CONSOLIDATING GAINS MADE IN MENTAL HEALTH AND DEVELOPMENT IN GHANA

2011

ANNUAL EVIDENCE-BASED REPORT

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Mental health service users in the Upper West region planing their annual advocacy activities

BasicNeeds

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Mental health is a right, not a privilege

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LIST OF ACRONYMS AND INITIALS

BNGh	BasicNeeds Ghana
CBO	Community Based Organisation
CSO	Civil Society Organisation
CSRC	Community Self-Reliance Centre
DFID-CSCF	Department for International Development of the United Kindom's Civil Society Challenge Fund
DFID-ODI	Department for International Development of the United Kindom's Overseas Development Institute
EC	European Commission
EU	European Union
GHS	Ghana Health Service
GKS	Gub-Katimali Society
MDA	Ministries, Departments and Agencies of the Republic of Ghana
MEHSOG	Mental Health Society of Ghana
MHD	Mental Health and Development model of BasicNeeds
MPs	Members of Parliament
NGO	Non-Governmental Organisation(s)
NSA-LA	Non-State Actor and Local Authorities funding window of the EU
PDA	Participatory Development Associates
SHG	Self-Help Group
STAR-Ghana	Strengthening Transparency, Accountability And Responsiveness in Ghana
ZOVFA	Zuuri Organic Vegetable Farmers Association

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EXECUTIVE SUMMARY

The year 2011 was one that could be described as consolidation of a transitional process of BasicNeeds Ghana. It was the last year of BNGh's five-year strategy as it continued working on stretegy for the next five years. It was a year BNGh was firming up its status as a registered national organisation resulting in some restructuring of its setup including realighnment of its partnership relationships

It also saw the completion of most of its projects There have also been realignment of partnership arrangements and relationships, and restructuring of staffing. BNGh began the year with only one project that was running its fourth of a five-year duration, which potentially could constrain the tremendous activities and achievements of the organization over the years.

BNGh strongly ended the year with four new projects of between one and three years, nine months. The grants for the projects were secured from four donor organisations. These are the STAR-Ghana, PDA-Mwananchi Project funded by DFID-ODI, the DFID-CSCF and EU NSA-LA. It was particularly significant that three of the grants were from in-country donors.

As stated above, BNGh realigned its partnership with implentation NGOs/CBOs to better improve services and support to the several service user and carer SHGs and their representative district associations. The emergence of the national user associations – MEHSOG – also informed the nature of the working relationship with the implementation partner organisations, where they have now become more of resource partners to the SHGs.

BNGh also developed relationships with two women-based organisations, namely, the Ark Foundation and FIDA Ghana, as part of improving mental health issues in gender and women-based work, as well as provided opportunity for a joint project concept sent to the EC in response to a Call for Concept Notes.

An important development was the start of operations of BNGh in the middle zone of Ghana. The mid-Ghana area had been one area BNGhs has been largely called upon to work and it was a fulfillment that this finally happened with the commencement of implementation of a project of almost four year duration funded by DFID-CSCF. All project activities were implemented largely according to schedule with little variances. Key operation areas were around supporting MEHSOG, that had its first full year of operations as a legally registered entity, to lead in advocacy issues mainly with the Ministry of Health, the Department of Social Welfare and the Parliament of Ghana.

There was also support to meetings and engagements of SHGs with the local government and traditional authorities. Such local level engagements were widely supported by the region-based Alliance for Mental Health and Development. The Alliance for Mental Health and Development continued to serve as an appropriate forum to have many more CSOs/CBOs.

BNGh hosted a number of external visits, mainly undertaken by independent monitoring consultants appointed by STAR-Ghana. The West and Central Africa Director of DFID also visited BNGh as part of his field working visit to project funded by STAR-Ghana, (a pooled funding scheme that DFID substantially contributes to), whilst a two-man team from India NBJK also undertook a familiarization visit to BNGh to understand general implementation of the MHD and particularly policy advocacy and working with government..

The finances of the organisation were largely on with just a few variances with individual budget lines. Human resources were on track but reduction in staff numbers have added some bit of added work load to each of them. The year ended largely on a fairly good note with high anticipation of achievement and successes even in the face of challenges with regards funding and a stretched staff team.

OVERVIEW OF 2011 PROJECTS

In the year under review, BNGh engaged in 5 projects with its partners. The projects were generally carried out in the Upper East region, Upper West region, Greater Accra region, Brong Ahafo region and Ashanti region.

1. Self-Representation for Mentally Ill People and their Carers in Ghana

This Comic Relief funded project commenced in October, 2007 and is scheduled to end in November, 2012. The implementing partners are *MindFreedom, Zuuri Organic Vegetable Farmers (ZOVFA), Gub-Katimali Society (GKS), Centre for People's Empowerment and Rights Initiatives (CPRI), Programme for Integrated Rural Development (PRIDE), Department of Community Development-Upper East Region, Ghana Health Service and Shekhinah Clinic.*

The project has, so far, reached 183 Self-Help Groups (SHGs) from 42 Districts (located in the Upper East, Upper West and Greater Accra regions) and a National User Association.

2. Promoting Mental Health and Human Rights in Ghana

This project, funded by STAR-Ghana, started in May, 2011 and ended in March, 2012. It affected 115 Alliance members, 380 members of SHGs and 38 Members of Parliament (MPs). The catchment areas for this project were the Northern, Upper East, Upper West and Greater Accra regions.

The implementing partners were *Gub-Katimali Society (GKS), Northern Sector Awareness Action Centre (NORSAAC), Community Self-Reliance Centre (CSRC), Programme for Integrated Rural Development (PRIDE); Centre for People's Empowerment and Rights Initiatives (CPRI); Bahass Foundation*

3. Enabling People with Mental Illness or Epilepsy Access their Human Rights in Mid-Ghana

This project started in July, 2011 and is scheduled to end in March 2012. It is funded by DFID-CSCF. In collaboration with our partners namely *MIHOSO Foundation, CEDEP and GHS,* we hope by the end of the project to reach 3500 women, men and children with Mental Illness, 3300 primary care-givers and 130 SHGs, all located in the Brong Ahafo and Ashanti regions.

4. A Picture of Mental Health

This DFID ODI/PDA funded project commenced in September, 2011 and expected to end in August, 2012. The primary participants of this project are 80 SHGs and 20 leaders/delegates of SHGs. The project sites were located in districts of the Northern, Upper East, Upper West, Greater Accra, Brong Ahafo and the Ashanti regions.

Implementing partners for this project are the District Associations of SHGs of people with mental illness or epilepsy and primary care-givers, Gub-Katimali Society (GKS), Community Self-Reliance Centre (CSRC), Programme for Integrated Rural Development (PRIDE), Centre for People's Empowerment and Rights Initiatives (CPRI)

5. Promoting an Inclusive and Empowered Civil Society to Advance Socio-Economic and Political Development in Ghana

Funded by EU NSA-LA, this project was started in October, 2011 and is scheduled for completion in September, 2014. In collaboration with partners (namely Gub-Katimali Society (GKS); Zuuri Organic Farmers Association (ZOVFA); Centre for People's Empowerment and Rights Initiatives (CPRI); Mental Health Society of Ghana (MEHSOG)), this project is operational in selected districts of the Northern Region, Upper East Region, Upper West Region, Greater Accra Region, Brong-Ahafo Region, Ashanti Region

The primary target of this project is set to affect 3200 individual participants - 20 Self-Help Groups (SHGs) of PWMIE and their primary carers; 20 other district and region-based DPOs; 20 women's groups; 20 youth groups; 20 vocational/trade-skills development associations.

