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Editorial

Introduction to the Special Issue of the DCID Journal on Systems of Support to Enable Community Inclusion of Persons with Disabilities and their Families

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Disability rights advocates are increasingly highlighting the critical importance of care and support systems to functioning societies and economies, recognizing their capacity to promote dignity, social inclusion, and human rights of persons with disabilities (United Nations, 2026). For example, using a disability-rights-based approach to understanding community support for persons with disabilities, the United Nations Human Rights Council has recognized a need for knowledge around support strategies and practices to enable community inclusion of persons with disabilities around the world (A/HRC/55/34). The need for improvement of human rights-oriented care and support systems was also a key focus at the 19th Conference of State Parties to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in New York in June 2026. Despite existing global momentum around the care and support agenda, significant challenges persist, and especially in the Global South. Issues such as resource scarcity, inadequate coordination between formal and natural support mechanisms, and enduring stigma are particularly pronounced. Within this context, families and community networks often assume the primary responsibility for providing essential care and support to their loved ones with disabilities, often without adequate recognition, formal training, or supportive policy frameworks. Formal support providers are often functioning in resource constrained contexts and experience great challenges providing adequate levels and quality of care and support required. Nevertheless, these grassroots actors are also at the forefront of developing innovative, contextually relevant practices that promote inclusion and compensate for the deficiencies of formal systems.

We are delighted to introduce this special issue, which sought to identify research from the Global South that would enhance our understanding of support systems for individuals with disabilities and their families, with a particular priority on highlighting good or promising care and support practices. This special issue features studies from different countries in Africa, including Ethiopia, Ghana, and Tanzania.

In Ethiopia, Gebeyaw and colleagues have explored experiences of giving and receiving natural support for persons with disabilities and their neighbours. This study illuminates how people with disabilities in Gondar, Ethiopia receive support for essential necessities, such as food, clothing, and school supplies, among others. Authors also identified that persons with disabilities were not passive recipients of support, but rather they were active contributors in their communities, offering important emotional and instrumental support to their neighbours in turn. In Ghana, Cobbina and colleagues examined how adolescent mental health support systems intersect with families, schools, communities, and policy frameworks through a narrative review of the landscape of support systems for adolescents with mental health disorders and challenges. Although this review

identified valuable existing support structures in Ghana and highlighted the importance of rights-based, integrated community-based rehabilitation (CBR) approaches in promoting inclusivity, it also highlighted similar challenges to those highlighted by Gebeyaw and colleagues, including limited resources, stigma, and lack of trained professionals. Finally, to round out the special issue, de Groot and colleagues discuss the impact of peer-based coping interventions for adolescents with Albinism in Tanzania. In this study, authors demonstrate how natural support systems such as connections to peers with similar lived experiences can combat stigma and ableist cultural norms. This study showcases the strength of collective resilience, peer mentoring, and empowerment—values that resonate deeply with CBR's commitment to participation and local inclusion. Across all these studies, we can see strength and opportunities to mobilize naturally existing resources within each community, yet also the challenges that can arise when natural support networks are not built upon a strong foundation of formal supports, particularly those that might be expected from various levels of government. This collection of studies also shows us how integrated support systems are typically entrenched within environments of stigma and misinformation. These findings not only inform us but also inspire action toward a more inclusive and supportive future. This special issue adds to the growing body of evidence that integrated support systems require formal (and government-led) investments for individuals and families and thrive through community-driven efforts based on participation, respect, and human rights.

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Original Research Article

We Support Each Other: Lived Experiences of Natural Support among Persons with Disabilities in Ethiopia

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ABSTRACT

Aim: Evidence suggests that natural support plays a crucial role in promoting the inclusion of persons with disabilities. Despite its significance, the community's role in providing natural support remains underexplored in Ethiopia. This lack of exploration may obscure the importance of such support, resulting in it being undervalued and underutilized in a context where formal support systems are already limited. This study sought to understand the breadth, impact, and value of natural support for persons with disabilities, and to identify factors that could enhance it.

Method: We employed an exploratory-descriptive qualitative design, semi-structured interviews for data collection, and a reflexive thematic analysis. The study utilized Ethics of Care, Dependency, and Disability, and Appreciative Inquiry as theoretical lenses. Purposive sampling was used to recruit 21 participants. Persons with disabilities were recruited through the University of Gondar's community-based rehabilitation program, while neighbours were recommended by those persons with disabilities and/or their caregivers.

Results: Persons with disabilities receive food, clothing, school supplies, transportation, emotional support, information, and advocacy support from family, friends, and neighbours. They reciprocate by offering emotional support, helping with household tasks, and financial and material support. Improving community awareness, expanding social networks for persons with disabilities, and providing livelihood support for caregivers can strengthen natural support.

Conclusion: In the Ethiopian context, where formal support is limited, the government and its partners must recognize the importance and value of natural supports within communities for persons with disabilities and design community-based programs that effectively enhance these supports.

Keywords: Disabilities, Natural Supports, Informal Supports, Community Supports, Reciprocity

INTRODUCTION

The ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) created an obligation for State Parties to ensure access to a wide range of support services to facilitate social inclusion and personal development for persons with disabilities (United Nations [UN], 2006). A recent UN Human Rights Council (2025) report on the human rights dimension of care and support for persons with disabilities stated that support forms the foundation for the enjoyment of a wide range of rights for persons with disabilities, and recommended that all stakeholders, including local and national governments, work together to enhance care and support systems. Laws and legislative efforts alone however, cannot fully ensure appropriate actions related to the realization of rights and support for persons with disabilities (Chibaya, et al., 2022; Hussey et al., 2016; Musenyente et al., 2022).

Globally, failures in implementing legislation reduce the availability of formal supports, thereby restricting persons with disabilities' access to education, employment and healthcare(Gomda et al., 2022; Gréaux et al., 2023; Huus et al., 2021; Shahidi et al., 2023). Formal supports are provided through structured private or government organizations (Reynolds et al., 2018). In Ethiopia, formal support for persons with disabilities is constrained by a lack of effective implementation of national and international laws (UNICEF, 2019). Researchers found that persons with disabilities have been experiencing challenges in accessing formal support (Dassah et al., 2018; Tiruneh et al., 2021) and social and economic problems (Jemberu et al., 2023). As a result, persons with disabilities in Ethiopia often rely on natural supports provided by primary caregivers (Baheretibeb et al., 2024; Gebeyehu et al., 2019). However, caregivers also need support but often do not receive the needed support due to stigma and discrimination experienced in the community (Tekola et al., 2020). This suggests that comprehensive support systems that attend to both formal and natural supports are urgently needed in Ethiopia to improve the lives of persons with disabilities (Tefera et al., 2018).

Natural support, defined as a range of unpaid support provided through love, loyalty, or personal networks developed within the community (Marsack-Topolewski, 2020; Reynolds et al., 2018), often plays an important role in the lives of persons with disabilities (Friedman, 2025; Jaitely & Gaurav, 2025). Researchers have documented the important role of natural support in enabling well-being and resilience, quality of life, health, employment, housing, and participation for persons with disabilities (Friedman, 2025; Sanderson et al., 2019; Sanderson et al., 2024). Researchers have also identified the value of natural support in fostering financial security and empowerment for decision-making (Jansen-van Vuuren et al., 2024) and independent living (Duggan & Linehan, 2013). Natural support can provide emotional, informational, and instrumental support, and facilitate community integration and belonging (Friedman, 2021; Jansen-van Vuuren et al., 2024).

Although natural support for persons with disabilities can come from various sources, existing studies in Ethiopia have consistently identified primary caregivers as the main natural support providers (Baheretibeb et al., 2024; Gebeyehu et al., 2019; Gelaye & Andualem, 2022; Tefera et al., 2018; Weldeab & Opdal, 2007). However, family caregivers in Ethiopia face a heavy caregiver burden in their caretaking duties, often in isolation, with a severe lack of formal psychosocial support (Baheretibeb et al., 2024, p. 1). Additionally, the perceived and experienced stigma directed towards primary caregivers and their child affects the support of persons with disabilities (Tekola et al., 2020). Further, caregivers' capacity to support their children with disabilities is undermined by poverty, hopelessness, domestic abuse, and the multiple burdens faced by single mothers (Szlamka et al., 2023).

These studies have predominantly relied on caregivers' perspectives, leaving a gap in understanding the broader natural support network from the perspectives of persons with disabilities and other natural supporters beyond the primary caregiver, such as neighbours. This study aims to explore the perspectives of persons with disabilities and their neighbours on disability-related natural supports. Specifically, we asked: (a) What are the natural support experiences of persons with disabilities in Gondar City? and (b) How might natural support be better enabled for persons with disabilities in Gondar City?

METHODS

Theoretical Frameworks

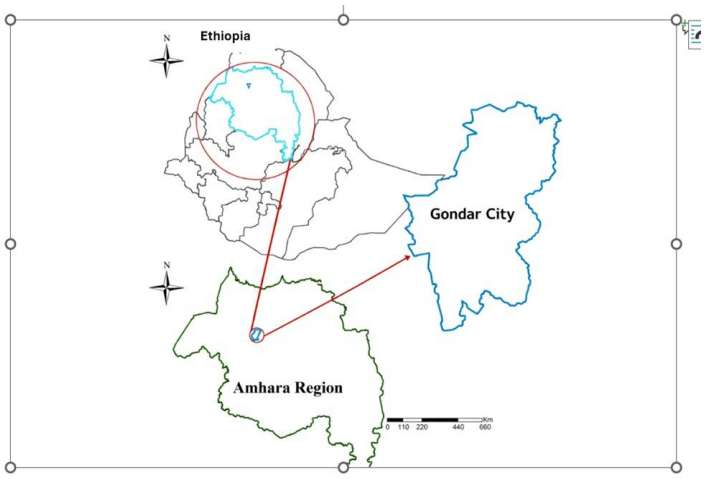
This study is situated within the social constructivist paradigm (Creswell & Poth, 2018; Denzin & Lincoln, 2018). Social constructivism informed our understanding that experiences and meanings of natural support are not fixed or universal, but are shaped through social relationships, cultural values, and everyday interactions of communities. Accordingly, we explored how persons with disabilities and neighbours experienced natural supports within their local context, rather than treating such supports as pre-given or static entities.

Additionally, this study employed Kittay's (2011) Ethics of Care, Dependency, and Disability and Cooperrider et al.'s (2008) Appreciative Inquiry as theoretical lenses. Kittay (2011) argues that all human beings experience phases of dependency and that even those without disabilities are only temporarily able, highlighting the interdependence among individuals with varying abilities. Appreciative Inquiry focuses on the strengths of organizations or communities in order to understand what contributes to their success (Cooperrider et al., 2008). These theoretical lenses provided comprehensive insights into the phenomenon of natural support (Reeves et al., 2008), and were specifically used to formulate the interview questions and establish the study's conceptual foundation (Reeves et al., 2008). Further, these theoretical lenses served as interpretive or sensitizing tools that guided our analysis. However, they did not function as a rigid template for coding and theme development. Instead, theme development was rooted in participants' accounts, with the theories used to enhance the construction of those themes.

Setting

This study was conducted in Gondar City, Amhara Regional State, northwest Ethiopia, about 745 km from Addis Ababa. Teda, Arbaya, and Woleka are satellite Kebeles in Gondar City (see Figure 1). Our study aimed to capture a diversity of experiences relevant to the research question, so we do not have participants from all satellite Kebeles, nor claim representation from central Kebeles. As a qualitative study, we focused on depth and diversity of experiences rather than representativeness.

Figure 1: Study area Map



Source: Shape File CSA 2021 Map Done by ArcGIS 10.7 Software.

Study Design

This study is one piece of a larger PhD dissertation that also explored the CBR program support experiences of persons with disabilities. This study employed an exploratory, descriptive-qualitative (EDQ) design (Hunter et al., 2019), which provides methodological flexibility for investigating a phenomenon of interest and is recommended when exploring a topic that has received limited research attention (Bradshaw et al., 2017; Hunter et al., 2019).

Participants

In line with EDQ methodology (Bradshaw et al., 2017; Hunter et al., 2019), we used purposeful sampling to select participants among persons with disabilities and their neighbours. This sampling method aimed to ensure the sample closely matched the research objectives, thereby enhancing the rigor and trustworthiness of the data (Campbell et al., 2020). Persons with disabilities were purposefully chosen. All persons with disabilities were recruited from those who had received support from the University of Gondar CBR program. Neighbours were recruited through recommendations made by persons with disabilities or their caregivers. Neighbours were included as study participants because they are an essential part of the social environment for persons with disabilities. Natural support often comes from nearby community members, such as neighbours, but they are often overlooked in Ethiopia. Understanding neighbours' perspectives offers insights into community attitudes toward natural support for persons with disabilities and what could better enable natural support to capture these dynamics, providing a comprehensive view of natural support in the community.

The inclusion criteria used for the persons with disabilities were: (1) able to provide informed consent OR informed consent from the primary caregiver along with assent to participate; (2) speaking Amharic or sign language; and (3) being aged 14 or older. The inclusion criteria for neighbours were: (1) individuals recommended by persons with disabilities or/and their families as persons who support them, AND (2) a minimum of six months of experience in supporting persons with disabilities (This criterion was used to ensure that participants had adequate and sustained involvement in supporting persons with disabilities); AND (3) reside close to persons with disabilities and their families; AND (4) speak Amharic or sign language.

The EDQ methodology allows flexibility in determining sample size (Hunter et al., 2019). We applied information power to estimate sample size (Malterud et al., 2016). Data collection continued until information power was reached (Malterud et al., 2016), which means when sufficient data had been collected to develop a robust and valid understanding of the aim.

