---|---|
| What is mental illness? | • What mental illness is<br>• Causes<br>• Examples of mental illness<br>• Common signs<br>• How do people feel when experiencing a mental health condition<br>• How it can be managed<br>• How to support<br>• Where to find professional help |
| Myths about mental illness | • Mental illness and work<br>• Mental illness as a sign of weakness<br>• Mental illness and violent behaviour<br>• Mental illness and suicide<br>• Mental illness and marriage<br>• "immunity" to mental illness |
| What is depression? | • Occasional feelings of sadness versus clinical depression<br>• Common causes of depression<br>• What do individuals who experience depression say<br>• Common signs of depression<br>• How to support someone dealing with depression<br>• Professional help |
| What is anxiety disorder? | • Occasional anxious reactions<br>• When anxiety is a problem<br>• What people living with anxiety disorders say<br>• Causes of anxiety disorders<br>• Help for a person living with an anxiety disorder |
| What is bipolar disorder? | • What bipolar disorder is<br>• Causes of bipolar disorder<br>• Help for people living with bipolar disorder |
| What is schizophrenia? | • What is schizophrenia<br>• Common symptoms<br>• Causes of schizophrenia<br>• Help for people living with schizophrenia |

### *Step 3: Piloting the materials*

At the inception meeting with our champions, we informed them of our intention for them to use the e co-developed materials to create awareness about mental health in their respective faith communities in October, in celebration of World Mental Health Day. Champions had the option of presenting any of the topics in the co-developed manual in Table 2. Each team member had a copy of the co-developed mental health education manual.

Each champion was paired with one of the student authors to discuss plans for using the material in creating awareness in their faith communities. Together, they developed timelines and scheduled dates and times for the mental health awareness programme. Each champion also practised their presentation during group meetings. They contacted the leadership of their faith communities to seek approval and create opportunities for discussing mental health issues during the month of October 2021. Upon receiving approval, the champions informed their assigned student author and finalized the arrangements for the sessions. Each champion organised at least one programme, either independently or collaboratively with another champion. At least one of the authors attended each awareness programme to support the champions. In subsequent meetings, the champions reflected on their experiences. Below are sample reflections:

> C6: I and C8 did it at [faith community] …The reception was good. The target was more of the graduating ceremony of the freshers, those who have completed senior high school and also universities …The second training was just yesterday. We targeted an adult group in the church. It was more geared towards depression…

> C4: The manual actually provides better understanding, and it cleared the understanding, and there are no questions that I was asking myself because everything looked clear [ … ] I personally felt it [the message] really sunk down.

> C2: We had our programme on a Friday evening, that was after, they call it Maghrib [Muslim Prayers], so I think around 7: 15pm... I had this programme with [Participant C1] … So we did the first part of the manual that we have, so the introduction aspect about the mental illness. We added the myths about mental illness.

## Discussions

We conducted this pilot study to assess the feasibility of co-developing mental health education materials with champions from faith communities in Ghana. Ten volunteers who participated in a six-month collaborative effort to develop simple educational materials covering six topics: what mental illness is, myths about mental illness, and basic information on common mental health disorders such as depression, anxiety, bipolar,

and schizophrenia. The manual also included guidance on how to support people with mental health conditions and professional referral sources.

Our engagement with the champions created valuable learning opportunities for all involved. The champions guided the research team in tailoring the mental health information for non-professionals. Additionally, collaborating with non-professionals enriched the development of a resource that could serve as a catalyst for mental health conversations within faith communities. The champions reported that the experience enhanced their understanding of mental health in simple, lay terms.

Limitations include the fact that there were only two Muslim champions. Also, we could not assess the impact of the pilot on congregants. Notwithstanding, this pilot study shows that it is feasible to collaboratively develop mental health education materials with faith communities in LMICs such as Ghana.

### *Implications for practice and research*

Our findings have implications for both faith communities and mental health professionals. The study highlights the potential for collaboration with faith communities in Ghana to co-develop mental health materials. Faith communities are open to task-sharing, particularly in the development of simple mental health education materials. Future programmes should consider the mode of delivery, as the current programme demonstrated that virtual meetings facilitated participation. Virtual meetings enabled champions from different regions of the country to participate, thus enriching the process while also reducing travel-related costs. The study also highlights a strong willingness to engage in co-learning opportunities aimed at enhancing mental health awareness within faith communities. This enthusiasm presents an invaluable opportunity to foster partnerships that promote mental well-being at the community level.

Future studies are needed to test this model. It would also be necessary to examine how to develop the manuals in local languages. Future studies might benefit from adopting Theory of Change (ToC) frameworks in designing, implementing, and evaluating such interventions in faith communities.

## Conclusion

We set out to co-develop simple mental health education materials in collaboration with champions who are non-mental health professionals within Muslim and Christian communities in Ghana. Through this process, we were able to produce a user-friendly mental health education manual that supports mental health advocacy. The project demonstrates a promising approach to fostering partnerships between researchers, practitioners, and community champions in the co-development of mental health resources for mental health advocacy in faith communities.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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