PROGRAMME IMPLEMENTATION

1.1 SERVICE PROVISION

Treatment Services:

Treatment services were provided through specialist psychiatrist outreach clinics and community Psychiatrist Nurses (CPN) follow-up outreach clinics including, community mental health education.

Mental Health (MH) Outreach Clinics were organised in the district hospitals, polyclinics and sub-district facilities.

This made it possible for people in need of mental health services to access them
In the year under review, 50 of such outreach clinics were organised with BNGh providing transport, allowances for health professionals and supplementary medicines. The Government provided venues, staff-time and vehicles while partners and volunteers supported by mobilising users and communities for services.

The services provided were consultation and diagnosis, prescription of medications and provision of free medicines as well as counselling and referral as may be required.

The specialist psychiatrist services were held for durations of one week per quarter in all of Northern Ghana (Northern, Upper East and Upper West regions) and the Mid-Ghana project area (five districts in Ahanti Region and ten districts in Brong Ahafo region). In the Accra project area, specialist outreach clinics were carried out once a day in each of the four sub-metropolitan area.

In 2011, a total of fifty (50) outreach clinics were organised by BasicNeeds-Ghana. These were carried out in the districts and sub-metropolitan areas of project coverage areas. BNGh provided fuel (and sometimes vehicles), flight costs for psychiatrists, stipends for the mental health professionals and support staff, including support to community volunteers, accommodation and supplementary medicines.

The government, through the Ghana Health Service, made available health facilities at the district and sub-district level, staff time and vehicles, occasionally. BNGh implementation partners, community volunteers as well as Self-Help Groups (SHGs) of the service users and carers and families supported with mobilising persons with mental illness and their communities for the services.

Follow-up outreaches and related community mental health education activities are organised were organised with the CPNs and the active support of the community volunteers and SHGs. BNGh supported with fuel, and stipends, education materials and stationery for the activities.

On-going consultations at the Community Psyschiatric Units (CPUs) ensured continuity of care and making of referrals when deemed necessary, to the psychiatric hospitals. In all, ninety-six (96) such consultations were held in nineteen (19) CPUs in the three Northern Regions, seven (7) CPUs in Mid-Ghana and four (4) in the Accra metropolitan area. These services were provided mainly by CPNs and occasionally by Pyschiatrists.

1.2 HUMAN RESOURCE DEVELOPMENT

Improving capacity of community mental health personnel was pursued as part enhancing community mental health service provision. Training workshops focusing on basic psychiatry and human rights were provided to categories of community level mental health and general health personnel, community volunteers and owners and managers of prayer camps. This was done using the BasicNeeds' *"Essential Skills for Mental Health Care"* manual and the *WHO Patient's Charter.*

Community Psychiatric Nurses

Seventy-six (76) CPNs received training in basic psychiatry with focus on management of common mental disorders, including understanding concepts of mental health and mental illness, integration of mental health into primary health care and general health service delivery, the patient charter and effective communication in mental health, rehabilation and integration of persons with mental illness into the community, stigma, descrimanation and human rights of persons living with mental illness and epilepsy.

Supplementary Medications

BNGh made contributions towards providing psychotropic medicines and anti-epilepsy medicines to persons under treatment, especially in the rural and deprived districts. The main medicines provided were Carbamazeppine/Tegretol (200mg), Tabs Phenobarb (60mg and 300mg) and Phenytoin (100mg). Over 65% of these was used for specialist outreach clinics and the remaining 35% was used to respond to requests from community psychiatric units in the districts and regions.

Altogether, BNGh spent a total of GH₵ 12, 000 was spent on the provision of supplementary medicines for communities.

Community Volunteers

Sixty community volunteers were also trained in topics such as Understanding mental health and management of mental illness, integration and re-integration (rehabilitation).

Resource persons for this training were a Community Mental Health Officer (Ghana Health Services),a private Social Worker and a Project Officer of BasicNeeds Ghana.Training report and attendance for this training session was produced by CEDEP.

Prayer Camp Managers

Finally, 15 prayer camp managers also received training in the following topics: Understanding mental health and management of mental illness HIV/AIDS, and human rights of persons with mental illness. Their training was facilitated by a Community Mental Health Officer from Ghana Health Services, a private Social Worker and a Project Officer of BasicNeeds Ghana

The Remarkable Story of Francis Kuubilla Pii

Francis Kuubilla Pii from Kongo in the Upper East Region has made a remarkable recovery from the schizophrenia he was diagnosed of. He was shackled with a log by a traditional healer for close to two years until he was discovered by a team of BasicNeeds staff.

Francis has not only stabilised from his condition within a couple of months of being put under treatment by a Community Psychiatric Nurse (CPN) of the Bolgatanga regional CPU, with the financial and moral support of BasicNeeds, but also authorities of the Ghana Education Service of the circuit he was teaching in have agreed to reinstate him. His wife has also rejoined him and is supporting Francis go through the treatment and to begin life again.

According to Francis, “It was by God that you people discovered me. I feel fine and ready to go back to teaching. I know I have a lot to impart to children and I wish to do so as soon as possible. I am willing to share my experience at any forum BasicNeeds will organise as it will help others not to go through what i have been through.”

The Circuit supervisor of the circuit that Francis was teaching in confirmed that they are considering his reinstatement, adding that “I have followed the progress of Francis during his illness. You [BasicNeeds] must be commended for the great work you have done”.

1.3 LIVELIHOODS

A Story Of Livelihood

Sanatu Mahama was supported with a sewing machine and accessories (worth about GBP£50) to revive her trade as a seamstress, having significantly stabilised from depression. To rebuild her trade she underwent some apprenticeship with an established tailoring shop.

After six months and with the help of her family, she constructed a shed under which she began to sew again. Her business is yet to pick up but Sanatu feels satisfied she is back to doing something for herself. She adds that

“I have just started and customers are trickling in. It will take time for me to get customers and win back my customers since my illness made me loose them. They are also yet to be sure I am recovered and sewing well so I will be patient. I am however happy because, I back to doing what I used to depend on and it means I will soon be earning something and also just get busy”.

Sanatu explains that soon she would accept apprentices to also impart her skills and knowledge. According to Sanatu she believes self-employment, especially for young girls, is important, when compared with people looking for white-collar jobs.

BasicNeeds Ghana builds on livelihoods related activities familiar to beneficiaries and the local conditions. They also relate to those activities beneficiaries were engaged in before the onset of their conditions. For those that had no livelihood activity, considerations are given to activities that reinforce stabilisation and recovery, and means of generating income. Innovative activities such vegetable gardening and craft-making as as an alternative to crop farmers and people with mental illness or epilepsy whose illness have kept them out of formal employment or who have had no skills and/or qualification what-so-ever.

Mechanisms used in identifying people for livelihood support include compliance to treatment (plans), particularly taking of medications, including any other non-drug sessions that may be recommended, progress of recovery and/or of reduction of symptoms of the illness, level and frequency of participation in Self-Help Group (SHG) activities (meetings especially), an expressed desire to engage in a livelihood activity or enterprise and commitment from the primary care-giver to support the beneficiary. In the case of the primary care-giver support to the ill person and participation in SHG activities suffices. Reports from community volunteers, Community Psychiatric Nurses (CPNs), SHGs and field staff of implementation partners constitute important sources of information for identifying and supporting beneficiaries.