Sufficient information power depends on five factors: the study aim, sample specificity, the use of established theory, the quality of the dialogue, and the analysis strategy (Malterud et al., 2016). The study posed a specific research question and focused on a particular group with experience in natural support, making it highly relevant to the study's objectives. The interview dialogue was effective; participants shared detailed experiences that aligned with the study's aim, and the research was supported by established theory. Although the participants represented various disability types, all were selected for their direct experience with natural support. The study focused narrowly, yielding rich, in-depth accounts that revealed recurring patterns across participants. Rather than striving for exhaustive representation of each disability category, the analysis aimed to deepen understanding of natural support experiences. For instance, we initially interviewed 9 individuals with disabilities, but after reviewing the data, we decided to conduct 3 additional interviews for greater depth.

Participant Recruitment

We reviewed a de-identified list provided by the University of Gondar CBR program that excluded names, phone numbers, and home addresses. This list provided detailed information on the number of persons with disabilities, their disability type, age, services received, and the length of engagement with the CBR program. Using this information, we identified potential participants based on the study's inclusion criteria. CBR field workers, after being briefed on ethical considerations and signing confidentiality agreements, initially approached potential participants to see whether they would be willing to be contacted about participating in a study. Then, with consent, CBR workers connected us with interested participants. To recruit neighbours, we asked the study participants with disabilities to recommend neighbours who provided them with natural support. Persons with disabilities obtained their neighbours' consent to share their contact information with the lead author. In total, 21 participants were included in the study: 12 persons with disabilities and 9 neighbours.

Data Collection

We used a semi-structured interview guide with open-ended questions to encourage participants to describe their natural support experiences (Kekeya, 2021). Interview questions were prepared in English and then translated into Amharic, the local language. To ensure accurate translations, the protocol was translated by an expert trained in both English and Amharic. Interviews were conducted in Amharic, audio recorded, and transcribed. All transcripts were de-identified, and participants were assigned unique code numbers (ID).

We conducted a pilot interview with two participants, one from each group. We transcribed and translated the pilot data to evaluate depth. Finally, we created a refined interview guide for the actual interviews. The sample questions for persons with disabilities included: (a) Could you please share your experiences of support from: (i) family, (ii) neighbours, and (iii) friends who have helped you without expecting any payment?; (b) Could you please share how you support your family, neighbours, and friends in return for their support? And (c) thoughts on how natural supports could be improved for you?; The sample questions for neighbours: (a) Could you please tell me what support you provide for your neighbour with a disability? (b) Thoughts on how natural supports can be improved for persons with disabilities?

Data Analysis

The data collection, analysis, and report writing stages were interconnected and occurred concurrently, rather than as discrete steps (Creswell & Poth, 2018). Since EDQ research aims to explore and describe the core elements of participant experiences (Hunter et al., 2019), we employed reflexive thematic analysis (Braun & Clarke, 2022) as an

analytical approach. Reflexive thematic analysis involves identifying, analyzing, and reporting patterns within the data (Braun & Clarke, 2022). Throughout data collection and analysis, we documented and discussed our ongoing reflective process (Barrett et al., 2020; Hunter et al., 2019), acknowledging and exploring how our experiences were shaping and influencing the research (Olmos-Vega et al., 2023).

We followed Braun & Clarke's (2022) six steps of reflexive thematic analysis. The interview data were coded and thematized in their original language to maintain the nuances of participants' responses, with selected excerpts translated into English by experts. **Familiarizing with the data:** After each interview, we listened to the audio recording, took notes, transcribed it, and read the transcripts multiple times to immerse ourselves in the data. **Coding:** Two coders independently coded data from six participants to learn from each other's processes. The lead author coded the remaining data with ongoing briefings with the last author. The coded data from the first two participants were translated into English and reviewed by the last author. The process was entirely inductive, and we used NVivo 15 (NVivo, 2025) for coding. **Generating initial themes:** We identified shared patterns across the dataset and organized code clusters around core ideas to address our research questions. **Developing and reviewing themes:** We assessed candidate themes against both the code extracts and the full dataset. **Naming themes:** each theme was clearly defined and focused on a strong core concept, ensuring alignment with the data and our research purpose. **Finally**, we structured our analysis and selected excerpts into a coherent narrative.

Ethical Considerations

The study was conducted in accordance with the Queen's University General Ethics Board (GREB) (TRAQ 6038846), approved on June 26, 2023, and the University of Gondar Institutional Research Ethics Review Committee (IRERC), approved on August 16, 2024. Participation in the study was voluntary, and informed consent was obtained from all participants. For children under 18, both their assent and their caregivers' consent were obtained. We explained the study's purpose, procedures, potential risks and benefits, participants' right to withdraw at any time without penalty and confidentiality. Accessibility accommodations were arranged for each participant, including interview locations, personal assistants, and sign language translators as required.

RESULTS

Persons with disabilities, seven males and five females, aged 14 to 45, participated. Half of the participants were under 18 years old, and the other half were adults. In terms of disability type, nine had physical disabilities (mobility and cerebral palsy), two had sensory disabilities (hearing and visual), and one had intellectual disability. Neighbours consisted of eight females and one male, aged 30 to 43. The duration of the relationships between the persons with disabilities and their neighbours spanned from 7 to 17 years.

Table 2: Themes and Sub-themes

No	Theme	Subtheme
1	Types of Natural Support	Basic Needs Support Educational Support Emotional Support Information and Advocacy Support
2	"የሰው ጌጡ ሰው ነው"(People are the Beauty of the People): Why the Community Supports Persons with Disabilities	

3	Reciprocity: Persons with Disabilities Supporting the Community	
4	Seeking Improvement in Natural Support	Creating Community Awareness Medical and Livelihood Support for Caregivers Enabling Social Networks of Persons with Disabilities

Types of Natural Support

The findings indicate families, friends and neighbours are the primary source of natural support for persons with disabilities in the community. We identified four major types of natural support: (1) basic needs support, (2) educational support, (3) emotional support, and (4) information and advocacy support.

Basic Needs Support

Participants identified receiving or giving support for basic needs through nutritional, material, and financial resources, as well as support for routine daily activities. Nutritional support included groceries, while material support consisted of clothing and personal care items. Financial support refers to the money received as gifts or loans to cover basic needs, such as food and housing. All neighbours mentioned providing food, especially during the holidays, when individuals faced challenges accessing food. A neighbour (code 03, age 38, female) noted:

I do not have any money myself. However, whenever I have something to eat, I invite her [a person with a disability] over to my place. Inviting her into my home is my way of expressing my love for her. We share whatever little I have and spend joyful holidays together.

Neighbours invited persons with disabilities to celebrate and eat together when they organized activities in the church. A person with visual impairment (code 033, age 29, female) mentioned:

My neighbours invite me; I eat and drink. I have a neighbour who has helped me get here from the sixth grade until now [now, she is a University student]. … She helps me with anything I need. She gave me beans, chickpeas, pepper, salt, and powder.

Persons with disabilities received material support from their families, neighbours and friends, including clothing. Persons with disabilities noted that they received material support during special occasions, such as weddings, baptisms, funerals, and religious events. During these occasions, materials are required to build temporary shelters and to prepare food for guests. These materials are typically purchased by a collective composed of community members who divide the costs among themselves and use the resources exclusively. According to persons with disabilities, they accessed these materials for free thanks to their neighbours' willingness to support them. A person with visual impairment (code 033, age 29, female) noted, "*When I have any events, I bring cups, dishes, and tents and use them like anyone else from the collective for free of charge.*"

Financial support was provided in the form of gifts and loans. Neighbours described this support as a crucial means of addressing the immediate needs of persons with disabilities and mitigating their challenges. A person with physical impairment (code 031, age 45, female) observed that "*neighbours are nice to me. When I tell them that I am in trouble, they lend me money. They also give me money as a gift when I need it.*"

Another form of support received by persons with disabilities is assistance with daily activities. This included help for routine activities, such as using the washroom, eating, changing sleeping positions, personal care, mobility assistance, and household chores. Temporary home care was provided by neighbours and other family members when primary caregivers were unavailable. Participants with disabilities and neighbours reported that family members sometimes entrusted neighbours with the care of their children with disabilities when they needed to work or engage in social responsibilities. One neighbour

(code 03, age 38, female) remarked: "*As neighbours, we need to support the child [with a disability] when her mother is not around, treat her like our own child, and be there for her. Feeding her and assisting her in using the restroom means a lot.*"

Persons with cerebral palsy and mobility impairments corroborated that they received temporary home care from neighbours, friends and extended family members. A person with cerebral palsy (code 01, age 14, female) described:

My mother goes to work at 5 am every morning, and during that time, she keeps the door locked while I stay inside. Our neighbours help by unlocking the door and providing me with breakfast. Whenever I need to use the restroom, they are always there to help me get there. I can't move my wheelchair on my own and always rely on support from my neighbours.

Neighbours described providing personal care and mobility assistance. Mobility support included helping persons with disabilities outside their homes for activities such as attending church and social events, while in-home support involved assisting them with mobility within their homes. Participants with mobility impairments and cerebral palsy confirmed receiving such support from their parents, siblings, friends and neighbours. A person with a physical disability (code 020, age 23, male) indicated, *"They [neighbours] help me get out of bed and assist me as I move into my wheelchair. They push my wheelchair and walk alongside me, ensuring I move safely. Whenever I need a haircut, they even cut my hair themselves."*

Educational Support

Persons with disabilities attending school reported receiving various forms of educational support from their families, neighbours, and friends, including transportation to and from school, stationery, encouragement, tutoring, and help with reading and writing. Persons with disabilities affirmed that their parents or primary caregivers were the main sources of educational support. However, these primary caregivers often faced economic challenges, as their caregiving responsibilities affected their ability to generate income. In such cases, siblings and extended family members played a significant role in providing educational materials and covering transportation costs. A person with physical disability (code 025, age 17, male) commented:

Usually, it is my mother whom I ask to buy me paper, markers, exercise books and pens. She buys them if she has money. ... My aunties tell me to let them know what I want them to buy for me. They bought me a school bag and gave me money for transport since the school I attend is far from [home]. I pay sixty birr for a round trip every day. I spend a lot of money on a cart to travel to school. My brothers also cover that cost.

Persons with physical impairments received mobility support to and from school from neighbours and friends, especially when primary caregivers were unavailable. For example, a neighbour (code 017, age 36, female) reported that "*When his mother was sick, I paid one thousand birrs for a Bajaji [three-wheeled electric vehicle] transport to take him [a person with a disability] to school and bring him back home. As much as I could, I support him so that he does not drop out.*" Those with disabilities highlighted that this support was critical for their education. Without natural support from the school or community, participants often could not attend school, particularly when their primary caregivers faced health issues and work commitments. A person with cerebral palsy (code 01, age 14, female) explained:

My mother has epilepsy. Every time she has a seizure, our neighbours bring me to school and return me home. Oftentimes, the organization my mother works for does not let her leave early to pick me up from school. When that happens, friends from my neighbourhood take me home. My mother tells our neighbours that she cannot come and asks for their support in taking me home. It takes me 30 minutes to get to school, and my friends also take me there and bring me home.

Typically, persons without visual impairments read printed materials aloud for those with visual impairments. This participant (code 033, age 29, female) described, "*My friends are very supportive. They read to me when I study. They made me reach this level. …I pay a lot of*

money to readers, but friends read for free. I think their reading support is worth more than money." A participant with a hearing impairment also mentioned receiving writing support from friends to help compensate for the lack of sign-language skills among teachers. The participant (code 036, age 19, female) stated:

While the teachers are teaching in class, I learn by watching what they write on the blackboard and reading their lips because the courses are not given using sign language. But my friends at school allowed me to write down what I did not understand [through lip-reading] and what the teachers did not write on the blackboard. I copied from a friend's notebooks. Friends are good at helping me with that.

All participants with disabilities and their neighbours described encouragement as vital support and an important motivating factor, enabling persons with disabilities to continue their education. A neighbour (code 030, age 43, female) indicated, "*I encourage him to study with my children, to write, to learn, and to achieve a great level. I give him counselling support, saying 'learn your lesson, and you will teach the people who insulted you because of your disability'*"

Emotional Support

Emotional support for persons with disabilities included: (a) offering advice and encouragement, (b) spending time or playing together, and (c) treating persons with disabilities equally. These supports demonstrated care, acceptance and respect. Neighbours emphasized that love and acceptance are essential supports that everyone should extend to persons with disabilities. One neighbour (code 03, age 38, female) described:

What matters most to her [a person with a disability] is love. I believe that love comes first. Material support is secondary. She [a person with a disability] needs to feel loved above all else. We must give them love and our time. Even dedicating just 20 minutes to speaking with them can provide them with hope.

Persons with disabilities received advice and inspiration from family, neighbours, and friends to help them cope with the stress associated with their disabilities and the stigma they faced, while also motivating them to become better individuals in the future. They confirmed that such encouragement significantly enhanced their emotional well-being. Both persons with disabilities and their neighbours highlighted that natural support providers with an optimistic attitude offered valuable encouragement and advice. Neighbours noted that advice was the main type of help they provided and one of the easiest ways to support persons with disabilities. Participants with disabilities reported that this support increased their commitment to academic success, nurtured their passions, enhanced their emotional well-being, and fostered a positive attitude toward themselves and their community. A person with physical disability (code 025, age 17, male) described:

My brothers and neighbours encourage me to keep painting and be successful. I have a cousin who is a teacher. He encouraged me to ask him anything he could help with. …They [families, friends and neighbours] encourage me to keep going, continue painting, and become successful.

Participants with disabilities often faced bullying and stigma. In these cases, they observed that advice and encouragement motivated them to envision a better future and to recognize the community's lack of awareness. They indicated that natural support providers were crucial to their emotional well-being by offering hope through advice and encouragement. A person with visual impairment (code 033, age 29, female) remarked:

I focus my attention on those who encouraged me. It gives me hope. I got to this level by following people who encouraged me. This is the biggest role of support. When people give you advice and encouragement, you feel like anyone else, and you tend to forget your disability. It makes you think that you will be successful and help other people.

