EQUITABLE ACCESS TO TREATMENT FOR PEOPLE WITH MENTAL ILLNESS IN SUB-SAHARAN AFRICA REPORT

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MENTAL HEALTH: ACCESS TO TREATMENT AND MACROECONOMICS IN GHANA

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TABLE OF CONTENTS

TABLE OF ACRONYMS

ADHA	Additional Duty Hour Allowance
AFRC	Armed Forces Revolutionary Council
AIDS	Acquired Immune Deficiency Syndrome
APH	Accra Psychiatric Hospital
CHAG	Christian Health Association of Ghana
CPNS	Community Psychiatric Nurses
CVD	Cardiovascular Diseases
CWIQ	Core Welfare Indicator Questionnaire Indicator
DALY	Disability Adjusted Life Years
DFID	Department for Intentional Development
DHMT	District Health Management Teams
EPI	Expanded Programme on Immunization
GDP	Gross Domestic Product
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GHS	Ghana Health Service
GLSS	Ghana Living Standard Survey
GLSS	Ghana Living Standard Survey
GNP	Gross National Product
GPRS	Ghana Poverty Reduction Strategy
GSS	Ghana Statistical Service
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
IGF	Internal Generated Fund
ISSER	Institute of Statistical, Social and Economic Research
MDG	Millennium Development Goal
MH	Mental Health
MOH	Ministry of Health
MTHS	Medium Term Health Strategy
NDPC	National Development Planning Commission
NGO	Non Governmental Organisation
NIAMH	Northern Ireland Association for Mental Health
OPD	Outpatient Department
PHC	Primary Health Care
PNDC	Provisional National Defence Council
PNDL	Provisional National Defence Council Law
POW	Programmes of Work
PRO	Public Relations Officer
RMN	Registered Mental Nurses
SAP	Structural Adjustment Programme
SAPRI	Structural adjustment programme Review Initiative
SRN	State Registered Nurses
SSA	Sub-Saharan Africa
STEP	Skills Training and Employment Programme
SWAp	Sector-wide Approach

UK	United Kingdom
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Fund
USA	United States of America
WHO	World Health Organization

EXECUTIVE SUMMARY

The present study is an attempt to understand the macro and micro level influences on mental health with regard to access to treatment and care in Ghana. This study is part of a larger research project of BasicNeeds in Ghana,, which was supported by the International Development Research Center (IDRC), Canada. The primary aim of the project is to provide recommendations to improve mental health through equitable and affordable access to treatment so people with mental illness can benefit from development.

In most developing countries like Ghana, mental health programmes have very low priority (WHO, 2001). Provisions for mental health care and facilities, therefore, are usually limited to very few institutions which are inefficient, understaffed and overburdened. Given this backdrop of dismal situation of mental health provisions in Ghana, the study firstly explores the mental health system in Ghana, its link with and its importance, within the overall health system in the country. It also analyses those aspects of mental health resources and functioning which are linked to larger economic policies and factors in the country. More specifically, the study investigates the macro-economic factors which influence mental health policy making and implementation. The methodology followed for the study is exploratory in nature and descriptive of government documents, laws and policies and other existing literature.

In Ghana, even though mental health disorders and substance abuse are on the rise, they have not been given sufficient emphasis in national and district policies and programmes (MOH, 2005). The mental health policy is embedded in the overall health policy framework of the country. Mental health care remains woefully under-resourced in Ghana. Relative to the total budget ceilings of the Ministry of Health and GHS the psychiatric hospitals received below 3% in 2004 and about 7% in 2005 (MOH,2005).

The study further finds that the existing mental health policy in the country is limited in perspective, as it sees mental health only as a clinical problem and not as a developmental issue. Its failure to address the inconsistencies between physical and mental health care also compounds the problem of implementing effective mental health policies. It has no consideration for community mental health and rehabilitation of people with mental illness. The principle objective of the newest National Mental Health Policy, 1994 fails to meet its top goal of decentralization.