Sustainability of livelihoods intervention is ensured by a concerted effort to include family members in the discussions to support the identified beneficiary. Beneficiaries are also encouraged to make savings to repay the support provided them, the Self-Help Groups (SHGs) serve as social collateral that ensure member beneficiaries repay they support they receive. Using the SHGs and encouraging a culture of savings gives opportunity to grow their businesses. Sustainability is also ensured with training in areas of financial management, understanding and differentiating profit from working capital as well as business planning enterprise development provides knowledge and skills to building and sustaining businesses. The opportunity to earn ensure people can look forward to continuing to participate in activities of the programme which in turn enable them continue to benefit from equipment and tools, finances and training (both from existing enterprises or directly from the resources of on-going project) to development lasting source of livelihood, in addition to treatment support received.


BUTTERFLY

BasicNeeds Ghana Livelihood-Related Activities

Indicators	*Data*	*Data Source*	*Description*
Number of users given livelihood-related training	Total 296 157 males 139 females	Collated from reports of partners, including those of MEHSOG. Data is from the northern Ghana and Accra areas	Apprenticeship training in dress-making and tailoring, hair-dressing & barbering, mechanics and masonry facilitated by Master trainers and artisans
Number of Users given microcredit support	Total 252 85 males 167 females	Sources of the figures are from reports of MEHSOG secretariat, partners and SHGs	Credit amounts range from £25 to £60 to clients engaged in sale of groceries, foodstuff (including food processing and sale of cooked food)
Number of Carers/ other family members given micro-credit support	Total 4 4 females	Source of data is the agreements signed with the beneficiaries and e-mail correspondence	Support given through BasicNeeds Ghana under a BasicNeeds-Ghana collaboration with Ghana Behaviour Change Support (BCS) Project, Johns Hopkins Bloomberg School of Public Health, Centre for Communication Programmes. Credit facilities of GH₵ 1,000 given in support of selected clients engaged in Sale of groceries, foodstuff (including food processing, such as rice par-boiling, sale of local snacks, and sale of cooked food)
Number of Users given non-monetary livelihoods support (tools, assets, livestock)	Total 121 30 males 91 females	Report of partners and BasicNeeds-Ghana.	ZOVFA and PRIDE, through BasicNeeds-Ghana provided livestock (goats, sheep and pigs), dress-making and tailoring equipment, carpentry and gardening tools and equipment to beneficiaries
Number of carers/ other family members given non-monetary livelihoods support (tools, assets, livestock, literacy)	Total 251 112 males 139 females	Report of partners and BasicNeeds-Ghana.	ZOVFA and PRIDE, through BasicNeeds-Ghana provided livestock (goats, sheep and pigs), dress-making and tailoring equipment, carpentry and gardening tools and equipment to beneficiaries

1.4 CAPACITY BUILDING ACTIVITIES

Seven (7) community meetings were held at Walewale, Karaga, Gushiegu, Yendi, Zabzugu, Bimbilla, and Salaga to monitor activities of SHGs, identify capacity building needs and design training programmes to respond to the capacity gaps identified.

The Regional Alliance for Mental Health and Development also held their quarterly meetings to share and learn good practices and enhance collective advocacy.

Again, fifty-six newly elected Assemblymen and Assemblywomen (54 males and 2 females) were introduced to topics such as what constitutes Mental Illness and Epilepsy, Perceived Causes, Signs and Symptoms, management and referrals. The resource persons were Mental Health Officers of GHS

Donor Activities and Visits

PDA/ODI Mwananchi also conducted donor visits to families in order to monitor activities of grant to increase user advocacy on mental health.

Donor monitoring visits were, likewise, conducted by STAR-Ghana (to Walewale) and DFID (to Tolon) to monitor project outcomes and BasicNeeds monitoring and evaluation frameworks and processes.
NBJK also engaged in working visits (to Accra, Tamale, Bongo and Bolgatanga) in order to learn about BasicNeeds-Ghana good practices on policy engagement and influencing activities with government health and development authorities.

1.5 USER IDENTIFICATION

Ten home visits were embarked on on the bases of referrals and directions of community workers. These were mainly done by field staff of NGOs and other community leaders who knew of the work of BasicNeeds-Ghana and directed clients to the offices, and who were usually in turn referred to the Community Psychiatric Units.

Regarding outreach clinics, 1433 cases (749 males and 684 females) were dealt with. These outreach clinics were usually recommended to clients by members of SHGs, community volunteers and CPNs and families who have heard of the outreach clinics in community near them.

1.6 STAKEHOLDER MOBILISATION

Fifty-four members (31 males and 23 females) of partner NGOs were trained in mental health. These were staff of CEDEP, MIHOSO. They were taken through concepts of mental health, mental illness common mental conditions and the BasicNeeds Mental Health and Development model by a Government Mental Health Officer, and staff of BasicNeeds Ghana.

Participants of a BasicNeeds-organised workshop for newly elected Assembly Members.

A number of government officials (28 males and 6 females) were given an orientation to mental health. They included staff of the Ghana Police Service, Ghana Immigration Service, Ghana Prisons Service, Ghana Fire Service and the Customs Excise and Preventive Service. They were taken through topics such as common mental illnesses and human rights of persons with mental illness and epilepsy. Resource persons for this orientation were three CPNs, two officials from CHRAJ and two BasicNeeds staff.

1.7 RESEARCH ACTIVITIES

A number of research-based activities were embarked on by BNGh within the year under review. There were psychiatry reviews, community consulting and external workshops. These activities were conducted by BasicNeeds staff, CPNs, staff of partner organisations and other volunteers.

During the year, data of 429 (235 males and 194 females) vulnerable people were gathered. These data were collated from the clinical files of patients at the various CPUs. Baseline data was also gathered from 1437 persons with mental illness and epilepsy. These were made up of 757 males and 680 females. These data were gathered by CPNs, community volunteers and during outreach clinics.

Participator Data Assessment

However, during the year under review, only one PDA session (instead of the usual 2) was held. About 30 participants (21 females and 9 males) were present, nineteen (4 males and 15 females) of who were service users and 11 primary carers (5 male and 6 females). Service users and carers found the sessions as avenues to express their views various issues related to treatment services and community acceptance and how far they had progressed in their involvement in the activities of BasicNeeds Ghana.

1.8 MANAGEMENT OF OPERATIONAL PARTNERSHIPS

Working relations with the various implementation and resource partners have been cordial and professional. The partnership agreements signed with each of them have significantly helped to steer the relationships between and among BNGh and the partners individually and collectively. Below is a summary of an assessment of the nature and quality of the relationship of BNGh and its partners.

Gub-Katimali Society (GKS):

GKS Implements project activities covering the Northern Region, particularly with regards the EU NSA-LA funded project. GKS is also the lead organisation for the Northern Region Alliance for Mental Health and Development.

Northern Sector Awareness Action Centre (NORSAAC):

NORSAAC is a members of the Northern Region Alliance and a leading partner of the consortium of partners implementing the STAR-Ghana funded project to enable the region-based alliance for mental health and development advocate on mental health and human rights in the Northern Region

Community Self-Reliance Centre (CSRC):

CSRC is one of the organisations of the Upper East Regional Alliance for Mental Health and Development that is leading implementation of the STAR-Ghana funded mental health and human rights awareness project.

Zuuri Organic Vegetable Farmers Association (ZOVFA):

ZOVFA is one of the partners implementing project activities in the Upper East Region, particularly around the Garu-Tempane District, Bawku Municipal, Bawku West, and Talensi-Nabdam District. ZOVFA

is currently an associate implementation partner the EU NSA-LA funded project

Programme for Integrated Rural Development (PRIDE):

PRIDE works with BasicNeeds to implement projects in the Upper East Region, especially around the Bolgatanga Municipal area, Bongo District, and parts of Kassena-Nankana East District. PRIDE is also a meber of the the Upper East Regional Alliance for Mental Health and Development and is one of the consortium of partners of the region-based alliances implementing the STAR-Ghana funded mental health and human rights advocacy project.