Participants with disabilities noted that spending time and playing as equals with family, neighbours, and friends was an important source of emotional support, helping to protect them from feelings of isolation and discrimination. Both persons with disabilities

and their neighbours highlighted that these interactions contributed to a sense of belonging and inclusion within their families, communities, and social circles. A person with physical disability (code 020, age 23, male) recounted:

[Families and neighbours] see me as a person, not someone defined by a disability. They never hurt my feelings. They know what I want, and they make it happen. Sometimes, I tell them what I need, and they do it.

Those with severe impairments (cerebral palsy) reported that they were often confined to their homes and relied on friends and neighbours to visit, which strengthened their sense of belonging: "*We [families] play with toys. He [friend] brings me toys and play materials, and he brings kids over to my place when I ask him. … My cousins also come to play with me.*" (Code 07, age 15, male).

Information and Advocacy Support

Persons with disabilities reported receiving information and advocacy support from their families, friends, and neighbours. Neighbours confirmed providing this support, helping to challenge negative community attitudes, facilitate social interactions, advocate for medical access, and refer participants to potential formal support resources. Additionally, participants reported that advocacy from families, neighbours, and friends was essential not only for addressing their immediate needs but also for promoting inclusion in education, employment, and safety-net programs. A neighbour of a person with disability (code 08, age 30, female) noted:

I always talk to our neighbours and ask them why they don't stop their children from laughing at others because of their disability. I also tell them: "You have a child too. You never know what the future holds for your own child. So you should not allow them to hurt others because of their disability; instead, you have to support them." I ask them why they don't invite them during holidays.

Persons with disabilities highlighted that they often had limited mobility and faced challenges accessing information about formal government support. They emphasized the vital role natural support providers play in informing them of formal community supports. Families, neighbours, and friends shared information about organizations that can assist with medical costs, including community-based rehabilitation programs. They also provided information on how to access free health insurance from the Kebele (the smallest administrative unit of Ethiopia). Not only did they provide information, but families, friends, and neighbours also contacted potential organizations directly on behalf of the person with disabilities. A person with cerebral palsy (code 016, age 14, male) noted:

They [natural support providers] inform me whenever there is support available from the Kebele for persons with disabilities. …Then, once I was identified, the Kebele enrolled me as a beneficiary. They [natural support providers] communicate with the Kebele administrators to ensure I receive assistance whenever there are opportunities. …The local community reported my situation, indicating that I need support. ...Due to this community information, I received educational materials.

'የሰው ጌጡ ሰው ነው': [People are the Beauty of the People]: Why the Community Supports Persons with Disabilities

In this theme, participants with disabilities explained the reasons their natural support providers help them, while neighbours shared their reasons for offering support. Participants mentioned four major reasons: social and cultural value, creating a better future for persons with disabilities, religious teaching, and their residences being in close proximity.

The primary reason was the social and cultural value of interdependence and mutual assistance within the community. For example, the proverb 'የሰው ጌጡ ሰው ነው' (code 031, age 45, female) underscores the value of one human being to another, emphasizing human

connection, solidarity, and mutual support. Another key reason was a sense of responsibility. Participants indicated that primary caregivers were considered the sole responsible individuals for supporting their loved ones with disabilities.

Additionally, participants noted that support providers were motivated by the desire to create a better future for persons with disabilities. All neighbours expressed their hope for a better future for persons with disabilities. A neighbour (code 03, age 38, female) noted:

She [neighbour with a disability] holds a special place in my heart. She is like a daughter to me. Even though I am not her biological mother, I care for her deeply. She will have a better life in the future. Her current situation will not be permanent. Nobody knows what the future holds for her. She will graduate and lead a better life.

All neighbours highlighted that religious beliefs, which encourage mutual support, also motivated them to help disadvantaged groups, including persons with disabilities. These neighbours mentioned their commitment to religious principles as a reason for providing support. A neighbour (code 019, age 35, female) confirmed that *"God has instructed us to support one another and live together. Therefore, it is a must to help each other. Regardless of their religious background, people should support one another within their means. That's why I am supporting them."*

Finally, both persons with disabilities and their neighbours confirmed that living in close proximity to each other was one of the reasons for providing support. This proximity made neighbours aware of the social and economic situations faced by persons with disabilities, motivating them to provide support.

Reciprocity: Persons with Disabilities Support the Community

This theme discusses the reciprocal support experiences of persons with disabilities provided to their natural support providers, such as help with household chores, emotional support, financial and material assistance, and educational support. A woman with a physical disability (code 031, age 45, female) noted, "*Nowadays, if you always look for support from them, they will get tired of you and may even stop supporting you. Therefore, I will do what I can for them as well.*" Similarly, all neighbours stated that reciprocity is essential for maintaining their support networks and that they view it as a mutual obligation, in which individuals with disabilities and neighbours give and receive support based on their abilities.

Persons with disabilities described how they supported their families, friends, and neighbours by making coffee, washing clothes, baking injera, cooking, and cleaning. They explained that the support they offered to their natural support providers not only sustained their networks but also served to repay the support they received. A person with an intellectual disability (code 012, age 25, female) stated:

I wash their clothes in return for what they do to me. I can do nothing to support them other than do their laundry. I sometimes cook for them. I support my friend when she gets sick. I offer her something in my abilities. I help her as she helps me. When she needs me, I respond promptly and provide her with the support she needs.

Persons with disabilities shared that they provided emotional support to their natural support providers, encouraging them to become resilient and optimistic in facing the challenges they encountered. They believed that the challenging experiences they had endured due to their disabilities strengthened the emotional support they were able to offer others. A person with physical disability (code 020, age 23, male) discussed:

I encourage my friends and neighbours not to give up and to be as strong as I am. I tell them to go to school, gain power. In the neighbourhood, you can see families in need. I encourage these families to stay strong and know that better days are ahead. I advise everyone in the neighbourhood to stay resilient and look forward to the rewards of tomorrow. That's how I motivate my family, friends, and neighbours.

Neighbours acknowledged receiving emotional support from persons with disabilities, describing it as advice, spending time together, and exchanging ideas. A neighbour (code 026, age 32, female) confirmed that "*she gives us advice and helps us. She is with us during both good and difficult times. We laugh and play together.*"

Persons with disabilities discussed the financial and material support they provided to their natural support providers, including money, food, and household items. A person with a physical disability (code 031, age 45, female) noted:

I feed them [family] if I have. I give not only to my family but also to the neighbourhood. I do not request a return for those who took a loan from me unless they remember and return it to me. If I have money and there are people in need like me, I will share it with them. Often, if they ask me for a loan, I have loaned it to them. I invite them to have coffee and breakfast.

Persons with disabilities discussed the educational support they provided to others. This support came from children with disabilities who offered academic assistance to their natural support providers, both in school and at home. For example, a participant with cerebral palsy (code 016, age 14, male) shared, "*I am very good to my friends. I lend them pens, exercise books, and textbooks. I motivate them in their mathematics education. I encourage them as they encouraged me. I let them study with me.*"

Areas of Improvement in Natural Support

Although persons with disabilities reported receiving a wide range of natural supports, both participants with disability and their neighbours identified three key areas requiring improvement in order to enhance natural support: raising community awareness, providing medical and livelihood support for caregivers, and strengthening social networks of persons with disabilities.

Creating Community Awareness

Despite having people who provide different forms of natural support, there are also others in the community, including family members, neighbours and the school communities who contribute to stigma and discrimination against persons with disabilities. To address this problem, participants emphasized the need for awareness creation to expand and strengthen natural support within the community.

Persons with disabilities emphasized that stigmatizing community attitudes foster social distance and exclusion, thereby restricting opportunities to develop informal relationships that often form the basis of natural support. They reported that the community believes the impairments of persons with disabilities can be transmitted to others. Neighbours also confirmed that some community members did not understand disability and its impact on persons with disabilities. According to them, this lack of understanding hindered the provision of natural support from the community for persons with disabilities. Both groups noted that this misunderstanding was evident in both schools and neighbourhoods. A person with cerebral palsy (code 01, age 14, female) stated:

We used to live in a rented house. The owner of the house used to give us a hard time. I used a bedpan, and they used to prohibit her [mother] from emptying the bedpan into the toilet, thinking that they [owner of the house] would acquire my disability.

Persons with disabilities who were students reported experiencing stigma from peers. They found it more challenging when there was no formal support from the school. This stigma hindered their access to support from their peers and participation in extracurricular activities. A student with a hearing impairment (code 036, age 19, female) described:

Many children pointed to me, saying, "She is deaf", and at that moment, I felt bad. I do not participate [playing with peers in school] because I am the only one who is deaf. When I go to play with them, I see them point out that she is deaf, and I feel awful, and I sit. They laugh and play, and I sit holding my bag.

Persons with disabilities noted that some families lacked awareness about disability, especially in rural areas. This limited support from parents, extended families, and siblings forced some persons with disabilities to migrate to urban areas in search of better support options. A person with visual impairment (code 033, age 29, female) noted:

Due to the loss of my eyesight, my family did not want to help me or teach me, and I left them to [go to] the city to find support. I saw many things done for them [my other siblings], but my family didn't want to do it for me. I was born in a rural community where there was no education. I think that my poor health made them not pay attention to me.

In addition, participants commented on the mistaken belief that persons with disabilities were not capable of reciprocal support. They stated that persons with disabilities were often seen solely as recipients rather than providers of support. A person with physical disability (code 031, age 45, female) stated, "*Sometimes, I think the reason the neighbours believe that we may not be capable of supporting them is that my husband, my children, and I are disabled. They think I can't help them in return when they help me.*"

Medical and Livelihood Support for Caregivers

Health problems of caregivers can hinder persons with disabilities' access to natural support. Nine participants with disabilities confirmed that when their primary caregivers became ill, their natural support diminished, increasing their challenges. The data showed that this problem worsened when persons with disabilities and their families had weak social networks among peers, neighbours, extended family, and siblings. Consequently, persons with disabilities and neighbours expressed a desire for medical support for caregivers and for continued access to natural supports when primary caregivers experience health issues. A person with cerebral palsy (code 01, age 14, female) noted:

The major challenge I face is when my mother gets ill. I find it difficult to use the restroom unless my mother is around to support me. I want to get immediate medical support for my mother when she gets ill. Even though others support me, my mom is the one who supports me in a way I need.

To effectively support persons with disabilities, participants indicated that it was essential to provide livelihood support for caregivers. Persons with disabilities noted that many caregivers faced reduced employment opportunities and heightened financial strain due to their caregiving responsibilities. As persons with disabilities observed, improvements to livelihood support for caregivers would be essential to sustaining the natural supports they received.

Enabling Social Networks of Persons with Disabilities

Persons with disabilities emphasized the vital importance of fostering positive relationships with neighbours, friends, and family, not only for building and maintaining social networks, but also for ensuring the sustainability of natural support. Persons with disabilities and all neighbours stressed the importance of social networks for persons with disabilities. However, participants with disabilities expressed challenges in building these networks, which affected their ability to access natural support beyond primary caregivers. Factors, such as conflict with family members, parental overprotection, and negative attitudes from extended family, hindered their social networks. Among these, caregiver overprotection was identified as a significant factor limiting the development of social networks. A person with hearing impairment (code 036, age 19, female) disclosed:

I do not even have a friend. I am not even allowed to play with friends. I just do housework. The house is always closed, and no friend comes because it is said that a friend is not good at this time. … I would like to play with them, have fun, tell jokes, and laugh with them. … My father is very controlling and wants me to sit at home and never wants me to go out and meet people.

DISCUSSION

The aim of this study was to describe natural support experiences and to better understand how natural support could be enabled for persons with disabilities, using the perspectives of both persons with disabilities and their neighbours. Including neighbours' perspectives highlights the importance of natural support grounded in their own views, rather than relying solely on the perspective of persons with disabilities. Neighbours play a significant role in providing natural supports embedded within community contexts. These perspectives broaden understanding of natural supports and underline the value of non-familial relationships in maintaining mutual support, as they show how natural support emerges from mutual willingness, trust, and social networks.

We have learned that natural support plays a crucial role in the lives of persons with disabilities, assisting with daily activities, meeting basic needs, offering emotional and educational support, and providing information and advocacy. These findings are best understood through the lens of Appreciative Inquiry, which highlighted existing strengths within neighbourhood relationships and community life that enable natural support for persons with disabilities. From an Appreciative Inquiry perspective, these findings reveal the everyday assets, relational strengths, and community capacities that exist and can be built upon to foster inclusion and belonging. This study is consistent with the findings of Sanderson et al. (2020) and Sanderson et al. (2019), who found that extended family and non-family supporters (friends and neighbours) provide temporary home care, personal care, mobility assistance, and support with household chores and recreation.

Our study confirmed that persons with disabilities experienced challenges in attending events outside their homes due to their mobility impairments. Nevertheless, the support they received from natural support providers enabled them to participate in activities outside their home, such as attending church and social events. Similarly, Sanderson et al. (2019) noted that adults with intellectual and developmental disabilities in the United States received the most extensive natural support in recreation, and that individuals who resided with their families had a higher level of daily activity support.

Our findings show that persons with disabilities receive educational support from families, friends, and neighbours. Parents and primary caregivers are the main support providers, but their limited financial resources and caregiving responsibilities often create challenges. In these situations, extended families provide school materials, transportation, and encouragement. This suggests that natural support played a significant role in achieving academic inclusion for persons with disabilities, through immediate caregivers and broader family and social networks. Similarly, a study of postsecondary students with mobility impairments in Canada found that having someone to spend time with and talk to was crucial to an individual's educational success (Berry & Domene, 2015). A literature review by Rossetti & Keenan (2018) found that friends were crucial for educational support, including companionship, instrumental support such as information, practical help, and advocacy, and emotional support.

Our findings show that persons with disabilities receive both regular and occasional nutritional aid, often through grocery shopping, food sharing, clothing, personal care items, and financial assistance. These findings are consistent with the studies by Arnold & Harris (2025) and Friedman (2025), which indicate that families, neighbours and friends provide nutritional and financial assistance.