Fifteen years down the line, only five tertiary and regional hospitals have psychiatric units (besides the three Psychiatric Hospitals in the country). Additionally, the mental heath sector is constrained by inadequate human resources. Access rates to mental health services in Ghana are generally low, attributable to low density of health facilities, high inequality in the geographical distribution of health facilities and inadequate mental health professionals. According to the WHO estimates, the ratios of psychiatrists and neurosurgeons per 100,000 populations in Ghana are about 0.08 and 0.01 respectively (WHO 2005). The ratio of psychiatric beds in mental hospitals per 10,000 population is as low as 1 in the country as compared to 4 and 15 in South Africa and Netherlands respectively. The

community mental health care system offers only limited services to about 53 districts out of 138 districts in Ghana due to human and financial resource constraints.

The principle recommendations of the study include:

- Mental health should be viewed as a developmental issue and policy needs to be changed to accommodate that perspective.
- Access to mental health services needs to be widened through decentralisation of services and facilities.
- In view of serious human resource constraint, renewed training and recruitment is the urgent need of the day.
- And finally, it is important to dissociate mental health from expensive facilities and shift to less costly community based but more relevant treatment and rehabilitation services.

Chapter 1

INTRODUCTION

The post-world war II can be said to have witnessed tremendous improvements in the health of every nation. Average life expectancy at birth of all nations has, for instance, increased from 46 years in the early 50s to 65 in 2003. Similarly average probability of a child dying before the age of 5 years has improved from 124 in 1978 to 83 per 1000 in 1998. In Ghana, for instance, available data shows that morbidity pattern or prevalence of diseases have improved a lot over the years since independence in 1957. Ghanaians live longer, and are healthier today than at any other time in its history. Since 1950 life expectancy in Ghana has increased from about 41 years to 58 years - a gain of about 17 years. Similarly there have been tremendous improvements in the control and the eradication of diseases like onchocerciasis, polio, leprosy, small pox, etc. With increasing utilization of safe motherhood services by reproductive women, maternal and child health have witnessed tremendous improvements. Maternal and infant mortality rates (U5MR) have reduced substantially from 255 per 100,000 live births and 133 (155) per 1000 live births in 1983-1987 to 214 and 57 (111) in 1999-2003 respectively[1].

Despite the tremendous progress made in controlling the burden of disease, morbidity and mortality rates world-wide due to increased efforts, it appears that mental health is not accorded the same importance as physical health. Particularly, in most developing countries like Ghana, as noted by the WHO (2001), mental health programmes have very low priority. Provision of mental health care is limited to a small number of institutions that are usually overcrowded, understaffed and inefficient. Service provision is concentrated only in large mental hospitals that operate under legislation which is often more penal than therapeutic, and the locations of these are not easily accessible. In Ghana, for instance, there are only three psychiatry hospitals located in only two towns all in the southern part of the country. Even though mental health disorders and substance abuse are on the rise they have not been given sufficient emphasis in national and district programmes (MOH 2005). Despite experts estimates that about 200,000 people currently suffer from severe mental disorders[2], mental health issues do not even feature in the country's health strategic plans (MTHS in MOH 1999). Neither do they feature in the country's two rolling programmes of work for the health sector (POW II 2006, MOH 2003).

Consequently, services reflect little understanding of the needs of mentally ill people or the range of approaches available for treatment and care. Thus in Ghana like most of the developing countries a large majority of the population do not have access to psychiatric care. This led WHO to conclude in a world wide study in 2001 that mental health, even though very crucial to the overall well-being of individuals, has been

[1] The data included in here were taken from various sites from WHO website.

[2] From the WHO world wide estimates Ghana can estimate the prevalence of mental disorders on the basis of a total population of 20 million people, as follows:

- 5,000,000 will suffer from neuro-psychiatric conditions during their lifetime.
- 2,000,000 will suffer from neuro-psychiatric conditions at a given time.
- 200,000 will suffer from severe mental illness.

neglected for far too long and consequently made a call for a new understanding of mental health to address the treatment gap. The call was made in the light of the rising magnitude and burden of mental and behavioural disorders.