Centre for People's Empowerment and Rights Initiatives (CPRI):

CPRI is the implementation partner of BNGh is the Upper West Region (UWR). BNGh works with CPRI and also extensively collaborates with the Ghana Health Service at the regional and district levels to improve mental health care provision, and strengthening capacities of mental health and epilepsy service users and their primary care-givers to mobilise themselves into SHGs for self-advocacy.

Mental Health Society of Ghana (MEHSOG):

MEHSOG represents and leads self-help user groups' policy engagements and meetings at the national level. It also partners with BasicNeeds-Ghana in advocating for needs and rights of persons with mental illness or epilepsy.

MIHOSO Foundation (MIHOSO):

MIHOSO is the NGO partner of BNGh in the Brong-Ahafo Region under the Mid-Ghana Programme. They are being supported and capacity built to implement to entire Mental Health and Development (MHD) model.

Centre for the Development of People (CEDEP):

CEDEP is the project implementation partner of BNGh in the Ashanti Region under the Mid-Ghana Programme. They are being supported and capacity built to implement to entire Mental Health and Development (MHD) model in the Ashanti Region.

Ghana Health Service (GHS)

As the national health service outfit of Ghana, BasicNeeds extensively collaborates with the Ghana Health Services in areas of mental health service provision and provision of training/orientation to health workers, officials of other government decentralised ministries, departments and agencies, and civil society operators

Commission for Human Rights and Administrative Justice (CHRAJ):

BNGh collaborates with CHRAJ on human rights and general empowerment issues, where CHRAJ expertise are brought to bear on trainings provided to SHGs and other relevant stakeholders. Annual activity plans and project Logical Frameworks conducted through:

1. Periodic (quarterly) monitoring visits to partners organisations delivering projects

2. Use of templates for collecting baseline information and update of progress for people with mental illness or epilepsy covered under the programme

3. Activity and statistical tracking sheets used to maintain progress of project activity implementation and statistics

4. Half-year and annual programme partners review meetings

PROGRAMME OUTCOMES

2.1 USERS AND FAMILIES

A. Treatment Access

	MALE	*FEMALE*	*TOTAL*
Total Number of Users accessing treatment AT BASELINE	585	554	1139/1437
Total Number of Users accessing treatment DURING INTERVENTION	4093	5916	10009/19143
Total Number of Users accessing treatment AT BASELINE	183	161	344/1437
MH Outreach Clinics	5818	5668	11486
Community Psychiatry Units	3837	3779	7657

B. Service Accessibility: For Users and Families

Access to treatment is improving as increasing numbers of persons with mental illness or epilepsy come forward for treatment. The growing numbers of people covered (19143) under BNGh's programme attest to more people having access to treatment services. It has reduced distances people have to travel for mental health treatment services, including having access to a specialist and to medicines, and follow-ups. Even though specialist psychiatrist visits were fewer than the normal four visits to the northern parts of Ghana, CPNs involved in the outreach clinics maintained contact and support to service users. Community volunteers also provided extensive support to families and carers. These were continued at the community psychiatric units.

Service users and their families are positive about the improved access. For example, Ben, from Babile, near Lawra, explained during an outreach that "I was lucky to be first seen by a doctor from Accra [referring to the Psychiatrist]. I make sure I attend the outreaches as I cannot travel to Accra to see him. Since then I have been receiving support from Mr. Kakraba [the CPN of Lawra district CPU] and I feel much improvement now". Improvement for the future should be focused on supporting establishment of Community Psychiatric Units , at least, at the district level and this requires some logistics and personnel support for that.

Location	*Frequency of Availability*	*Distance (avg. in km) for users*	*Mode of transportation*	*Medicines (period given for & cost for Users/families)*
MH Outreach clinics	Quarterly & monthly	5km	Foot, bicycle/ motor cycle, Bus/Taxi	Free medicine, given to last a month. Subsequent medicines should be taken from the Community Psychiatric Unit till the next specialist psychiatrist visit
Community Psychiatry Units	Monthly	3km	Foot, bicycle/ motor cycle, Bus/Taxi	Free medicine, (sometimes it is prescribed for on-the-counter purchase) monthly. When purchased cost an average of the equivalent of GBP£6 per month

C. Symptoms and functional capabilities

A total of 19143 persons with mental illness or epilepsy are covered under the programmes of BNGh and receiving regular treatment services. These are contained in the Statistical Tracking Sheet and database of BNGh. New beneficiary service users for the year were 1433 and the remaining 17710 being users in the programme over the years. Of the 19143 users, key conditions that people are being treated for include schizophrenia (1710) making up just about 9% of the total number of users. A total of 3391 were diagnosed with unspecified psychosis, and 761 with depression, with a further 2532 with other mental disorders. People with epilepsy constitute some 53% of the total number of users.

Over the years people with no change in condition or relapse have been just about less than 10% of the total number of persons under treatment for the mental illness or epilepsy. The year 2011 was used for collection of baseline information of new beneficiaries covered under the programmes. There were no reports of relapse from the constant figures either.

There is no clear data source to discuss this section but considering that there have been no adverse reports on the conditions of users under the constant figures, it can be said that they continue to positively improve in their conditions. Such changes are seen in coherence in conversations with the user. The people under treatment also improve in the personal hygiene and are reported by the families to be taking their medications regularly with a good amount of punctuality.

Reduction in the symptoms of users is seen in an improvement in their general outlook and interactions. Users met will remark that they have clearer thoughts and sleep better. For those with epilepsy they mention reduction in the number of seizures they have in a month, which for them indicates a path to complete recovery. Improvements in attendance to meetings by users also give good indication that they symptoms have reduced and their faring well to integrate with the families and communities.

Increase in activities of primary care-givers of users also is an indication of improvement and reduction in symptoms of the mental illness of epilepsy users have.

The number of people doing productive work (818) and earning (344) lends credence to the significant progress and improvement in the condition and functional capacity of the service users.

Extensive public education and activities of the SHGs and their district associations have also been invaluable, with regards to the confidence they gain from their delieberations during meetings and livelihoods support received through the groups, is increasing functional capacity of users of mental health and epilepsy services and the carers. The Bongo SHGs enabled a destitute mentally ill person, popularly called *Guy 2* attain stability and thus able to participate in household chores and an active and quite articulate member of his SHG.

The involvement of service users in various activities such as in family discussions and SHG meetings are positive indications of the functionality of the service users. Most service users met usually express a desire to engage in a livelihood activities which is a positive sign to their functional capacity. Primary care-givers are also having enough time to go away from the persons they look after to engage in other productive activities. This is significant and points to increased functionality of the service users.

D. Understanding about mental illness and its management

At Baseline:

Most of the persons with mental illness or epilepsy and their primary care-givers usually reach service points with some exhaustion after a series of failed searches for treatment from such sources as traditional healers or spiritual. They would normally attribute their illness to some mystical or metaphysical. Some may have some knowledge of coping with the illness, whilst other may not at all but generally there is usually desperation to getting a cure for the conditions, until they are supported with some counselling.

Intervention – At the time of reporting:

Desperation and self-doubt have given way to hope for a better quality of life. Persons living with mental illness and epilepsy, and their primary care-givers have come to terms with their condition, which is important in coping with the condition. They have received more insight into mental illness and epilepsy and they have come to realise that they are not alone and that from within themselves, service users and primary care-givers could close ranks in bringing emotional relief and support to each other.

E. Ability to work, earn, study

Observations on Working, Accessing Credit

Adherence to treatment together with readily available financial resources and working tools made it possible for persons with mental illness or epilepsy and their primary care-givers to easily return to work or commence a paid job. Reduction is symptoms served to provide confidence of master trainers and craftsmen and women to train and offer payments for work carried by the apprentices under training.