Our study highlighted that persons with disabilities received emotional support through advice, spending time together, playing, and equal treatment. These supports reflect the care, acceptance and value that significant others provide, making life more meaningful (Berry & Domene, 2015; Friedman, 2025). This suggests that emotional support enhances the sense of belonging among persons with disabilities within their families, friends, and neighbours. Consistent with our study, research on students with

disabilities in Canada found that natural support, such as encouragement and affirmation from family and friends, enhanced a sense of belonging, involvement in social interactions, and self-esteem (Berry & Domene, 2015; Nuri et al., 2025).

Finally, persons with disabilities and their neighbours acknowledged the role of advocacy and information in accessing both formal and natural supports. In a country like Ethiopia, without an organized, readily available system for disseminating information about disability related support, natural support is vital for persons with disabilities to obtain and explore support. This suggests that the community is not only a provider of direct support but also a source of advocacy and information. Similarly, Aldersey et al. (2025) noted that persons with disabilities often cannot access disability-related support without advocacy, and that this should be the collective responsibility of families, formal support providers, and the community.

Our findings suggest that natural support networks are particularly important for individuals with limited ability to advocate for themselves, and that these networks can also shape community attitudes, strengthen social connections, and connect persons with disabilities to available resources. Likewise, Nuri et al. (2025) found that natural support was essential for advocating for system change, access to employment and long-term financial goals for persons with disabilities.

Support Reciprocity

Our findings show that natural support relationships are reciprocal, with persons with disabilities actively supporting their friends, neighbours, and family members through household assistance, emotional care, educational support, and financial and material support. This suggests that our findings challenge the dominant tendency in disability research to frame support as flowing primarily towards persons with disabilities.

In the Ethiopian context, where previous studies have mainly emphasized the family as the primary source of support for persons with disabilities (Alemnh, 2025; Jemberu et al., 2023; Leeuw et al., 2024; Tesfaw et al., 2023), our findings extend this understanding by showing that persons with disabilities are not only recipients within these networks but also contributors. Similarly, previous studies suggest that persons with disabilities can offer various forms of support within their networks, although the forms of this support vary by disability type and context (Callus, 2017; Edwards & Loughnane, 2024; Giesbers et al., 2020; Liu et al., 2016; Naudé et al., 2024; Truesdale et al., 2021).

Our findings suggest that persons with disabilities provide instrumental and emotional support to friends, neighbours and family members, supporting existing evidence that they play meaningful and active roles within their social networks. Rossetti & Keenan (2018) similarly found that persons with disabilities offer companionship, instrumental and emotional support to friends. Through friendships, persons with disabilities offer emotional support and spend time together (Callus, 2017), thereby enhancing their social integration within the community (Liu et al., 2016). Our findings build on this literature by demonstrating that these reciprocal supports extend beyond friendship networks to include neighbour and family members. Additionally, Giesbers et al (2020) found that persons with mild intellectual disabilities view themselves as supportive to their families and create reciprocal relationships that involve both tangible and emotional support (Truesdale et al., 2021).

Our findings and the broader literature highlight natural support as a vital asset for fostering interdependence and sustaining networks among individuals with varying abilities (Edwards & Loughnane, 2024; Kittay, 2011). This perspective underscores that support involving persons with disabilities should not be viewed solely in terms of receipt of support, but rather as a mutual and relational process, highlighting the value of persons with disabilities within their communities. Our findings strengthen the theoretical lens of the ethics of care, dependency, and disability, which highlights that support is not an

unidirectional act but a dynamic and reciprocal exchange in which individuals give and receive support (Kittay, 2011).

Enabling Natural Support

Our findings also suggest areas for further improvements for natural supports to flourish. The main barriers identified were stigma, limited integration of health and livelihood services and fragile social networks. The findings further noted that low community awareness about disability restricts the support that family, friends and neighbours can provide. This indicates that community awareness-raising is a key strategy for strengthening natural support for persons with disabilities. These findings are consistent with previous studies showing that stigma, limited community understanding, and limited social networks can constrain natural supports (Harrison et al., 2021; Sanderson et al., 2020).

Strong social networks are central to natural supports, but our findings suggest that parental overcontrol limits these networks. This finding is consistent with studies showing that social isolation, limited mobility, and reduced self-determination often restrict persons with disabilities from building supportive relationships, especially those living in family homes (Friedman & Rizzolo, 2018; Hemm et al., 2018; Meral et al., 2023; Sanderson et al., 2020). Our findings suggest that organizations should prioritize social networking intervention to strengthen natural support, consistent with the recommendations from Friedman & Rizzolo (2018). Other studies also noted that preventive and inclusive strategies such as community groups, peer support, circles of support, and inclusive events are needed to build confidence and expand connections (Aldersey et al., 2025; Araten-Bergman & Bigby, 2022; Friedman, 2025; Sanderson et al., 2020, 2020).

Based on these findings, it is recommended that, in Ethiopia, where formal support is limited, the government and partners must recognize the value of natural supports for persons with disabilities and develop effective community-based programs. Policymakers should integrate disability inclusion into support strategies and enhance coordination between formal and natural support systems. Policies must encourage active involvement from families, neighbours, and local leaders. NGOs and service providers should implement disability awareness initiatives, strengthen social networks, and establish community support groups. Additionally, training for community members, religious leaders, and community-based organization workers can reduce stigma and improve support. These actions can transform natural support into a more intentional community resource.

Limitations

This study is not without limitations. The first author interviewed a person with a hearing impairment with the assistance of a sign language translator. During the interview, information may have been lost when the translator conveyed the questions to the participant and relayed the answers to the interviewer. Translating the study material from Amharic into English may also result in some loss of meaning. To minimize this meaning loss, this research material was translated by an expert in both Amharic and English, and the first and second authors of this study are also Amharic and English speakers, and they verified translations. Furthermore, the study features the perspectives of persons with disabilities and neighbours on natural support. Although these insights are essential, they could be further complemented with perspectives of family, such as siblings and extended family members, friends, or formal support providers. Finally, this study features perspectives from participants with diverse disability experiences, including persons with physical, intellectual, and sensory impairments. As such, the findings reflect general cross-disability experiences rather than insights into experiences of those with specific impairment categories. This diversity, although intentional to capture a

range of perspectives and experiences, may have limited our ability to deeply explore experiences unique to specific disability or impairment groups.

CONCLUSION

Persons with disabilities benefit from natural support provided by friends, neighbours, and family. These supports enhance various aspects of their lives. Although Ethiopian culture values interdependence and community support, stigma against persons with disabilities hinders natural support, underscoring the need for interventions to establish structured natural support systems. Given the limited formal support in Ethiopia, it is important to promote community assets to strengthen these networks and nurture natural support. However, relying solely on natural support without formal services can be risky, especially in an underfunded formal support system with low awareness about disability. Therefore, natural support should complement, not replace, inclusive policies and adequate professional support because natural networks alone are often uneven, fragile, and shaped by social stigma. While family, friends, and neighbours provide important emotional and instrumental supports, they cannot guarantee consistent access to rights and services. Inclusive policies and professional support are therefore essential to create a reliable system in which natural support strengthens inclusion rather than carrying the full burden of care.

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Original Research Article

Rising Above Stigma: Exploring the Coping Strategies of Adolescents with Albinism in Tanzania Through a Group Coping Intervention

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ABSTRACT

Aim: Adolescents with albinism in Tanzania regularly experience stigmatisation, yet little is known about their coping strategies or related interventions. This qualitative brief report aims to explore the stigma-coping strategies employed by adolescents with albinism, and to gain insight into the influence of peer support on those strategies through a group coping intervention.

Methods: Data were collected from ten Tanzanian adolescent girls with albinism who participated in four sessions of a group coping intervention, followed by individual interviews. One universal and one stigma-specific coping framework were used in the analysis.

Results: Data suggest that adolescents with albinism employed, prior to the intervention, mostly strategies related to disconfirming stereotypes, such as becoming educated. Through participation in the intervention, the participants mostly learned about coping strategies linked to primary and secondary control engagement, such as building self-acceptance and help-seeking, indicating some form of empowerment. All but one participant expressed a desire to continue meeting with the peers in their intervention group to discuss stigma and coping.

Conclusion and Implications: Adolescents with albinism in Tanzania possess a diverse range of strategies to cope with stigma. Group coping interventions can be beneficial for the development of complementary and potentially healthier stigma-coping strategies. Peer support could be a positive factor. More research into the careful implementation and interpretation of a group coping intervention for stigmatised youth is warranted.

Keywords: Group coping intervention, stigma-reduction intervention, qualitative, peer support, albinism, stigma, coping

INTRODUCTION

Oculocutaneous albinism is a genetic mutation causing hypopigmentation of the skin, eyes, and hair (Lund, 2005). In Tanzania, the prevalence of albinism is relatively high (UNICEF Tanzania, 2021). Around one in every 2,000 children is recorded born with

albinism, which is about six times higher than the average of one in 13,000 in European countries (Kromberg et al., 2023). In reality, the prevalence of people with albinism in Tanzania is estimated to be higher, as families can be hesitant to report the birth of a child with albinism due to fear of discrimination from community members (Lund & Roberts, 2018).

Prevailing myths about albinism cause an unsafe situation for people with the condition (de Groot, 2020). For instance, the birth of a child with albinism is seen as a curse (de Groot et al., 2023), body parts of a person with albinism are thought to bring good fortune when sold to a witchdoctor (Brocco, 2016), and having sexual intercourse with a person with albinism is believed to cure HIV (Nkrumah, 2020). As a result of these and other beliefs (Reimer-Kirkham et al., 2019), many people with albinism live in fear of abduction, rape, decapitation of body parts, and murder (Nkrumah, 2020). Up to 2024, there have been 208 reported attacks on people with albinism in Tanzania, of which 78 have been fatal (Under The Same Sun, 2024).

Stigma

Stigma refers to the stereotypes, prejudices, and discrimination expressed towards people who have a socially undesirable characteristic, causing a devalued perception of that person (Goffman, 1963). In Tanzania people with albinism experience stigmatisation on a day-to-day basis (Possi & Milinga, 2018; Nkrumah, 2020). A distinction can, among others, be made between public stigma, self-stigma and structural stigma (Corrigan et al., 2005; Herek, 2007). Public stigma refers to the expression of negative prejudices, stereotypes and actions against a population, while self-stigma is the internalisation of such views (Corrigan et al., 2005; Link & Phelan, 2001). Structural stigma acts at the societal level, where institutional practices work to the disadvantage of the stigmatised group (Link & Phelan, 2001). Stigma creates a threat to identity (Major & O'Brien, 2005), and adolescents may be more vulnerable to stigma's negative effects, since they are in a critical period for identity formation (Albarello et al., 2017). Experiencing stigmatisation can, among others, impact psychosocial wellbeing negatively and be a risk factor for suicidal ideation (Tambala-Kaliati et al., 2021).

Coping

According to Major and O'Brien (2005), coping with stigma and stress can reduce the impact on self-esteem, academic achievements and health. Coping, as defined by Compas et al. (2001, p. 89) is the "conscious, volitional efforts to regulate emotion, cognition, behaviour, physiology, and the environment in response to stressful events or circumstances". The Responses to Stress model (Connor-Smith et al., 2000) proposes that coping strategies can be distinguished into three universal categories: *primary control engagement coping*, *secondary control engagement coping*, and *disengagement coping* (Table 1). Primary and secondary control engagement coping are generally associated with positive psychological outcomes, whereas disengagement coping is generally associated with negative psychological outcomes (Connor-Smith et al., 2000). For coping with stigma especially, Moses (2015) identified two additional categories: *confrontational and aggressive coping*, and *disconfirming stereotypes* (Table 1). While both of these strategies can generate positive outcomes when used to some extent, excessive use may lead to backlash and increased stigmatisation (Moses, 2015).

Table 1: Categorisation of Coping Strategies

	Primary Control Engagement Coping	**Secondary Control Engagement Coping**	**Disengagement Coping**
Universal coping strategies (Connor-Smith et al., 2000)	Controlling or changing a stressful situation by altering objective conditions, such as the stressor itself or one's emotional response to the stressor.	Adapting to a stressor by means of cognitive restructuring.	Avoiding or denying a stressor and its effects.
	Confrontational and Aggressive Coping	**Disconfirming Stereotypes**	
Stigma-specific coping strategies (Moses, 2015)	Reacting verbally or physically to people enacting stigmatisation.	Behaving contrary to the stereotype of one's stigma.	

Interventions to address self-stigma

Reviews looking into stigma reduction interventions beyond a specific stigmatised label, such as having a mental health condition or being a refugee, have shown that adults are targeted more than children, and that only a minority of interventions address self-stigmatisation and coping (Majeed et al., 2024; Hartog et al., 2020). Self-stigma reduction interventions include (individual and group) counselling and peer support groups, among others (Hartog et al., 2020). In a trusting environment of people who have all experienced stigma, a peer support group is defined by mutual support and information exchange among participants, sharing life experiences, exchanging problem-solving advice, and taking collective action (Hartog et al., 2020). Multiple studies have shown the positive influence of peer support interventions on the quality of life of stigmatised populations, such as the reduction of social isolation and feelings of shame, an increase in feelings of empowerment, a greater sense of own wellbeing, and the creation of social ties which increases social and emotional support (Bunning et al., 2020; He et al., 2024; Paudel & Baral, 2015). Furthermore, peer support groups have demonstrated their capacity to aid the development of positive self-concepts and identity, and increase action for change and social integration (Bunning et al., 2020; Dale et al., 2016; Heijnders & Van der Meij, 2007).

Peer support groups may also benefit participants' coping abilities through the sharing of coping strategies, though in most studies this is a secondary focus (e.g. Bunning et al., 2020; He et al., 2024; Paudel & Baral, 2015). Few studies explore peer support groups primarily focusing on the development and strengthening of coping strategies (i.e., group coping intervention). Fuster-Ruize de Apodaca et al. (2016) demonstrated the benefits of a group coping intervention for people living with HIV. The intervention reduced perceived stigma, increased participants' self-efficacy to cope with stigma, increased their usage of coping strategies, and improved their self-esteem and quality of life. Gaebel et al. (2019) and Luoma et al. (2023) found varying results, yet both studies highlighted the importance of further research on group coping interventions for stigmatised populations.