Today mental and behavioural disorders are known universally to affect 20–25% of all people at some time during their life and this is irrespective of country and society, or age (WHO 2001)[3]. Currently about 400 million people across the world are assumed to suffer from mental and psychological disorders. Experts expect mental disorders to surge to the second most common cause of death and disability by 2020[4]. It is estimated that major depressions are now the leading cause of disability globally and ranks fourth in the ten leading causes of the global burden of disease, costing an average of 1-4% of yearly GDP in lost productivity and other social costs (Jenkins et al., 2004, IoM 2001). The seriousness of the issue is that mental problems and disorders also affect children and youth from all socioeconomic and racial/ethnic backgrounds, with the majority of them not receiving treatment. According to estimates, one in five children and adolescents has a mental health disorder and at least one in ten — or as many as six million children — suffers from a serious emotional disturbance that severely disrupts daily functioning at home, in school, or in the community (NIHCM 2005). Moreover, many developing countries like Ghana have been forced to implement economic reforms in the face of stagnating economic growth and these reforms have generated deep social and economic crises. These conditions of crises create socio-economic stress and a favourable context for mental disorders.

The importance of the renewed call for more understanding of mental health reflects attempts to dismantle many of those barriers – particularly of stigma, discrimination and inadequate services – which contribute to treatment gaps and inequitable access to mental health care, particularly, in developing countries. These attempts can also be seen against the background that mental disorders have a large direct and indirect socio-economic impacts, including service costs. For instance, the negative impact on the quality of life of individuals and families is massive. It is estimated that, in 2000, mental and neurological disorders accounted for 12% of the total disability-adjusted life years (DALYs) (WHO 2002). By 2020, it is projected that the burden of these disorders will have increased to 15% (Murray and Lopez 1996). For a developing country like Ghana the burden could be enormous if the barriers to equitable access to mental health care are not dismantled as soon as possible.

Purpose of the Study

This study is part of BasicNeeds Ghana larger research project and is supported by International Development Research Centre, (IDRC) Canada. The project's aim is to improve mental health through equitable and affordable access to treatment so people

[3] WHO estimates that at any one time, as many as one in four of the world's population suffer from different forms of mental, behavioural and neurological disorders, including affective disorders, alcohol and drug abuse, epilepsy, dementias, mental retardation, schizophrenia and stress-related disorders (WHO 2002a).

[4] BBC News (Tuesday, 9 January, 2001, 20:12 GMT) Surge in mental disorders predicted, http://news.bbc.co.uk /1/hi/health/1108793.stm

with mental illness can benefit from development. This specific study has the objective to improve understanding of micro- and macro-level influences on mental health with regard to access to treatment and care.

Research Questions

i) What does the Mental Health (MH) system look like in Ghana? And how does it link with the existing health system?

ii) What aspects of MH systems i.e. resourcing and functioning – linked to economic policies/factors

iii) Are there macro-economic factors/policies that affect mental illness and MH policymaking?

iv) How do these economic factors influence MH policy making and implementation?

Scope of the Study

1. National Economic aspects.

The study covers relevant government economic policies and indicators for investment, trade, loan & debt payments, health, education, and social expenditures, income levels, insurance coverage, government's poverty reduction/eradication programmes in relation to mental health delivery in Ghana.

2. Mental Health Policy aspects

The study also covers mental health systems and MH policy for resource allocations and services, patterns, infrastructure and available human resources and their link to the overall mental health service delivery in Ghana.

Chapter 2

The Ghanaian Economy and Poverty in Ghana – An Overview

Ghana, about 238,538 sq. km in size, is located on the West Africa's Gulf of Guinea only a few degrees north of the Equator and has a population of about 20 million. The country is predominantly agriculture, which contributes about 42.5% of its GDP, followed by services (32.5%) and industry (25%) (see table 1). The country's economic development trend has been uneven over time since independence. After enjoying rapid economic growth in the fifties and early sixties the economy experienced successive declines till the early eighties, when it introduced an economic recovery programme. Even though the programme has succeeded in reversing the downward trend in the economy, poverty still remains very high in Ghana with a per capita income of about US$420.

Table 1 Sectoral Distribution of Real GDP (Period Averages (%))

Sector	1970-75	1976-82	1983-86	1987-90	1991-95	1995-00	2000-05
Agriculture	52	51	52	46	42	39.5	42.5
Industry	19	17	12	14	14	27.5	25.0
Services	29	32	36	40	44	33.0	32.5

Source: Calculated from Statistical Services Quarterly Digest of Statistics, various issues, ISSER The State of the Ghanaian Economy Report, (various issues).