The main difficulty was getting primary care-givers and families to provide match-funding for to support training and related activities of stabilised people going into training of engaged in paid jobs such as for feeding and transport expenses to commute to and from work. A key innovation was to encourage take up of productive activities and jobs within proximity of the users. The master-trainers and craft-men and women also went out of their way to provide small stipends to the users to support themselves.

Productive activities undertaken include household chores and participating in apprenticeship training. Inputs of beneficiaries have mainly being their time and cleaning of the work area, which include packing and unpacking of items (work tables and chairs) used.

Encouraging SHGs to operate a banking account and to disburse and repay any credit BNGh provides them using their banking accounts. This make it easier for them to built the needed recognition to apply for financial credit from the financial institutions. The challenges have been a combination of low literacy levels and irregular payment of membership dues and other related financial commitment. These were and continue to be addressed by an encouragement to match-fund initiatives of individuals and their groups to the tune of their contributions.

BNGh works with children and there is usually the challenge as to whether to support them through formal schooling or support then to acquire a trade skill. Their young age leaves dilemma with regards how best to support them with the limited resources available to work with.

F. Participation in User Carer SHGs, Other Groups

BNGh's operations deal mainly with the SHGs and their district associations and national association on one hand and the programme partners on the other. The programme partners are now more of resource organisations to the SHGs as the presence of the national secretariat of the national users and carers association is the structure around which operations of the SHGs revolve, with the extensive support of BNGh

There are several vibrant groups, among which are those based in Tinguri, near Walewale, Bimbilla, Bongo, Damango, Gushiegu, Kariga, the Garu and Bawku areas, Sandema, Lawra, Dafiamah, Ablekuma, Okaikoi, and Nima-Mamobi areas. Their vibrancy is due to commitment of members to attending meetings. Improved health status and financial credit support they secured from BNGh continues to play a role in galvanising members to stick together. Generally there has been appreciation strength in number which requires all service users and their carers come together for collective advocacy.
The groups in Tamale need support to pick-up in vibrancy. The SHGs in Tamale has suffered attrition as fairly stabilised users tend to drift away to engage in some activities rather remain in the groups.

A resource person facilitating SHG meeting at Bolgatanga

Of most benefit to users have been access to treatment services and resources (both financial and non-financial and logistics) that services users and primary care-givers which has made it possible for them to progress from treatment to productive activities.

Future plans for SHGs is to enable them collaborate with organisations and maintain such identify that can enable to effectively engage other as equal civil society organisations. Subsequent SHG development should be actively led by existing SHGs in order to increase their constituency for collective advocacy.

Regular Users

BASELINE				INTERVENTIONS				
	Male	Female	Total	Male	Female	Total	Data Source	Description
Working	***239***	***191***	***430***	571	***896***	1467	Built from reports of partners, including MEHSOG and BasicNeeds from activities implemented and from monitoring visits, especially on activities members of SHGs	People are variously engaged in food crop farming, vegetable and fruit gardening, making crafts and artefacts, tailoring and dress-making. Data is taken mainly from partner reports
Number Of Users involved in productive (non-remunerative) work	323	319	642	313	391	704	Reports of partners, including MEHSOG; available for verification	*At Baseline:* Household chores and being at home *intervention* Household chores (sweeping/cleaning rooms, doing the dishes and disposing of household refuse, baby-sitting, participating in family farms/gardens, collecting fuel-wood and water for domestic use.
Number of Users earning	239	191	430	258	505	763	Reports of partners, including MEHSOG; available for verification	*Types of work undertaken:* Hawking of fruits, sale of poultry and livestock; dress-making and tailoring, masonry and carpentry works, craft making and repair of footwear and bicycles
No. of Carers earning	636	272	908	785	1253	2038	Reports of partners, including MEHSOG; available for verification	*Types of work undertaken:* Processing of food stuff, including shea-butter extraction and making of local cooking spices, craft making, sale of provisions (groceries); sale of poultry and livestock; dress-making and tailoring, masonry and carpentry works
No. of children going to school	236	158	394	72	81	153	Reports of partners, including MEHSOG; available for verification	

Activity	Number of Users			Data Source	Description
	M	F	T		
Gained Insurance coverage	69	148	217	Reports of programme partner and MEHSOG	Mutual health insurance scheme to benefit from free treatment of illnesses apart from mental illness

G. Rights

The right to seek audience with policy authorities and be accorded and given a hearing was the most successful for users. as users engaged with the select committee of Parliament for health, the Minister of Health, Minister of Local Government and Rural Development, as well as several District (this includes the Municipal and Metropolitan) Chief Executives and a number of local traditional authorities.
Users have cultivated some assertiveness which is helping them in their own efforts to engage and make their voice heard. " I feel happy with the way the Members of Parliament so well received and listen to us. Every member of the committee listened to us with attention and respect" (Rose Z. a member of the National Executive Council of MEHSOG). The engagements have taken away from the users the fear they had that was making it impossible for them to engage with such high profile persons.

i. User Carer Self Help Groups, Children or Youth groups (mainly for Users)

Level &Type of Group	Number of SHGs	Number of Members	Users	Carers	Data Source	Main Activities
Community/ Village	183	11213	M 2320 F 3318 T 5638	M 850 F 3725 T 5575	Records of the SHGs they maintain themselves	Group meetings, peer support to members, collective advocacy, access to financial credit and secure livelihoods activities. Almost all the 57 active community volunteers provide support to the various SHGs and their district associations, even though they are neither service users and care-givers
District	43	3360	M 441 F 673 T 1084	M 996 F 1380 T 2276	Records of the district associations of SHGs, partner reports	Represent community SHGs at the district level mainly engaged in advocacy and mobilisation of resources for member SHGs
National	1	11213	M 2320 F 3318 T 5638	M 1850 F 3725 T 5575	Records of the national secretariat of national mental health service users & carers association	Support to member SHGs Advocacy for MH inclusion of people with mental illness or epilepsy and primary care-givers in resources and opportunities for secure livelihoods and on the passage of the mental health Bill into law by parliament

H. Gender

There were slightly more male than female users at the baseline. However, females dominate in most activities ranging from membership in SHGs and district associations, engagement in productive activities and/or paid jobs and earning income. The prominence of women is justified in the general demographics

of the country but also because socio-culturally females are more of care-takers and nurses of ill people than men. Female also tend to be more in small scale enterprises and willing to take up small credit facilities to engage in livelihoods activities and this is reflected in the number of female that are engaged in productive activities and earning income.

Maama Sumaila's Story

Maami Sumaila is a senior high school leaver, who was diagnosed with epilepsy and benefited from treatment under the BNGh-supported specialist outreach clinic. Even though quite young she became one of the very active members of the Walewale SHG and was elected into the leadership of the SHG. She had been key in organising many of the meetings with the District Assembly. Maami's symptoms have significantly reduced and the dosage of her medications was stepped down. Following such remarkable improvement she decided to travel to her half-brother living at Atebubu in the Brong-Ahafo Region.

Being active and using experience of engaging with the local government authorities, Maami was successfully included in a sponsorship package for remedial classes to improve her grades. She was also successfully recruited as a volunteer teacher to serve in one of the deprived schools. In a meeting, Maami recounted that: *"I have applied the training we received in lobbying and advocacy and have benefited from the District Assembly. I am known in the District Assembly because I know how to go about things and the District Chief Executive is keen to help me progress with my education. People are surprised about me but I have learnt through the trainings to be confident and pursue my dream, no matter the experience I endured with the seizures I used to suffer. On learning that BasicNeeds had just begun to work in mid-Ghana of which the Atebubu-Amanten District is one of the districts covered by the programme area, she assured that "I will bring my experiences of our SHG in Walewale to support the work here. I see a lot of people need to be supported with treatment and a voice to address their needs and rights"*.