The Current Research

The potential benefits that group coping interventions offer for stigmatised populations may also extend to adolescents with albinism in Tanzania. However, to our knowledge, no studies have yet addressed this. Therefore, this exploratory research aimed to gain preliminary insights into which coping strategies adolescents are using, and in what way a group coping intervention influences the development of such strategies.

METHODS

Participants

To explore the stigma-coping strategies and the related workings of a group coping intervention for adolescents with albinism in Tanzania, the current brief report describes participants' engagement in a group coping intervention, followed by conducting individual interviews. In total, 10 adolescents between 14 and 17 years old with albinism were purposefully approached and they all participated in the current research. All participants were recruited from an all-girls secondary boarding school in Tanzania's Lake Region, as the prevalence of albinism is relatively high in that region (Nkrumah, 2020). To increase the intervention's sustainability, it was desirable to conduct the research at a location where adolescents with albinism met naturally. The boarding school, a common way of schooling in Tanzania, in question was purposefully selected, since the relatively large number of adolescents with albinism living at that school could easily continue seeking each other's support after the intervention ended.

Group coping intervention

The group coping intervention was inspired by recent work (Hartog et al., 2023). Table 2 illustrates the flow of the research alongside the implementation of the intervention: four group intervention sessions, followed by individual interviews. By the completion of the intervention, four goals were intended to be reached: (a) recognition of existing coping strategies; (b) the participants' development of their own stigma-coping strategies, (c) the participants' empowerment and the reduction of experienced (self) stigma, (d) the enablement of social support and learning between participants.

After the first collective session, participants were divided into two groups. Groups were based on participants' ages, in case this would influence their understanding of stigma, and to create a non-hierarchical environment. All intervention sessions were held in Swahili, facilitated and guided by the researcher with the assistance of an English translator. The intervention sessions lasted one hour and 10 minutes, one hour and 20 minutes, one hour, and 35 minutes, respectively. There were six, three, and four days between the intervention sessions, respectively.

Table 2: Flow of the research alongside the implementation of the intervention

Group Coping Intervention	Data collection
Session 1: Identity reflection. Participants shared identities. Other participants reacted in one of two ways expressively: agreement (if identity applied to them too) or appreciation (if identity did not apply to them). Followed by a group reflection on identity. Duration: 1h10min Pax: 9	
Session 2: Board game. Participants developed a narrative of a main character with albinism, who encounters stigma. They identified ways for the main character to cope with stigma, inspired by included coping strategies in the intervention material. Followed by participants writing a personal development goal, and with which coping strategies they intend to reach this resolution. Duration: 1h20 min. Pax: 5 + 5	i. Unstructured observations ii. Recorded and transcribed conversations iii. Intervention material
iv. Session 3: Reflection. Participants wrote their personal goals (session 2) on a personal worksheet. They wrote which strategies they had tried and were planning on trying, and how. Tracing symbols on the worksheet (i.e. a star)	

helped the participants to track how far they had come with their personal goal. v. Duration: 1h vi. Pax: 5 + 4	
vii. Session 4: Maladaptive strategies. Participants worked on an additional worksheet. Each participant studied and presented one maladaptive coping strategy on the sheet. Participants evaluated whether it was a good or a bad strategy by marking a 1-10 scale. Followed by reflection. viii. Duration: 35 min. ix. Pax: 5 + 5	
x. Interviews: Individual interviews were conducted with each participant xi. Duration: 20 min.	xii. Recorded and transcribed interviews (20-30min) with the participants

Data collection methods

A qualitative approach was chosen for the current research, to explore whether and how discussions between participants would influence their opinions or usage of particular coping strategies. Data were collected through i) observations from each intervention session; ii) structured notes of visual observations; iii) intervention materials such as worksheets; and iv) 20 to 30 minute individual semi-structured interviews. In the interviews, participants were asked how they experienced the intervention, and whether it had influenced their usage of coping strategies. In an attempt to ensure validity, questions were based on the Responses to Stress Questionnaire (Connor-Smith et al., 2000), as well as on existing literature on stigma-coping strategies in other African contexts (Folayan et al., 2016; Moses, 2015; Mutumba et al., 2015). All data were recorded and transcribed.

Procedure

Ethical clearance was provided by Utrecht University. All participants provided informed consent, with additional mandatory parental consent for participants under 16 years. Parental consent was provided orally via phone call, since all participants lived at the boarding school. The matron of the school signed the consent form on the parents' behalf.

Data analysis

Data were coded using NVivo software and analysed using both deductive and inductive analysis. Deductive codes consisted of all intervention-provided coping strategies. Additionally, inductive codes were developed, related to additional coping strategies participants mentioned. Both deductive and inductive codes were grouped together thematically, according to the categorisation in Table 1. In each category, the reasoning for participants to use or not use a strategy was coded and compared to the reasoning mentioned for strategies in other categories. Furthermore, a comparison was made between strategies participants said to be performing before the intervention and those after. Lastly, the observations served to evaluate the intervention's execution.

FINDINGS

Coping Strategies

Table 3 displays all coping strategies participants mentioned. These are further elaborated on below, categorised as per Table 1.

Primary control engagement coping

When asked how participants cope by controlling or changing a stigmatising situation, the majority responded that they make efforts to reduce the stigmatising behaviours of others. For instance, six participants explained they stand up for themselves by educating others on the biological aspects of albinism, hoping to demonstrate the irrelevance of the differences between people with and without albinism:

> *I will sometimes need to explain to them and educate them about my situation. Because sometimes they might call me zeru zeru, which is not a good name to be called as a person with albinism. So, I will just go and tell them "You are not supposed to call me zeru zeru because I am just a normal person, and my skin and my situation made me like this".*

Participants also mentioned more self-focused coping strategies. For instance, six participants explained that when they experience stigmatisation, conducting stress-release activities helped them to divert their anger and regain their calm. As one participant recounted: "Sometimes you might bump into a group of people that say bad words to you. And then you get so mad, and then you think 'Okay now let me just go do some exercise or just go and sing', so I release my stress".

Table 3: Number of Participants Mentioning a Particular Coping Strategy

Coping strategy	Rejection	Appreciation	Usage	Total appreciation/ usage
Primary control engagement coping				
Educating others*	1	5	5	6
Conducting stress-release activities*	-	6	3	6
Asking for help	-	4	-	4
Seeking social-emotional support*	-	2	3	3
Seeking religious support*	-	3	2	3
Reporting to a teacher	-	2	1	3
Seeking psychological assistance*	-	1	-	1
Being kind	4	-	-	-
Secondary control engagement coping				
Building self-acceptance*	-	6	5	9
Learning from others*	-	3	3	4
Accepting the situation*	-	-	3	3
Feeling useful*	-	2	2	2
Using humour*	-	-	1	1
Disengagement coping				
Avoiding situations*	-	10	5	10
Ignoring*	3	5	3	5
Finding distraction*	4	-	1	1
Confrontational and aggressive coping				
Standing up for oneself*	-	2	4	4
Using verbal/ physical aggression*	7	3	1	4
Disconfirming stereotypes				
Becoming educated*	-	7	6	7
Managing the condition*	-	5	3	5
Joining a group*	1	4	4	5
Disconfirming stereotypes*	9	1	-	1

strategies participants criticised. *Appreciation* refers to strategies participants praised and/or intended to try in the future. *Usage* refers to strategies participants mentioned they had carried out. Due to overlap between participants that appreciated and used particular strategies, *total appreciation/usage* is not necessarily the sum of those two categories.

Note 2: The strategies with a *-symbol are strategies featured in the intervention. Strategies without a *-symbol were brought up by participants without them being a structured part of the intervention.

Secondary control engagement coping

During the intervention, participants also discussed ways to cognitively adapt to stigmatisation, for example in the form of building self-acceptance. Participants used terms such as "feeling useful", "feeling important", "believing in myself", "knowing I am valuable" and "knowing I can do many things". During the interviews, five out of nine participants who said they intended to work on this strategy, mentioned they had in fact felt more self-acceptance over the past few days. As one participant expressed: "I started to feel important and to accept myself".

Disengagement coping

All participants were positive towards avoiding situations that might lead to stigmatisation. As one participant explained: "I will need to avoid any situation and people that will lead me to feel stigmatised". Contrary to this unanimity, there was more disagreement in participants' opinions on ignoring acute expressions of stigmatisation. Three participants rejected the coping strategy of ignoring, yet five participants appreciated it.

Confrontational and aggressive coping

When discussing confrontational responses to stigmatisation, four participants mentioned they would stand up or have stood up for themselves when people stigmatise them, for example by telling them off: "I will always tell them not to repeat [the bad words] again". There was some disagreement in the group whether using verbal and physical aggression when doing so was a good strategy or not. Seven participants rejected using verbal or physical aggression, whereas four participants appreciated the strategy, and two more were even dismissive towards being kind in general. Two participants contradicted themselves by appreciating verbal/ physical aggression during the intervention, yet rejecting it during the interviews.

Disconfirming stereotypes

Throughout the research, it became apparent that the vast majority of participants coped with stigmatisation through compensating for stereotypes related to their situation. For instance, seven participants spoke about becoming educated as a coping strategy. They reasoned that becoming educated is a way of securing community members' respect instead of their disdain. As one participant explained: "having the identity [albinism], … we need to study very hard so we can be respected".

Moreover, five participants spoke about how joining in structured groups can help them to blend in with peers without albinism. They hoped to show that they are just as 'normal' as anybody else, as the following quote illustrates:

> *I think it [to join a group] is a good strategy because it will get me to involve myself with normal persons. So, it is going to get easier for me to interact with others, because they are now getting used to me and seeing that I am normal.*

Participants stressed the need for the normalisation of people with albinism in the community on multiple occasions throughout the research. On the one hand, participants expressed their desire for others to treat them as equals, and on the other hand to feel 'normal' themselves. However, while not wearing their sunhat would strengthen 'blending in' with peers, all but one participant indicated they would not leave off their sunhat.

Participants' Experiences with the Group Coping Intervention

During the interviews, participants were asked which strategies they were already performing before the intervention, and which they had learnt as a result of the intervention. An overview can be found in Table 4. Overall, while previously-known coping mechanisms included more disconfirming stereotypes, the group intervention triggered participant learning about primary and secondary control engagement, including self-acceptance. The following quote illustrates this process: "When I read my (personal development) goals, I saw myself as an ordinary person, like the others".

Table 4: Coping Strategies Participants Learnt About Through Intervention Versus Used Before Intervention

Learnt About Through Intervention	Used Before Intervention
Building self-acceptance (5)*[S]	Becoming educated (4)* [DS]
Asking for help (3) [P]	Joining a group (3)* [DS]
Accepting the situation (2) [S]	Managing the condition (3) [DS]
Conducting stress release activities (2) [P]	Learning from others (2) [S]
Becoming educated (1)* [DS]	Building self-acceptance (1)* [S]
Joining a group (1)* [DS]	Avoiding situations (1) [DC]
Educating others (1)* [P]	Educating others (1)* [P]
Ignoring (1) [DC]	Seeking social-emotional support (1) [P]
	Seeking religious support (1) [P]

Note: The strategies with a * symbol are present in both columns. [P]=Primary control engagement; [S]=Secondary control engagement; [DC]=Disengagement; [DS]=Disconfirming stereotypes

Reflecting about coping mechanisms in a peer group was key to this intervention, to facilitate learning from and inspiration by peers. Implementation observation showed that participants seemed hesitant to speak up, although some participants, during the interviews, mentioned that they enjoyed the group discussions, with one participant indicating she had gained confidence from seeing her peers speak: "I was always looking who was so brave and confident in answering questions… They inspire me to have the confidence to answer questions". Concurrently, participants voiced their desire to join groups of peers without albinism, since this would benefit the process of their normalisation. Nevertheless, multiple participants voiced their enthusiasm for the intervention and all but one participant wanted to continue to seek contact with the girls in their intervention group for discussing various issues.

DISCUSSION

The current qualitative brief report explored the stigma-coping strategies of adolescent girls with albinism in Tanzania, and the influence of a group coping intervention on the development of such strategies. Ten adolescents with albinism participated in four sessions of a group coping intervention, followed by individual interviews. The small set-up of the research necessitates one to read the findings and conclusions with caution. The following section explores patterns of coping strategies, and reflects on the group coping intervention based on the identified research goals. We propose future research to explore group coping interventions for stigmatised populations based on below interpretations.

The intervention firstly aimed to support adolescents with albinism to recognise existing coping strategies. Participants seemed to conduct mostly coping strategies categorised under disconfirming stereotypes. The notion that adolescents actively adopt strategies to gain respect despite their condition may be interpreted to mean that it is challenging to gain respect in harmony with their condition. Instead of embracing the identity of having albinism, adolescents sought to compensate for it. In the situation where one is constantly aware of how others evaluate their identity so they can actively endure compensating behaviours, a social identity threat is ever-present (Major & Schmader, 2018). This identity threat is then not only imposed by others, but also by the self. In other words, the efforts adolescents in the current research make to reduce public stigma, might actually increase self-stigma. Compensating for one's identity in an attempt to reduce stigma is common with various stigmatised populations (Shih, 2004). Nevertheless, it is found that it leads to lower levels of self-esteem, higher levels of anxiety, and is viewed as a draining process that ultimately hurts individuals (Ilic et al., 2011; Miller & Myers, 1998; Shih, 2004). The constant demonstration of disconfirming stereotypes connects to one of the basic sources of stigmatisation, namely the enforcement of social norms (Phelan, Link and Dovidio, 2008). By educating others and joining in groups with peers without albinism, adolescents reasoned others would see how 'normal' they are, thereby reducing the source of stigmatisation. Furthermore, adolescents sought acceptance and respect from the community, for example by becoming educated, which would prove their status in society. Bradbury-Jones et al. (2018), Huang et al. (2020), Varkaneh et al. (2022) and Wan (2003) described similar findings for coping of people with albinism, who display themselves as activists, advocators, hard workers and role models, all in the effort for normality and blending in. Condition management as a strategy, by keeping on their sunhats, overruled the desire to blend in.