In the face of the country's low level of development poverty remains very high, even though the level has declined in the 1990s from an estimate of 51.7% in 1991/92 to 39.5% in 1998/99. Moreover, the poverty picture masks wide spatial disparities. The headcount index amongst rural communities, for instance, compared to urban communities is higher (Table 2). Extreme poverty is also higher in the three northern regions of the country, ranging between 57% and 80% (Table 2) and lower (2%) in the Greater Accra Region. Even the decline in poverty did not occur in all regions of the country. The incidence of poverty even increased in the 1990s in three regions (Central, Northern and Upper East), two of which (Northern and Upper East) are amongst the poorest in the country.

Table 2: Incidence of Poverty by Region and Location in the 1990s

Region	**Proportion below the lower Poverty line,**		**Proportion below the Upper Poverty line**	
	1991/92	1998/99	1991/92	1998/99
Western	0.42	0.14	0.60	0.27
Central	0.24	0.31	0.44	0.48
Greater Accra	0.13	0.02	0.26	0.05
Eastern	0.35	0.30	0.48	0.44

Volta	0.42	0.20	0.57	0.38
Ashanti	0.25	0.16	0.41	0.28
Brong-Ahafo	0.46	0.19	0.65	0.36
Northern	0.54	0.57	0.63	0.70
Upper West	0.74	0.68	0.88	0.84
Upper East	0.53	0.80	0.67	0.88
Urban	15.1	11.6	27.7	19.4
Rural	47.2	34.4	63.6	49.5
Total	39.5	26.8	51.7	39.5

Source: Ghana Statistical Services (2000) The Pattern of Poverty in the 1990s, Accra.

Overview of Health System in Ghana

The provision of Health care in Ghana can be categorised into orthodox, traditional and spiritual systems (Appiah-Kubi 2003). The orthodox health care delivery system is clinic-based, and is mainly provided by government, private practitioners and religious missions. The government of Ghana, which manages the health sector through the Ministry of Health (MOH) and the Ghana Health Services (GHS), owns about 58.4% (Appiah-Kubi 2003; MOH 1999a) of facilities within the sector. Government health facilities in Ghana consist of four levels in the urban areas and five levels in the rural areas of health care providers. The divisions are based on the amenities, levels and type of personnel available in a facility. The MOH also provides mobile health services, including immunization as well as family planning and reproductive care to rural residents[5]. In addition the country has a network of maternal homes, which are owned by the government and private individuals (Canagarajah and Ye 2002). The government also pays a substantial share of the private and missionary health expenses in the form of subsidies.

The second largest provider of orthodox health care services comprises the private providers, which also include the (quasi private) missionary providers. There is also a Coalition of Non Governmental Organisations (NGOs) working in the health sector. However, whereas the majority (almost 60%) of health centres, clinics and the tertiary hospitals in Ghana are owned or run by the government, most of the facilities at rural areas are owned by private entities and missionaries. The missions providing health care in Ghana have of late grouped themselves under the umbrella Christian Health Association of Ghana (CHAG). It is estimated that in 1998/1999 almost half of all visits to health facilities occurred in the private sector (GLSS 4)

The traditional health care system on the other hand comprises herbalists and fetish priests, whose operations involve the use of herbs and invocation of 'spiritual powers'

[5] The latest population census (2000) estimates the share of the rural population of Ghana at about 56.2% and that of the urban population at about 43.8% (GSS 2002).

of a deity in diagnosis and treatment of diseases. Another source of traditional medicine, which is rapidly gaining currency, especially, among women, is religious spiritualism, where treatment is sought through prayers and faith healing. It is estimated that over 70% of the population use traditional medicine, even though it still remains to be adequately integrated into the formal health sector (GSS, NMIMR and ORC Macro. 2004: Ghana Demographic Health Survey, 2003). Self-medication or self-prescription without consultation or any expert advice is also rapidly becoming popular. Similarly the use of drugs on the suggestions of a drug store operator, who might not necessarily be a pharmacist, is on the increase. In both cases the patient avoids the payment of consultation fee of a medical expert and the distance costs to a health facility.