Maami is one good example of how under the activities of BNGh people have progressed in even in the face of stigma and other adversities they have to confront.

2.2 COMMUNITY

A. Awareness and perceptions about mental illness/epilepsy

At Baseline:

Findings of the baseline study for the Northern Ghana and Accra Programmes projects found mental illness and/or epilepsy to be highly stigmatised. Most people know mental illness exist but perceive it to be caused by supernatural factors abuse of hard drugs. This has made most people mainly use prayer camps and traditional healing practitioners in their search for remedies of the conditions. At the start of operations of BNGh in the country there was the general belief that mental illness can hardly be treated but there was understanding that something needed to be done to support people with mental illness or epilepsy.

Intervention – At the time of reporting:

A sea of change in awareness and attitude about mental illness or epilepsy has occurred for the better over the years that BNGh has been operating in the country. The increase in numbers of people demanding treatment services is evidence of the change in perception and attitude as individuals with mental illness or epilepsy and families with relation(s) with mental illness or epilepsy coming forward to treatment.

Theres has been, likewise, an increase in activities of groups of people with mental illness or epilepsy and their primary care-givers to mobilise and engage in policy advocacy and influencing activities. Media activities have increased information about the facts and realities of mental illness which is steadily replacing erroneous perceptions and attitudes. This is evidenced in the growing numbers of people with mental illness or epilepsy, individually, and with support of their families, accessing mental health services from formal health service facilities. Derogatory remarks formerly used by a section of the media (*eg. mad, insane, deranged, etc.)* are gradually giving way to more accommodating terms like *'mentally ill', 'mentally challenged', and 'mentally disabled'*. This is definitly evidence of an improved media awareness and attitude with regards to the media.

B. Involvement of Community Stakeholders

At Baseline:

There was limited involvement of community stakeholders in mental health activities. This could be attributed to limited opportunities and/or absence of structured programmes to promote inclusion of people with poor mental illness or epilepsy in mental health and development processes. Existing pro-poor projects did not include people with mental illness or epilepsy and primary care-givers. Traditional leaders and local government and health authorities hardly considered mental health issues in health and development issues.

Intervention – At the time of reporting:

Involvement of stakeholders is seen from the family, local community groupings to district and regional organisations and institutions that have a bearing on mental health and development and human rights of poor and vulnerable people.

Increased involvement of local assembly-members has been helpful for community organisation, especially community meetings. Community volunteers have linked effectively with local leadership such as traditional and religious leaders to publicly show involvement as a means to increase awareness and support for mental health.

District level decentralised Ministries, Departments and Agencies (MDAs) such as Department of Social Welfare, Department of Community Development, CHRAJ, and National Commission for Civic Education (NCCE) have individually and collectively supported mental health and development activities at the local and district level. A number of these MDAs have also been active in the region-based Alliance for Mental Health and Development which provides an effective forum for NGOs/CSOs and other government MDAs to promote mental health and human rights of users and their families and carers.

Traditional healers and managers of prayer camps have also been influenced to improve upon their practices and uphold human rights of people with mental illness or epilepsy they handle in their practices.

Case study

SHGs are actively operating in their various localities with little hindrance and are now recognised as representative entities for needs and rights of people with mental illness or epilepsy. Growing levels of family understanding and support to people with mental illness or epilepsy, and primary care-givers have gone a long way to enhance their happiness and confidence. "The fact that we see people who were quite ill due to their mental illness are living quite decent lives attest that one can still get well from his illness and play useful roles. You have to sit in their meetings and you will understand that serious matters" (Amadu, Assembly-member). "We used to behave badly towards destitute people with mental illness but now I understand instead they need our support most" (Abu Alhassan, family members of a mentally ill woman in Salaga).

C. Resources in the community

Intervention – At the time of reporting:

Resources in the community have mainly been its people. Before BNGh began operations, community members did not actively support or initiate mental health and development at such level. However, on commencement of operations, a large corps of community volunteers have served as valuable community resources supporting the operations implemented by BNGh. Close to 60 community volunteers are now actively involved in activities meant to improve the wellbeing of people with mental illness or epilepsy and their poor primary care-givers and families.

Space and appropriate venues of communities, such as schools and community centres, have been used for meetings and other gatherings for mental health and development, whilst local authorities (including chiefs and opinion leaders) support operations of BNGh. This has given BNGh the needed legitimacy to continue its operations with all the credibility it has. Financial resources and other logistics have, however, been difficult to secure.

2.3 POLICY

There is now increased attention to developing and implementing a community based mental health service integrated into general care. This shifts over-concentration on the three Psychiatric hospitals to emphasising community care and the strategic document being written would effectively response to this. It will also make the Ghana Health Service at the district level more responsibilities provide credence for increased investment at the District Assembly level to support mental health and epilepsy services and livelihoods activities. (*Refer to Appendix 1, table 2*)

2.4 PRACTICE

Observations on Practice

There is growing improvement in general attitudes and practices, especially from health workers and some policy authorities at the local and national levels. However complete transformation and integration of mental health in general health care at the all levels is hinged on adequate budgetary support and personnel, which are still highly inadequate.

A. Integrated Services:

Challenges

Issue or Problem	*Specific details of change or results achieved*	*Exact role and contribution of your programme*
Lack of transport to support CPNs to undertake community education	New motor-bikes have been provided to 8 CPNs with a weekly allocation of fuel to support community outreach activities	BNGh participated in 4 regional annual review meetings and raised the issue of lack of transport for CPNs and followed with meeting with specific District Directorates of Health services and which timely contributed to allocations of new motorbikes that were received by most of the districts for maternal and health related activities to CPNs as part of promoting integration of services
High costs in bringing Psychiatrist to outreach clinics	A number of District Health Management Teams provide accommodation to psychiatrists who travel to the districts to provide outreach clinics	BasicNeeds had 4 meetings and submitted memorandum to the district health authorities for provision of accommodation to psychiatrist

Human Resources

Trained MH Personnel available at	***Number***	***Who are the personnel?***	***Explanation***
Community level: - Northern Ghana - Accra Area	40 36 4	40 CPNs	*Trained by:* Nursing training college of the Ministry of Health/Ministry of Education and the Ghana Health Service/Ghana Education Service. In-service training has also been variously provided to the health workers as part of sharpening their skills and keeping them up-to-date on good practices *Duration of training*: 2-3 years training; *Topics covered:* General nursing, community psychiatry and clinical practices. BNGH supported INSETs have been around mental Illnesses and epilepsy, basic skills in identification and common medications in us, follow-up and documenting/ reporting on beneficiaries under the programme.
District/ higher levels	76	CPNs and general nurses	*Trained by:* a Psychiatrist and CPNs of the Ghana Health Service and, one private clinical psychologists and one social worker *Duration*: three days *Topics covered:* Common mental illnesses and epilepsy, basic skills in identification, medications for various common conditions, counselling and occupational therapy

Case study

The Psychiatric Unit at the Bolgatanga Regional Hospital, since its creation over two decades ago, was operating from a garage near the Pantry of the hospital . The unit was recently relocated to the Out-Patient Department (OPD) of where it occupies three of the five consulting rooms, with a large space to serve as waiting area for people waiting for their turn.