Secondly, the intervention aimed to let participants reflect about coping strategies currently unfamiliar to them. Participants seemed to have learnt most about strategies related to primary and secondary control engagement, such as building self-acceptance, asking for help and conducting stress-release activities. This could indicate that participation in this group coping intervention has triggered a shift from the psychologically taxing efforts to conform with local norms and obtain external validation (Major & O'Brien, 2005) to more internally focused adaptation and coping (Connor-Smith et al., 2000). Regarding building self-acceptance, findings of group-based interventions for other stigmatised populations have also indicated that people with HIV (Dale et al., 2016; Makoae et al., 2008; Paudel & Baral, 2015) as well as caregivers of children with disabilities (Bunning et al., 2020; He et al., 2024) reported more acceptance post-intervention. The current intervention's positive influence on the recognition of self-acceptance as a coping strategy can potentially be explained by findings of Bunning et al. (2020) and Makoae et al.'s (2008), which suggest that self-acceptance is fostered through peer support of others who face the same stigma. We can carefully assume that our participants found a level of social support in the group as they indicated enthusiasm to stay connected after the intervention.

Thirdly, the intervention aimed to contribute to participant empowerment and reduction of self-stigma. It can be argued that the recognition and appreciation of self-acceptance stimulates the reduction of self-stigma, since accepting oneself can help to counter feelings of shame and self-devaluation related to their stigma (Moses, 2015). Additionally, help-seeking, impeded by stigmatisation (Reimer-Kirkham et al., 2022) including self-stigmatisation (Cheng et al., 2018) seemed to be a newly recognised strategy emerging from the reflections, potentially linked to more self-acceptance or decreased self-stigma (Nickerson et al., 2020).

Lastly, the intervention aimed to create a supportive environment of learning between peers (Hartog et al., 2020). While indications were provided that engaging with peers with albinism was helpful, a desire for integration in groups with peers without albinism was omni-present. This could be explained by their need to fit in and 'be normal' (Phelan, Link and Dovidio, 2008), while on the other hand could be triggered by increased sense of self-acceptance, where they already see themselves fitting in, 'despite' their albinism.

Limitations

The researchers' positionality as Dutch researchers led to limitations. Firstly, the researchers may have interpreted findings from a Western perspective (Rhodes, 1994). Secondly, the usage of a translator might have influenced the results. The researchers attempted to manage both limitations by closely collaborating with the local NGO NELICO and the translator. Socially desirable answers due to social hierarchies in Tanzanian culture were minimised by emphasising there were no right or wrong answers throughout all stages of the research, however this still might have been at play. Thirdly, data were limited due to the sample size and the length of the interviews , therefore findings cannot be generalised. Data analysis was done by one researcher, though feedback was provided by co-authors. Additionally, the participants were not monitored in potential implementation of the newly acquired coping strategies. Still, the current research shows interesting findings, however conclusions should be drawn carefully.

CONCLUSION

Adolescents with albinism in Tanzania experience stigmatisation. In an all-girl secondary boarding school, a short group coping intervention expanded the coping strategies previously available to the participants, beyond the main use of disconfirming stereotypes strategies into primary and secondary control engagement coping, such as building self-acceptance and help-seeking. A group intervention with peers with albinism was appreciated, but the desire remained to belong to groups with peers without albinism. We urge other researchers to further study group coping interventions more rigorously.

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Review Article

Support and Services for Adolescents with Mental Health Issues in Ghana: A Narrative Review

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ABSTRACT

Aim: This narrative review explores and critically examines the current landscape of support systems for adolescents with mental health disorders and challenges (AMHCD) in Ghana, an area that has been unexplored and in need of extensive research.

Method: The study synthesised findings from literature accessed through computerized databases, manual searches, and grey literature.

Results: The review identified that the support system for AMHCD spans micro (family and individuals), mezzo (school and community), and macro (policy and healthcare systems) levels, offering both direct and indirect services. However, the themes identified reveal a significant disconnect between the levels of care, driven by limited resources, stigma, lack of trained professionals, and gaps between policies and practical implementation.

Conclusion: Unlike previous studies, this review underscored the need for more holistic services and offered valuable insights into Ghanaian adolescents' current mental health support systems. Doing so fills the gap in the literature by providing insight into the fragmented landscape of the support systems for AMHCD in Ghana to shine light on the issues, thereby promoting the need for further research to enhance support for this vulnerable population.

Implication: This review has important implications for policy implementation and key adolescent mental health support stakeholders. Policymakers can use these insights to improve services and make them more accessible to adolescents. Families and other actors in the ADMH support system will better understand available support, helping them seek appropriate care.

Keywords: adolescent, Ghana, mental health disorder, micro-mezzo-macro, support systems

INTRODUCTION

Mental health challenges are a broader term for psychological distress. In contrast, mental health disorders are conditions that meet international diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or the International Classification of Diseases, Tenth Edition (ICD-10). Ghana Mental Health Act (MHA, 2012) defines mental health disorders as "conditions of the mind in which there is a clinically significant disturbance of mental or behavioral functioning associated with distress or interference of daily life and manifesting as disturbance of speech, perception, mood, thought, volition, orientation or other cognitive functions to such degree as to be considered pathological but excludes social deviance without personal dysfunction". Though untreated mental health challenges can cause mental health disorders, disorders lead to mental health challenges such as stress, substance dependency, self-harm, suicidal ideation, strained relationships, poor academic performance, and increased interaction with the juvenile justice system (Murphey et al., 2013).

To prevent ambiguity in this review, 'mental health challenges' will be used throughout this paper to refer to broader psychosocial challenges, while 'mental health disorders' will refer to conditions that meet international diagnostic criteria. While diagnostic tools such as the DSM-5 and ICD-11 are commonly used in mental health assessments to distinguish between normal developmental behaviours and mental health disorders (Ame & Mfoafo-M'Carthy, 2016), some scholars argue that these tools may not fully capture culturally specific expressions of distress and explanatory models of disorders, leading to misdiagnosis or underdiagnoses of certain conditions (Patel & Hall, 2021). So, we must be mindful of these nuances in our usage of the word 'disorder', especially since most adolescents in Ghana who face risk factors that cause mental health disorders do not receive professional assessment for an official diagnosis, (Ame & Mfoafo-M'Carthy, 2016). Some mental health risk factors of Ghanaian adolescents are financial difficulties, stress, bullying, domestic violence, peer pressure, sexual health issues, HIV and STIs, nutrition, substance use, non-communicable diseases, injuries, violence, and exploitation, including child marriage, labour, and trafficking (Acquah et al., 2014; Addy et al., 2021; Ghana Health Service, 2016). Experiencing these stressors and traumatic events places adolescents at greater risk for developing mental health challenges and disorders. Research shows that 18.2% of Ghanaian youth have experienced suicidal thoughts, 22.5% have made suicide plans, and 22.2% have attempted suicide (Oppong et al., 2017). Ghanaian high school students also deal with academic stress, depression, and suicidal thoughts (Ahorsu et al., 2021). Moreover, 62% of Ghanaian youth report moderate to high levels of mental health disorders (Glozah & Pevalin, 2016), and 73% of homeless youth face severe mental health disorders (Dankyi & Huang, 2022).

Despite increasing recognition of mental health challenges and disorders among adolescents in Ghana, there is still limited empirical evidence on the mental health support systems available for them. Also, there is a lack of research that comprehensively identifies the levels of support available for adolescents with mental health challenges or disorders (AMHCD) in Ghana.

AIM OF THE REVIEW

There is a critical need for in-depth research to evaluate the scope and nature of support systems for AMHCD in Ghana. This narrative review outlines and critically explores the various levels of support accessible to Ghanaian AMHCD. By providing a comprehensive overview of current support and care for this demographic, this study aims to guide service users in navigating AMHCD support systems and inform future

policies and programs on culturally and contextually relevant mental health interventions.

METHODOLOGY

This review presents a comprehensive understanding of adolescent mental health care in Ghana by examining the support systems across the micro, mezzo, and macro levels of the social ecology surrounding adolescents. To contextualise the interconnectedness of these multi-levels, the researchers integrated secondary data from various sources to examine cultural and contextual factors in Ghana, as asserted by Collins and Fauser (2005). These factors included the family caregiving roles, stigma related to mental illness, explanatory models of mental health disorders, pathways to care, the structure of the local health system, and community-based care frameworks, all of which influenced both the selection of sources and the interpretation of findings within the Ghanaian context.

The authors utilized grey literature and authoritative texts from government agencies, international organizations, and reputable non-governmental institutions. Peer-reviewed articles from academic databases were also included to provide a more balanced overview of adolescent mental health support systems in Ghana. The authors acknowledge that a biomedical viewpoint may affect how the literature is viewed, due to their background in psychology and public health. The authors have used various sources, such as community-based research and grey literature, to mitigate bias.

Table 1: Sources of Literature

Literature Type	Source	Content of Literature
Reputable non-governmental institutions	- Mental Health Awareness Ghana - Ghana Mental Health Foundation - Basic Needs Ghana - Christian Health Association of Ghana - African Association of CAMH	Website contents from faith-based and professional organizations focused on child and adolescent or general mental health care in Ghana.
Authoritative Texts	- Ghana Mental Health Authority - Ghana Health Service - Ghana Education Service - Ministry of Health - Ghana Psychology Council	Content from official websites and reports from government agencies on mental health programs, plans, policies, and laws.
International Organizations	- World Health Organization - UNICEF	Reports and publications from international bodies with expertise in global mental health and adolescent care.
Peer-reviewed Articles	- PubMed - Google Scholar - African Journals Online	Academic research articles are sourced from databases that provide empirical data.

Note: Refer to the supplementary document for individual peer-reviewed articles included in the narrative review

Inclusion and Exclusion Criteria

The inclusion criteria used in the literature search included secondary studies focused on mental health challenges and disorders of adolescents aged 11-18, studies on support systems, mental health services, and relevant legislation and policies in Ghana. Studies outside Ghana and those before 2015 were excluded from the review to reflect the current picture of the country's adolescent mental health support since the

Adolescent Health Policy and the World Health Organization's 2021 Mental Health Situational Analysis in Ghana were introduced in 2016 and 2021, respectively. Also, most relevant adolescent mental health research in the country began after this period. Feasibility and pilot project studies, prevalence and predictive research, and assessment-focused studies were excluded since this review prioritized available adolescent mental health support over methodological, exploratory, or experimental studies.

Review process

The review process started with an initial screening of subjects, titles, and abstracts generated from keyword combinations like "adolescent mental health in Ghana," "adolescent mental health support, services, policies in Ghana," "barriers to adolescent mental health care in Ghana," and related terms. Additional search strings included variations like "child and adolescent mental health services Ghana," "adolescent mental health policy implementation Ghana," "challenges of adolescent mental health care Ghana," and "school-based mental health Ghana," to ensure a comprehensive capture of relevant literature across policy, service delivery, and access dimensions.

The authors employed a deductive thematic content analysis approach to explore the literature and identify meaningful patterns related to adolescent mental health support across their multi-level ecological systems. Two researchers independently read and summarised all eligible publications. They colour-coded common trends (e.g., family, peer, community, faith-based and religious healers, school-based support, clinical and health services, support from government, or non-governmental agencies, policies, barriers, and challenges) in how the literature responded to the research questions. Tentative categories and themes under micro, mezzo, and macro systems were developed through collaborative efforts by the researchers. To maximise trustworthiness, two additional researchers examined and analysed the emerging themes, and any disagreements were resolved through discussions until a consensus was reached on the final themes. The authors also used additional relevant data from unpublished reports and relevant web-based posts to address gaps not captured in the published literature. Using additional data to fill the gaps ensured a more comprehensive understanding of adolescent mental health support in Ghana, particularly where formal research was limited.

FINDINGS

The themes from the literature review showed that adolescents with mental health challenges are positioned within a multi-level support system of micro-level (family and individual), mezzo-level (school and community), and macro-level (policy and society), which all interact to determine their mental health outcomes. At the micro-level, direct support includes individualized care, which is complemented by mezzo-level care that encompasses community and school services, which provide broader and continuous support (Bajaj & Malhotra, 2009; Stabler et al., 2021). Macro-level support refers to broader and indirect societal assistance. Major themes identified represent direct support from individuals and organizations, and the types of direct services offered. On the other hand, themes related to indirect support encompass macro-level agencies that offer systemic support, relevant legislation and policies, and implementation of these policies and programs. Finally, recommendations to enhance the support already available were discussed.

Below is a diagram indicating the levels of AMHCD, which create a comprehensive system that improves the effectiveness and responsiveness of mental health care for adolescents in the country.

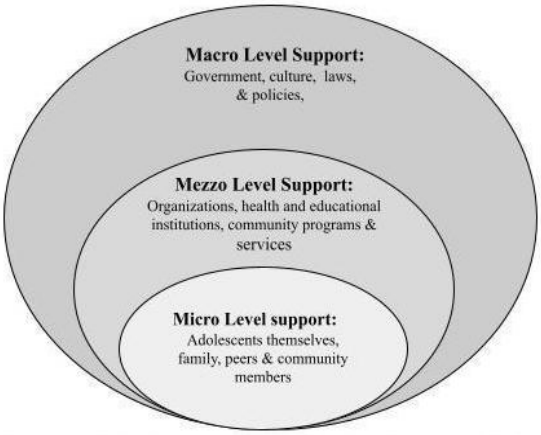

Figure 1: Levels of AMHCD Support Systems

Note: All levels of support within adolescent social ecology interact and influence one another. The micro and mezzo systems often work in close coordination to provide direct, immediate support to adolescents. In contrast, macro-level structures offer more indirect support by shaping the policies, resources, and culture that guide and constrain micro and mezzo-level intervention.