Structure of Health Service Delivery

Health care delivery in Ghana, as pointed out above, is provided by both the public and private sectors. Under the public health system, the service delivery is under-taken largely by Ghana Health Service, and teaching hospitals, both of which constitute the bulk of the Ministry of Health Institutions. In addition, other quasi government institutions and statutory bodies are also involved in health service delivery such as university, prisons, military police hospitals and mines (Table 3). However, the Ministry of Health exercises the oversight control over the whole health system as well as policy formulation, monitoring and evaluation of progress in achieving set targets.

Under Ghana Health Service, service delivery is structured according to a three-tiered system with regional, district and sub-district elements and become integrated as one goes down the hierarchy of health delivery structure from the regional to the district hospitals, many of which are mission based. The health centres operate at the sub-district level to provide both preventive and curative services, as well as outreach services to their respective communities. Of late the Community-based Health Planning Services has been introduced as a new sub-structure to provide basic preventive and curative services for minor ailments at the community and household levels.

Table 3 Distribution of Health Facilities by Facility, Type, and Region

Regions	MoH Institutions							Quasi Governmental Institutions				Christian Health Associa-tions		Nongovernmental Institutions				Total Institutions by Type				
	Regional Hospital	District Hospital	Health Centre/Pos	MCH Centre	Leprosy/Psych	Others Community Initiate Clinics	Total MoH Institution	University Hospital	Military Hospital	Police/Prisons/Hospital / Clinic	Others (e.g., Mines)	Hospital	Clinic	Planned Parenthood Association of Ghana	Ghana Reg. Midwives Association	Private Medical Practi-tioners		Hospital A+B+E+H+I+J+L+P	Health Centre/Post C	Clinic D+F+K+M+O+Q	Total all health Institutions	Percent Reg. Distribution of all Institutions
																Hos pi-tal	Clin ic					
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
Ashanti	1	20	85	21	2	9	138	1	1	3	6	14	33	12	101	43	64	85	85	246	416	18.4
B. Ahafo	1	5	84	13	0	0	103	0	1	1	0	9	9	3	46	4	6	21	84	77	182	8
Central	1	6	39	14	2	26	88	1	0	2	1	3	7	6	27	4	62	19	39	143	201	8.9
Eastern	1	9	46	12 2	6	14	198	3	0	0	2	4	15	10	47	5	23	28	46	233	307	13.6
GAR	1	3	29	13	2	14	62	1	2	3	4	2	3	2	87	37	142	51	29	265	345	15.3
Northern r	1	6	73	9	0	9	98	0	2	0	0	3	18	2	6	0	2	12	73	46	131	5.8
UER	1	3	21	7	0	40	72	0	0	1	0	1	9	0	2	1	11	7	21	69	97	4.3
UWR	1	3	41	5	0	0	50	0	0	0	0	2	15	0	5	3	5	9	41	30	80	3.5
Volta	1	10	14 1	48	1	4	205	0	1	0	0	6	11	3	29	6	23	25	141	118	284	12.6
Western	1	10	63	10	0	12	96	6	1	2	3	4	16	4	51	11	25	35	63	121	219	9.7
Total	10	75	62 2	26 2	13	12 8	1,11 0	12	8	12	16	48	136	42	401	114	363	292	622	1,348	2,262	100
Percent							49.1				2.1		8.1			40. 7						

Source: GSS Ghana Statistical Service, Ministry of Health (Health Research Unit), and ORC Macro (2003) Ghana Service Provision Assessment Survey, Calverton, Maryland: Ghana Statistical Service and ORC Macro.

Structure of Mental Health Care Delivery

Mental health care in Ghana can be categorised under orthodox and unorthodox care systems. The unorthodox mental health care in Ghana comprises traditional, herbal and faith healers who apparently treat the majority of mental patients. Traditional and herbal healers who treat mental illness are practically everywhere in the country. Similarly, faith-based healing camps abound and are scattered everywhere. Their treatment methods are largely unorthodox and lie outside any scientific proven therapy. Very often these methods are very cruel and violate the human rights of patients.