This allocation of the area to the Community Psychiatry Unit was over other units of the hospital that were jostling for selection to occupy the place. This has been as a result of the firmness of the Medical Director of the Hospital, Dr. Amia. He declared that he had made it a promise to find a suitable place for the psychiatric unit, explaining in his own words that:

> *"I think psychiatry deserves a pride of place than it is getting now. I consulted the Regional Director and he too was all for it. This is important for mental health because this OPD area is a central part of the hospital and it is my hope that soon services will be more integrated".*

The Deputy Director of Nursing Services (DDNS) in charge of mental health in the Upper East Region, Mr. Peter Akangwire, agreed they have been accorded the recognition that they have not had all these years. He added that he hoped the district hospitals will emulate the move of the Director of the Regional Hospital to provide adequate decent space for the privacy and comfort of people accessing mental health services.

2.5 FUNDERS

Funds Raised	*In cash (£)*
Total Funds raised by your organisation in 2012 (year)	- GBP£479,079 - USD$115,000 - EURO471,029
Funds raised for Mental Health	- GBP£479,079 - USD$115,000 - EURO471,029
Source(s) of funding - Development agencies of the governments of the United Kingdom (UK) and the European Commission (EC) - In-country polled funding schemes (such as STAR-Ghana to which DFID, DANIDA and the EU contribute to) - Funding project scheme (such as the Mwananchi Project run by the Participatory Development Associates of Ghana with funding from the Overseas Development Institute (ODI) of the UK	No of funder: 4

2.6 ENGAGING STAKEHOLDERS

A. Networks

BNGh is a member of the Network for Women's Rights in Ghana (NETRIGHT), a national network of organisations committed to gender and women's rights. This enables BNGh to raise awareness among the network members of mental health issues and women, especially in areas of burden of care and equity in care issues.

B. Collaborations

BNGh has collaborated with a number of organisations for awareness creation, policy advocacy and service provision. BNGh collaborated with the Ghana Behavior Change Support (BCS) Project of the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs to build documentaries and adverts on the links of malaria on epilepsy in children which were extensively aired over national television networks.

BNGh also worked with Ark Foundation and the Ghana chapter of the International Federation of Women Lawyers (FIDA) to make presentation on women and mental health in the context of rights of women.

C. Alliances

BNGh continues to build on and lead the region-based Alliance for Mental Health and Development where three of such are actively involved in advocacy and building capacity of member organisations to include people with mental illness or epilepsy and general mental health issues in their programmes and activities. The Alliances have also improved attitudes and practices of the organisations.

2.7 KNOWLEDGE DISSEMINATION

During the year under review, a publication enttled *'Predictors of Women's Mental Health in Ghana'* was successfully completed by Victoria De Menil, Akwasi Osei, Nedialka Douptcheva, Allan G. Hill, Peter Yaro And Ama De-Graft Aikins. This literature is scheduled to be published in the *Ghana Medical Journal of Science*

PROGRAMME CHALLENGES

3.1 CHALLENGES FACED BY PROGRAMME

Funding constraints and inadequate staffing for such a large expanse of the programme areas have severely increased work load of staff. Low capacities and resource standing of the programme partners have not helped the situation, just as a remarkable reduction in the number of community volunteers that were supporting the programme at a fee.

A lot can be achieved with little resources once there is commitment and willingness to partner government and build good networks and relations to drive the work. The growth of the programme has been anticipated, but significant reductions in the funding has somewhat affected the pace at which projects were carried out. This is also true for start-up initiatives and the ability to sustain existing operations.

This means a more strategic and innovative approach to fundraising, that will make it possible for BNGh and the mental health and development model to benefit from much more funding needs to be put in place. This, in turn, would help avoid spreading focus thinly and rather concentrate on key issues and geographical areas.

This is challenge considering how integrated and holistic the mental health and development model is in addressing the needs and rights of people with mental illness or epilepsy and their primary care-givers.

3.2 LIMITATIONS OF PROGRAMME'S DATA AND EVIDENCE

Limitations of programmes' data and evidence have been inadequate documentation, mainly attributable to incompleteness, in terms of disaggregation of the data, and poor timelines due to delays. BNGh relied substantially on Community Volunteers to provide updates and reliable statistics but since their reduction in number due to mainly funding reason, collection of information has drastically reduced.

The expanse of the programme areas continues to be a challenge and this is most affected by delays in information and reports coming in on time. This is closely related to the large number of beneficiaries operations of BNGh have covered, a number which continues to make it quite difficult to follow each and every one of them consistently over all these years.

Capacity of partners to produce good quality reports with relevant statistics and facts still leaves more to be desired.

Appendix 1

Programme Statistics

Table 1

OPERATIONAL FIGURES AS AT 31ST DECEMBER, 2011.

	ADULTS		ADOLESCENT		CHILDREN		
Number of people with mental illness/epilepsy in the programme	Male	Female	Male	Female	Male	Female	Total
Schizophrenia	803	810	26	29	22	20	1710
Unspecified Psychosis	1394	1740	76	74	50	57	3391
Bipolar Disorder	13	7	1	0	0	0	21
Anxiety	106	139	2	11	11	7	276
Depression	215	508	6	16	5	11	761
Phobia	1	1	0	0	0	0	2
Obsessive Compulsive Disorder	0	2	0	0	0	0	2
Psychosomatic disorder	7	22	0	1	1	0	31
Epilepsy	3106	2637	605	553	1835	1433	10169
Suicidal tendancy	5	5	0	0	0	0	10
Alcoholism/ Substance abuse	60	10	6	0	0	0	76
Other Mental Disorders	973	1029	58	46	228	198	2532
Diagnosis not known	60	59	4	9	17	13	162

Table 2

POLICY

Policy or legislation addressed	Specific change or results achieved	Exact role and contribution of your programme
National strategy on Mental Neurological Substance Abuse Disorders	Users' perspective included	BNGh contributed to drafting of policy; provided data from PDA and outcome study analysis
Ghana Health Service (GHS) national community mental health implementation strategy currently under development	Perspectives of NGO/CSOs of users and advocacy organisation shape the news policy	BNGh contributing to the drafting of the strategy, which is expected to be ready in 2012.

Table 3

FUNDS ALLOCATED (FROM GOVERNMENT) AND OTHER SOURCES

Source of Funds	*Amount*	*Explanation*
District Assemblies support to activities of SHGs	GHS¢1,500	West Mamprusi District Assembly gave GHS¢1,500 to the District Association through the Community Psychiatric Unit to support procure medicine for the users as stocks from general medical stores run out. Similarly the SHGs in Tolon-Kumbungu also received GHS¢500 for similar purpose
Health Directorate and hospitals Budget Management Centre	In-kind funding	Provision of fuel and means of transport for community outreaches and home visits, as well as payment of allowances to CPNs for filed visits

Table 4

CUMULATIVE FIGURE AS AT 31ST DECEMBER, 2011

Operational Figure	*Data Source*
19,143	BNGh MS Access database and Statistical Tracking Sheet