Micro and Mezzo-Level of Support through Direct Care

Individuals and Organizations that Provide Direct Care

The literature review highlighted the provision of direct emotional and mental health care and support from key individuals across various micro and mezzo levels of adolescent support systems. While some AMHCD actively support themselves by utilizing their coping practices, stakeholders such as parents, siblings, teachers, school guidance counselors, community members, traditional and faith-based healers, and health care professionals help to provide emotional and holistic support. These stakeholders together make up an integrated support network at the micro and mezzo levels of support to help address the multifaceted mental health needs of AMHCD.

Coping Practices and Help-Seeking Behaviours of AMHCD

In Ghana, adolescents use various coping strategies but show low help-seeking behaviours to manage stress and maintain mental wellness (Baidoo-Anu & Acquah, 2021). Many young people still avoid seeking help from more formal and professional practitioners. They often prefer engaging with religious and spiritual coping practices such as praying and church attendance (Glozah & Pevalin, 2016). Also, evidence suggests that adolescents in Ghana have low help-seeking behaviours (Addy et al., 2021; Adjorlolo et al., 2022) despite their exposure to multiple mental health risk factors like academic stress, interpersonal victimization, and substance misuse (Addy et al., 2021; Adjorlolo et al., 2022). This reluctance to seek help, particularly for mental health challenges, poses a risk to their long-term well-being. AMHCD's reliance on these practices may reflect cultural preferences for spiritually oriented support and internal emotional regulation. Also, reasons why they avoid professional help can be a sign of broader structural and attitudinal barriers, such as limited access and awareness of mental health care, confidentiality concerns about disclosure (Adjorlolo et al., 2022), or fear of social stigma for receiving formal care. Modifying treatment based on the answers to these concerns can help design culturally grounded mental health strategies

that both strengthen adolescents' preferred coping methods and reduce the risk of avoiding formal care.

Assistance from Families and Community Support Systems

Generally, caregivers frequently serve as the first line of support to adolescents since they detect early signs of psychological distress, facilitate treatment decisions, and bear the financial responsibilities and emotional costs associated with child and adolescent mental health (CAMH) services (Adu-Gyamfi, 2017; Ame & Mfoafo-M'Carthy, 2016). Caregivers specifically guide adolescents to make positive social choices, maintain appropriate behaviours, and manage relationships, helping them navigate social pressures and manage their mental health more effectively (Glozah & Pevalin, 2016). Also, positive relationships with parents, especially mothers, are linked to lower depressive symptoms, while supportive father relationships can reduce psychological distress (Nyarko et al., 2020). Likewise, sibling relationships provide a buffer against depressive symptoms, aligning with African cultural values of family support. While involvement from family in AMHCD care reflects the centrality of the support from kinship ties in Africa, it places disproportionate burdens on caregivers, especially in under-resourced settings (Ae-Ngibise et al., 2015).

Teenagers in urban, rural, and peri-urban areas sometimes seek help from school counselors and peers for psychosocial support, in addition to their family (Baidoo-Anu, 2021; Addy et al., 2021). Support from these sources builds adolescents' mental and social health (Glozah & Pevalin, 2016), hinting that educational settings can provide essential psychosocial buffers. Nyarko et al. (2020) point out that the role of peer relationships is effective in depressive symptom reduction in low-stress contexts. However, this type of informal support may be insufficient during periods of severe psychological distress. In this context, school counselors and other school-based mental health professionals will come in to help (Cobbina et al., 2025). The layered support system at school provides access to more formal interventions when stress levels go beyond the capacity of specific informal systems.

Traditional and Faith-based (TFB) healers and leaders still occupy fundamental positions in adolescent mental health care in Ghana, offering culturally sensitive, trusted psychosocial and spiritual dimensions of support. Boynton and Vis (2022) discussed how spiritually grounded interactions give rise to emotional control and meaning-making among adolescents, thereby foregrounding spirituality's unifying function in seeking mental well-being. The continued preference to seek support from TFB healers and leaders (such as pastors, imams, traditional priests, and healers), even as there is an increase in biomedical pathways to care, highlights not only enduring cultural belief structures around mental health but also a structural limitation to access formal mental health treatment (Ewusi-Mensah, 2001, in Idanwekhai, 2021). This two-way dependency calls for a rethink of the mental health ecosystem. Gradually, some religious leaders are entering into mutual referral exchanges with biomedical providers (Idanwekhai, 2021), which indicates the development of a hybrid model of care. This kind of collaboration elicits potential for culturally responsive mental health support for underserved populations yet also necessitates rigorous regulation and training to ensure that non-clinical providers can serve adolescents ethically and effectively.

Biomedical providers support AMHCD in Ghana by offering clinical services and care. Kumbet et al. (2023) found that 91% of 302 family physicians in Nigeria and Ghana treat adolescents with MHDs, with over half managing two to three cases annually. Mental health services are also offered by 39 psychiatrists, 244 psychologists, and several community-based mental health professionals in Ghana (WHO, 2021). Other formal health care providers include: Community Psychiatric Nurses (CPNs), Community Mental Health Officers (CMHOs), and Clinical Psychiatry Officers (CPOs) within Ghana's Community-Based Health Planning and Services (CHPS) system (Agyapong et al., 2015; WHO, 2020). Formentos et al. (2021) discussed that Community Health

Workers (CHWs) conduct outreach and patient education in Ghanaian communities. Social workers also perform similar roles, along with diagnosing and treating mental health disorders, and referring children and adolescents for specialized care when necessary (Idanwekhai, 2021). This combination of formal and community-based care reflects a multi-layered approach to addressing adolescent mental health needs in Ghana at the mezzo-level of care.

The Three Tiers of Direct Mental Health Services for AMHCD

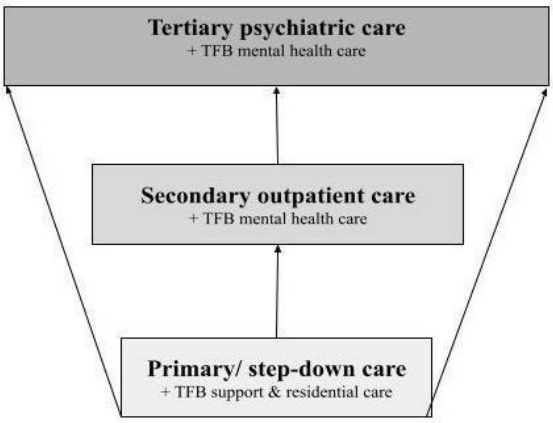

Figure 2: Three-Tiered Mental Health Care in Ghana

Note: Agencies that offer Primary/step-down care and Secondary outpatient care provide less intensive mental health services than those operating within Tertiary psychiatric care. Similarly, Primary care agencies offer less intensive mental health services compared to Secondary outpatient care facilities.

* Some Traditional and Faith-Based (TFB) centers treat mild to severe mental health conditions, mirroring treatment interventions found at each tier of formal health care.
* Residential care facilities may offer support similar to primary care and refer adolescents to secondary or tertiary facilities when advanced care is required.
* Created by authors

Successful mental health services for AMHCD require a multi-tiered care system that integrates both micro- and mezzo-level direct services. Micro-level care focuses on delivering individualized treatments, such as therapy or medication, to adolescents to address their immediate mental health, personal, and relational needs (Stabler et al., 2021). They are usually designed to create a baseline emotional regulation, healthy coping strategies, and healthier family dynamics with more indicated interventions tailored towards the adolescent's psychological or psychiatric needs. However, mezzo mental health services, which also center on direct care, have more focus on the social environment that shapes adolescent mental health. Interventions at this level can entail structured programs, group work, and community-based mental health services that increase access, eliminate stigma, and establish supportive environments for adolescents (Bajaj & Malhotra, 2009; Stabler et al., 2021). In Ghana, micro and mezzo level treatments are structured into a three-tier system: primary, secondary, and tertiary care. Each provides a range of interventions from initial assessments to specialized treatments for complex conditions.

Primary and Secondary Tiers of Mental Health Care

Ghana's primary care serves as the initial point of contact within the health system for families seeking care for children's health challenges. Non-specialist providers such as community health nurses, teachers, school counsellors, and social workers are crucial

in offering psychoeducation, screening for mental health concerns, and making referrals when necessary. On the other hand, Ghana's secondary tier of mental health care is theoretically meant to receive primary care referrals and treat AMHCD cases that are beyond the resources or training of primary care providers. It includes psychiatric consultation, community care, psychological therapy, and crisis management interventions delivered by mental health facilities, psychological centers, district hospitals, psychotherapy and counselling private practices, and non-governmental counselling agencies (Formentos et al., 2021; WHO, 2022). Also, though primarily designed to address physical health, primary care facilities provide this tiered care, with general practitioners and nurses occasionally managing mental health presentations and referring complex cases to specialized services. As of 2022, about 9,298 primary care facilities nationwide offered outpatient mental health services, reflecting a gradual integration of mental health into general health care (WHO, 2022). Secondary care handles more severe cases than primary care but does not typically involve intensive support or hospitalization. WHO (2021) has reported gaps in secondary services for children and adolescents in Ghana, with none of the 123 outpatient mental health facilities dedicated exclusively to CAMH, despite this group constituting up to 14% of outpatient service users (Idanwekhai, 2021; WHO, 2020).

There can be a functional overlap between primary and secondary care if there are unclear delineated services and practitioners operate beyond the intended function of primary care to provide stepped- mental health care (low-intensive interventions) or a referral model (Kyanko et al., 2022). Secondary and primary care facilities' operations are typically equivalent to micro practice since they deliver individualized and client-specific services. These interventions actively engage the adolescent and address symptoms, emotional regulation, and trauma recovery. Nevertheless, certain aspects of these two tiers of care also demonstrate mezzo practice attributes, especially where services are provided in institutional or group-care settings, where care is shaped by shared social environments and system interactions (WHO, 2020). Despite providing care for some severe disorders like bipolar disorder, substance abuse, and major depression (Kumbet et al., 2023), secondary care rarely includes inpatient care or intensive case management (WHO, 2020). This limitation creates a clinical gap between episodic and continuous care, particularly in facilities with limited secondary and tertiary care resources.

Tertiary Tier of Mental Health Care

Tertiary care, essential for severe mental health challenges and disorders, typically follows a referral from secondary care (Wasylenki et al., 2000). In Ghana, tertiary care facilities include the three public and two private psychiatric hospitals, in addition to psychiatric units within Korle-Bu, Komfo Anokye, Ho, Cape Coast, and Tamale teaching hospitals (WHO, 2021; Idanwekhai, 2021). The facilities, which are situated in cities of five regions, facilitate the provision of intensive treatments, including long-term inpatient care, pharmacological interventions, psychosocial rehabilitation, and substance detoxification services (WHO, 2020). While tertiary care is included in the administration of a long list of psychiatric drugs (like antipsychotics, antidepressants, anxiolytics, mood stabilizers, and antiepileptics), some pharmacological interventions are also provided at the primary level of care (WHO, 2021). Despite this, the unique features of tertiary care render it the most intensive and most resource-consuming phase needed to address the needs of adolescents with severe mental health disorders.

Other Mental Health Care outside Clinical Facilities

Ghana's informal mental health services are key in filling gaps in services from the formal primary, secondary, and tertiary care facilities. For example, informal services like TFB healing centers provide 1,705 mental health care facilities across the country with culturally grounded primary, secondary, and even tertiary care. Their services

include exorcism, prayers, herbal medications, ancestral consultations, and other spiritual interventions (Idanwekhai, 2021; WHO, 2020). Although these services seldom employ standardized assessments or evidence-based approaches, they can reflect locally grounded spiritual and cultural understandings of mental distress. Families may turn to them because they are familiar and readily available, though their practices and outcomes differ considerably. Given this variability, it would be helpful to provide citations supporting claims of feasibility and acceptance, as well as noting potential risks associated with some interventions

Additionally, institutional settings such as Ghana's 19 orphanages and 39 special schools offer residential and educational services to children and adolescents with mental and neurological disorders, thereby delivering direct care (micro) and structured institutional support (mezzo) (WHO, 2020). Collectively, they widen the scope of the primary care for AMHCD, even as they contend with unclear regulated policies for the mental health care they provide, referral networks, and adherence to ethical standards.

Programs that enhance the micro and mezzo levels of support

In Ghana, several government-initiated programs aim to enhance mental health care at both micro- and mezzo levels for adolescents and other vulnerable groups facing mental health challenges. Interventions such as the National Health Insurance Scheme (NHIS) and Livelihood Empowerment Against Poverty (LEAP) are aimed at lowering the cost barriers to accessing mental health care, as well as financial assistance for individuals who live with disability, which includes mental health disorders (Formentos et al., 2021). At the community level, the Community-based Health Planning and Services (CHPS) program is key to health promotion, disease prevention, and the delivery of essential mental healthcare, in addition to referring clients to secondary and tertiary care systems (Elsey et al., 2023; Ministry of Health, 2018). In education settings, the Guidance and Counselling Program offers socio-emotional and academic support to students in basic and secondary educational institutions. Though mental health school-based interventions are not rooted in evidence-based therapeutic interventions (Cobbina et al., 2025), it is broadly perceived by educators, counselors, and students as beneficial for mitigating learning difficulties, emotional regulation, as well as helping students make informed decisions, and promoting discipline among them (Asiedu-Yirenkyi et al., 2019). In addition to the aforementioned government-funded programs, nongovernmental organizations (NGOs) also run a range of micro- and mezzo-level interventions that provide psychosocial support and direct services for AMHCD and their families. The subsequent sections will describe these models used by NGOs more closely.

Indirect Mental Health Support at the Macro-Level System

Agencies Providing Macro-level Support

Indirect mental health support for AMHCD in Ghana involves a network of organizations and actors operating at the macro level. These include NGOs, community groups, educational institutions, and governmental agencies, all of which contribute to creating a supportive environment, informing policy development, reducing stigma, and enhancing the effectiveness of support systems for AMHCD at the micro and mezzo levels. The Ministry of Health (MoH) is pivotal in these efforts, leading key agencies and initiatives to advance mental health care and maintain high service standards (WHO, 2021).