The orthodox health care system includes the institutional care and integrated systems, whose services are free in government hospitals (see Box 1). Currently, orthodox mental health service in the country is provided by a number of organizations. There are the public specialized institutions which are the three psychiatric hospitals at Accra, Pantang and Ankaful near Cape Coast. In addition, there are also three private institutions in Accra, Tema and Kumasi which treat mental illness. These are manned by specialists and consultant psychiatrists. In addition to these institutions, there are other few orthodox facilities which are run by Christian Mission Houses that also offer mental health care to mentally ill people. Included in this category are Damien Centre in Fijai near Takoradi, Cheshire Home in Kumasi and Mercy Centre at Brafo Yaw near Cape Coast, Remar Centre in Accra and Kumasi etc.

Box 1

Integrated Mental Health Care in Ghana

The institutional mental health care confines people suffering from mental diseases to public and private psychiatric hospitals for treatment and care by qualified psychiatrists. In the face of increasing demand for mental health services, particularly, since the eighties, the country has been practising a partially integrated system of community and public mental health care system. The public mental health care integrates mental health care in the existing health care systems, whereby it is envisaged to have psychiatric wings in all regional and district hospitals. Even though the integrated system appears to have been formally introduced in the early nineties, the system is yet to exert any impact on mental health care in Ghana.

As shown in figure 1 mental health care continues to be provided primarily by institutions under institutional care unit of the Ghana Health Services. There are three psychiatric institutions specially designated to provide mental health care services in Ghana. These institutions include the Accra, Pantang and Ankaful Psychiatries. All these institutions, run and wholly funded by the government with donor assistance, offer free psychiatric services.

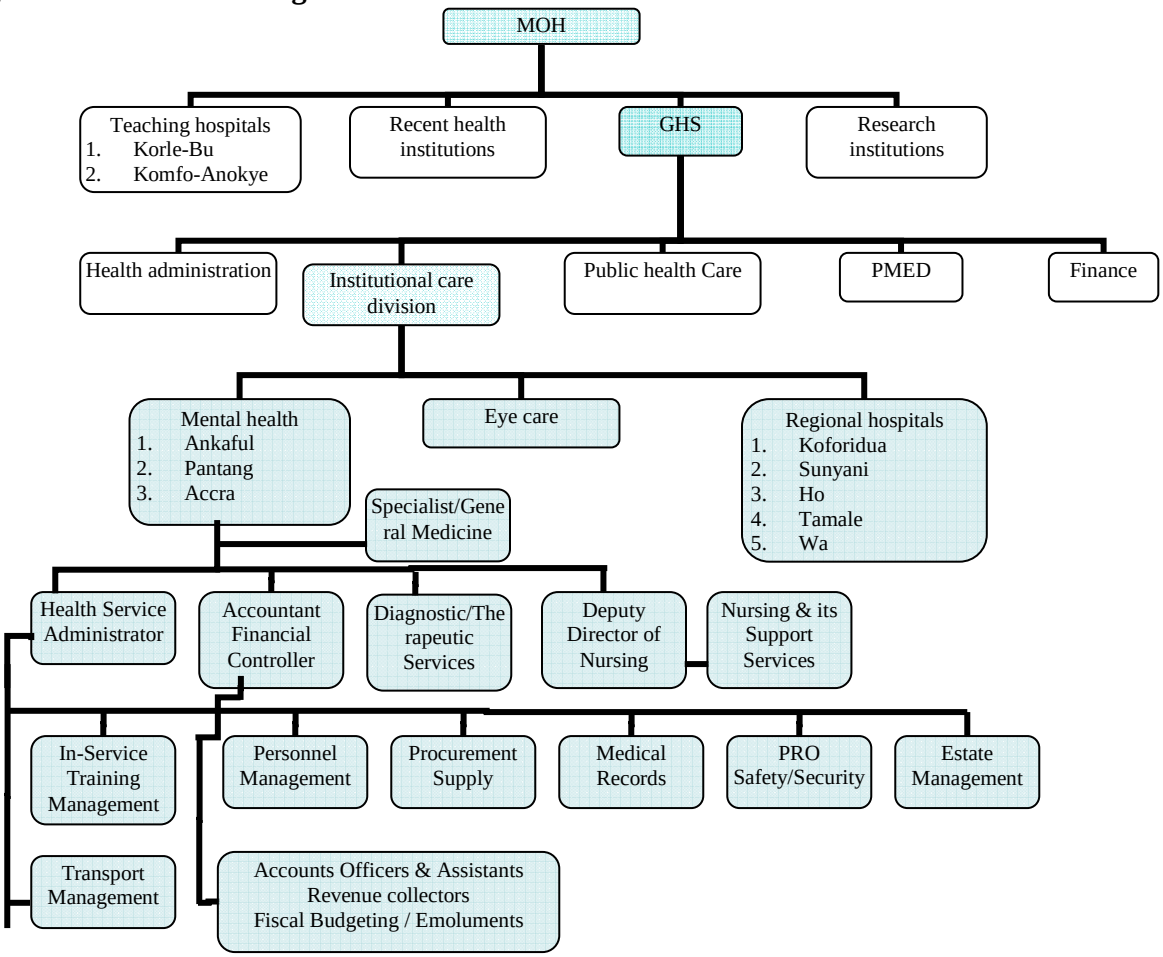
Mental health care occupies the fourth level on the organizational chart of the Ministry of Health. The mental health care unit of the Ghana Health Services is headed by a National Chief Psychiatrist, who usually also heads the Accra Psychiatry and a National co-ordinator of community psychiatry. The Chief Psychiatrist reports to the head of institutional care, who in turn reports to the director general of the Ghana Health Service. The Accra Psychiatry, for instance, has five organizational divisions comprising the Diagnostic/ Therapeutic Services, Deputy Director of Nursing, Accountant and Financial Controller, Health Service Administration and Nursing and Support Services.