Cumulative Figure
19143

Figure 1

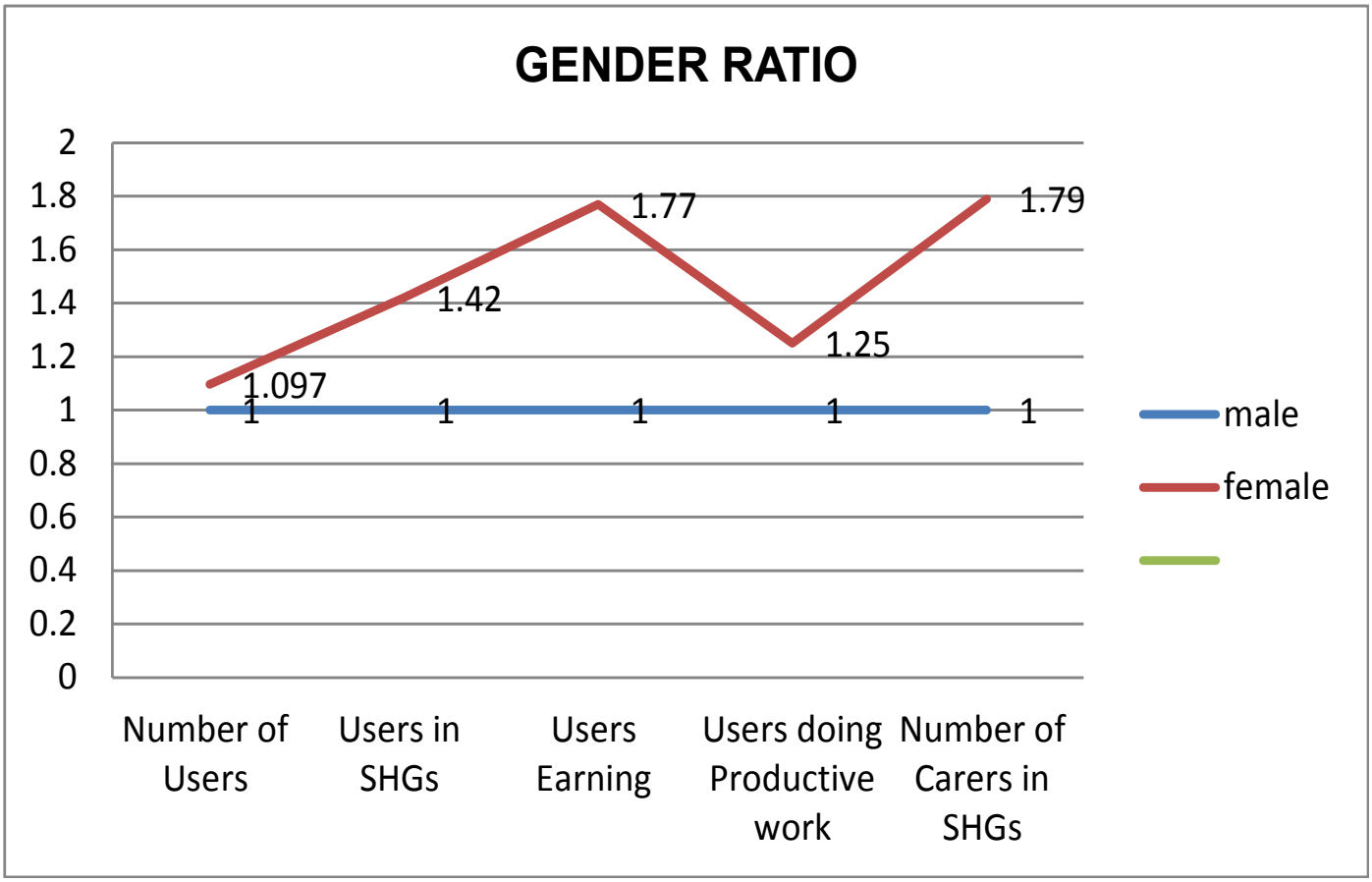
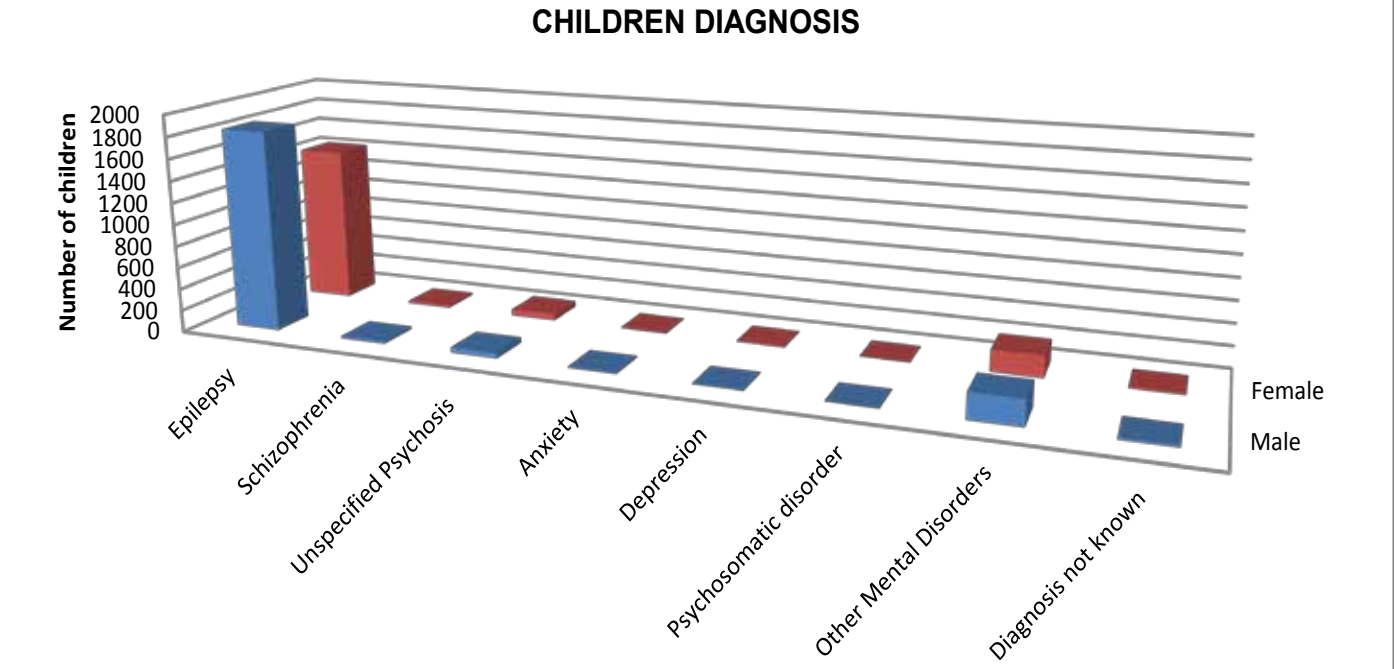


Figure 2



	Epilepsy	Schizophrenia	Unspecified Psychosis	Anxiety	Depression	Psychosomatic disorder	Other Mental Disorders	Diagnosis not known
Male	1835	22	50	11	5	1	228	17
Female	1433	20	57	7	11	0	198	13

Appendix 2

LIST OF DOCUMENTS AND EVIDENCE BASES USED TO PREPARE THIS REPORT

1. BNGh Activity Tracking Sheet – January-December 2011
2. BNGh Statistical Tracking Sheet – January – December, 2011
3. Process documents from participatory review sessions – Bolgatanga & Bongo
4. Report on training of partners of mid-Ghana project on basic psychiatry and the BasicNeeds model for community mental health
5. Report on Launch of photo-book, 'Ghana-A Picture of Mental Health'
6. Reports on training of leaders and selected members of SHGs on advocacy, campaigns and public speaking
7. Programme partners activity and quarterly reports (ZOVFA/CSRC, GKS, CPRI, MEHSOG, MIHOSO, CEDEP)
8. Report orientation/training of government agencies in mental health and human rights of people with mental illness or epilepsy and their care-givers
9. Report on orientation/training of elected district assembly members on mental health and human rights of people with mental illness or epilepsy

FUNDS FROM NON-GOVERNMENTAL DONOR SOURCES

Annual turnover was GH¢615,419 (£281,502) and this was primarily used for Mental Health. Donors were *Comic Relief, Jersey Overseas Aid Commission, PDA/DFID-ODI Mwananchi Project, STAR-Ghana, EU and NSA-LA*