The Ghana Mental Health Authority (GMHA), operating under the MoH, aids in developing mental health policies, integrates services, ensures standard compliance, and promotes mental health education (GMHA, 2024; Idanwekhai, 2021). The Ghana Health Service (GHS), another agency under the MoH, is responsible for implementing national health policies through its Mental Health Department. This department focuses on improving access to care, integrating mental health into primary healthcare, and

supporting national policies (GHS, 2021). GHS also engages in mental health research, including evaluations of adolescent health policies and strategies (GHS, 2021). The Ghana Psychology Council (GPC), also under the MoH, regulates the psychology profession by accrediting educational facilities, licensing providers, and setting ethical standards for psychologists and counsellors (GPC, 2024). Despite these efforts, no governmental body focuses exclusively on CAMH, as their mandates cover the broader population. The Special Education Division of the Ghana Education Service (GES) supports Inclusive Education within the educational system. This division addresses various disabilities, including mental or neurological disorders, through seven specialized units. Counselling services in public schools are regulated by the Guidance and Counselling (GC) Unit of GES. This unit regulates direct services in secondary education to support students' mental health and cognitive development (Addey et al., 2021).

NGOs and international agencies are also instrumental in supporting adolescent mental health. Notable NGOs include the Ghana Mental Health Association, BasicNeeds, World Vision, The Epilepsy Society, and the Ghana Organization Against Fetal Alcohol Syndrome (Twumasi-Afriyie, 2016). Faith-based organizations such as The Christian Health Association of Ghana (CHAG) and Ahmadiyya Muslim Mission support mental health by managing primary care facilities, particularly in rural areas (MoH, 2024; WHO, 2021). Moreover, international organizations, including UN agencies and the WHO, provide crucial guidance, financial support, and resources, contributing to Ghana's mental health infrastructure and policy development. Collaborative efforts between government organizations and some agencies, such as the African Association of CAMH (AACAMH, nd), strengthen micro and mezzo services and address service gaps. These combined efforts are essential in advocating for mental health and developing effective policies and laws to support adolescents in Ghana. Additionally, some agencies fund and design programs for micro- and mezzo-level initiatives to further AMHCD care.

Legislation and Policies for Mental Health Support

Actors providing indirect services shape legislation, policies, and plans for adolescent mental health. Their support is based on both national laws and international conventions. Key international frameworks include the UN Convention on the Rights of the Child (CRC), the UN Convention on the Rights of Persons with Disabilities (CRPD), the WHO Mental Health Action Plan 2013-2020, and the Global Strategy on Human Resources for Health: Workforce 2030—these guide Ghana's policies to align with global standards. Relevant national laws include the Children's Act of 1998 (Act 560), the Mental Health Act of 2012 (Act 846), the Education Act of 2008 (Act 778), the Ghana Health Service Act of 1996 (Act 525), and the Persons with Disability Act of 2006 (Act 715). These laws create a legal framework for protecting and supporting adolescent mental health by ensuring access to appropriate care and education as well as safeguarding rights for individuals with mental health needs. Together, these laws and conventions form a comprehensive system for enhancing mental health care for adolescents in the country.

Relevance of the Mental Health Act 846 (MHA) for Adolescent Mental Health

The Mental Health Act 846 is one of the significant policies for addressing mental health in Ghana. The Act offers a decentralized system integrated in communities with culture-sensitive and accessible care (Idanwekhai, 2021). For children and young people, the MHA establishes essential safeguards: mandating caregiver consent and treatment wishes of young people, implementing youth-only and age-specific accommodation in psychiatric facilities, advancing the least restrictive environment for care, and prohibiting such irreversible interventions as psychosurgery (Ame & Mfoafo-M'Carthy, 2016). It also regulates traditional and spiritual practices to ensure safety and adherence

to human rights standards. Collectively, these provisions position the MHA as a foundational framework for integrating adolescent mental health within a rights-based, decentralized, and culturally grounded care system.

Relevant health policies for AMHCD

Health policies, such as the Ghana National Mental Health Policy (2019–2030) and the National Mental Health Strategic Plan (2019–2022), aimed to integrate mental health services into primary health care and community-based services (WHO, 2021). These policies emphasize human rights, strategic partnerships, and responsiveness to disability and vulnerability, with frameworks for stakeholders like the GMHA (MoH, 2018). Again, the National CHPS Policy ensures the provision of services for AMHCD in underserved areas (GHS, 2016). However, certain health policies, such as the Adolescent Health Policy and Strategic Plan, which ended in 2020, indirectly support AMHCD but did not exclusively target CAMH. At the macro level, regulatory agencies play a crucial role in shaping the mental health landscape in Ghana by establishing policies and guidelines that govern care delivery.

Educational Policies for AMHCD

The Inclusive Education (IE) Policy in Ghana mandates provisions for children with special needs, aiming to adapt education to meet diverse learner needs (Mantey, 2015; Ministry of Education, 2015). The policy assigns the GES responsibilities for developing an inclusive curriculum, deploying trained special educators, and conducting universal screenings and assessments to identify students with disabilities (GES, 2015). Although the policy targets various disabilities and disorders, its primary focus is on neurodevelopmental disorders such as ASD and ADHD (Ame & Mfoafo-M'Carthy, 2016). Consequently, students with mental health challenges may not receive inclusive educational support if they do not have diagnosable special learning disorders (Cobbina et al., 2025.

Implementation of Policies and Programs that Impact Adolescents' Mental Health

In 2021, the WHO assessed Ghana's mental health system using a modified PRIME tool. Their report revealed limited implementation of mental health legislation and policies in Ghana due to inadequate funding and resources. Although the MHA is ideal on paper, several barriers affect its implementation. For example, although the MHA mandates free mental health care financed through various sources, free services are largely theoretical due to severe under-resourcing (Adu-Gyamfi et al., 2017; WHO, 2021).

Despite some progress, the treatment gap remains significant, especially for mood and substance use disorders. Evaluations consistently show that implementation challenges persist (Adu-Gyamfi et al., 2017; WHO, 2021). A study by Agblevo et al. (2023) found poor integration of mental health services with other health services. In their evaluation of the Adolescent Health Policy and Planning (2016–2020), only 17% of the planned strategies were fully implemented, 57% were partially implemented, and 26% were not implemented. Out of the health strategies in the plan, only one strategy focused on CAMH, and even that was partially implemented. Adu-Gyamfi et al. (2017) also note some persistent challenges in delivering comprehensive mental health services, especially outside urban centres.

Challenges and Barriers to Implementation

Although identifying challenges and barriers was not the focus of this review, it is worth dedicating a sub-theme to this topic, as numerous studies highlight significant challenges and barriers affecting the implementation of mental health laws and policies for micro and mezzo-level AMHCD support. These include limited funding, insufficiently trained mental health professionals, and inadequate infrastructure. Cultural perceptions and stigma, as well as a lack of public awareness, further obstruct the effective implementation of mental health services for adolescents.

Negative Attitudes towards Mental Health Services

Many Ghanaians attribute mental health disorders to supernatural causations, which can perpetuate negative attitudes, stigma, and discrimination towards people with mental health disorders (Adu-Gyamfi et al., 2017; Badu et al., 2019; Opere-Henaku & Utsy, 2017). Idanwekhai (2021) highlights six sub-themes of stigma affecting CAMH in Ghana: barriers to seeking mental health care, social interactions, labelling, parental abandonment and neglect of AMHCD, and discrimination at community and institutional levels. Stigma, a macro-level challenge, results in difficulties at the micro and mezzo levels that affect the accessibility, feasibility, and acceptability of services, leading to under-utilised services and delays in treatment. In addition to stigma and discrimination associated with mental health services, culturally embedded beliefs significantly influenced help-seeking behaviours, with families more likely to turn to prayer, herbal remedies, and traditional healers rather than formal psychological services for their AMHCD (Badu et al., 2019; Opere-Henaku & Utsy, 2017).

Inadequate Mental Health Care for AMHCD

The low prioritisation of mental health in Ghana is evident through systemic and resource-related challenges. Conflicting legislation, such as the Criminal Offences Act (1970), uses derogatory terms for individuals with mental health disorders and criminalises suicide attempts, and contrasts sharply with the MHA, which aims to protect individuals with mental health disorders (Ame & Mfoafo-M'Carthy, 2016). Also, only 6.2% of the Ministry of Health's 2014 budget was allocated to mental health for the entire country (Adu-Gyamfi et al., 2017). Moreover, regional disparities in mental health resources are also significant, with Greater Accra receiving the bulk of available resources while other areas face severe shortages in infrastructure and personnel (Adu-Gyamfi et al., 2017). For example, two of the three public psychiatric hospitals in Ghana are located in Greater Accra, and only one of these has a dedicated ward for children and adolescents with mental health disorders. However, this CAMH ward is rarely utilised by those with mental health challenges (MoH, 2020).

Furthermore, studies on mental health care facilities, community-based centres, and school counselling always report limited material resources and trained mental health providers (Asiedu-Yirenkyi et al., 2019; Cobbina et al., 2025; Elsey, 2023; Idanwekhai, 2021; WHO, 2021). The country's shortage of psychiatric staff and counselors results in inadequate care. For AMHCD receiving hospitalized services, this problem is compounded by logistical challenges such as long distances between hospitals and patients' homes, family abandonment due to stigma, and the courts' failure to ensure patient discharge (Adu-Gyamfi et al., 2017). Also, barriers to effective collaboration between biomedical and TFB healing systems hinder a comprehensive approach, where these professionals can exchange resources to assist their clients better (Badu et al., 2019). In Ghana and other sub-Saharan African countries, TFB view biomedical providers as culturally disconnected and reluctant to collaborate, and biomedical providers view these TFB practices as harmful, unethical, and leading to delays in accessing proper care (Akol et al., 2018; Badu et al., 2019).

Gaps in Training and Practice

Another challenge to adequate care for AMHCD is the limited training and practice among mental health providers, which results in unqualified individuals offering services such as assessments, counselling, and medication management (Badu et al., 2019; Idanwekhai, 2021). The Adolescent Health Policy and Planning included mental health training as one of its health strategies, but it was only partially implemented by the end of the implementation period (Agblevo et al., 2023). Besides, TFB healers lack formal training in mental health care, raising concerns about the safety and efficacy of their interventions. Although some TFB healers integrated their practices with modern medical approaches, the absence of standardised diagnostic tools obscures the treatment

process (Idanwekhai, 2021). These combined factors reflect the overall low prioritisation of mental health in Ghana and underscore the need for a more integrated and adequately resourced approach to support individuals with mental health disorders.

DISCUSSION

Adolescence is a crucial period of physical, cognitive, and socio-emotional changes that affect mental health (Hess et al., 2011). This review explored adolescent mental health support in Ghana, emphasising direct and indirect services. Themes identified in this study related to the critical need for a multi-level approach to supporting AMHCD in Ghana. Systems of support included the micro level, where adolescent coping practices, families, and other community members play a vital role in the immediate support network, and at the mezzo level, where organisations, educational and health care institutions, and community-based programs contribute to a coordinated support system. At the macro level, culture, policies, and laws affect the support available and utilised at the micro and macro levels. Despite the existing support systems, significant challenges persist, including stigma, the low prioritisation of CAMH, and limited funding. These macro-level barriers contribute to ongoing difficulties at the micro and mezzo levels. To address these challenges, a holistic and integrated approach to mental health care is necessary, one that improves outcomes for adolescents and eases the burden on caregivers.

RECOMMENDATIONS

Addressing the challenges in AMHCD support requires strategic recommendations to overcome obstacles within existing support systems. Expanding mental health services within schools and communities is crucial at the micro level. Integrating mental health education into school curricula and providing accessible community-based resources facilitates help-seeking behaviours among adolescents. However, it is important to note that recommending school-based counselling, without first rectifying the workforce investments, ignores the root cause and focuses on superficial solutions. In addition, strengthening family support systems is essential to equip families with the knowledge and tools necessary to support their adolescent members effectively. At the mezzo level, developing community-based mental health initiatives can offer localised support tailored to specific needs. As suggested by researchers such as Idanwekhai (2021) and Ame & Mfoafo-M'Carthy (2016), integrating formal mental health care with traditional practices can create a more comprehensive and culturally sensitive approach to mental health services in the country. This cross-sector partnership would mean leveraging existing faith-based infrastructure, making scalability probable. Policy must facilitate integration among biomedical and TFB providers using financial incentives, recovery-focused models of care, specific awareness-raising campaigns, and joint training programs with practical tools and protocols (Badu et al., 2019).

Increased government funding is vital for expanding mental health services, including investing in training professionals and improving mental health infrastructure. Also, public awareness campaigns can significantly reduce stigma and encourage help-seeking behaviours among adolescents and their families. Implementing national policies prioritizing adolescent mental health will provide a robust framework for these initiatives. Overall, a multi-level approach that addresses micro, mezzo, and macro-level factors is essential for creating a more inclusive, culturally responsive, and effective mental health support system for adolescents in Ghana.

Despite Ghana's work towards tackling mental health challenges and disorders, such as the passing of the 2012 MHA, there is still a significant lack of comprehensive research on AMHCD support in the country.

The research gap is alarming, given that adolescence has proven to be a crucial stage where MHD could develop. Most studies focus on urban areas, negating rural

areas, which do not provide a nationwide perspective. Additionally, the wide policy and implementation gap creates a more fragmented picture. Agblevor et al. 2023 thoroughly analyse these gaps, showing that only 17% of the 23 planned strategies were fully implemented in Ghana's adolescent health service policy and strategy (2016–2020).

Furthermore, limited data exist on the effectiveness of existing intervention support systems, making it harder to recommend programs such as the school-based support system. This fragmentation in the literature shows the lack of comprehensive, nationwide research that systematically maps the landscape of AMHD support in Ghana.

Ethical Considerations

Not applicable, as this review relied solely on secondary sources.

Conflict of Interest

The authors declare that they have no conflicting interests.

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