Due to increasing numbers of mental health patients, all the regional hospitals are now expected to have psychiatric wings and at least ten beds devoted to psychiatric admissions. Even though yet to be fulfilled, this is a new move towards integrating mental health treatment in the overall primary health care system of Ghana. Besides offering mental health services, almost all the mental health institutions also offer general medical services to people who live in surrounding towns. For instance, the Pantang and Ankaful Hospitals offer, in addition to psychiatric services, primary

health care and maternal and child health services to over 15 villages in their catchment areas of about 10 kilometre radius. These two institutions have Nursing Training Colleges attached to the hospitals, which also offer 3-year Diploma Courses in Mental Nursing. They also run affiliation training programmes in mental health for nursing students from both government and mission hospitals through out the country.

Mental health unit of the institutional care of the Ministry of Health is semi-autonomous in the sense that it has its own budget, which it draws from the institutional care, but restricted in many administrative ways. For instance, it cannot hire and fire personnel, or

Fig. 1 Organizational Structure of the MOH



undertake structural reform of the unit without authority from the director general of Ghana Health Service. The hiring and firing of personnel is done by the Ghana Health Service.

Brief History of Mental Health Service in Ghana

Formal government mental health service delivery in Ghana dates back to 1888 when the colonial authorities enacted a law to confine the mentally ill. As a result of the growing numbers of mental ill persons, a law known as the 'lunatic asylum Act' was

passed. This law led to the construction of the Accra Psychiatric Hospital (APH), which was commissioned as an Asylum Hospital in 1906 for the upkeep of only lunatics. The health needs of the patients at the APH were handled by a doctor from the Korle-Bu Teaching Hospital. In 1929, a psychiatrist was posted from the UK to Ghana to manage the asylum, which upon further expansion was converted into psychiatry in 1951. He instituted a program to train psychiatric nurses and doctors. Initially the hospital had the capacity to keep only 200 patients and this was later increased to 600, but currently it accommodates over 1200 patients.

In the post-independence period, as the country was faced with rising numbers of mental health patients, Dr. Kwame Nkrumah, first president of the Republic of Ghana, constructed the Ankaful Psychiatric Hospital in 1965. The institution had a capacity of about 500 beds but presently accommodates slightly below that number due to dwindling personnel and other resources. In addition to that, Nkrumah started a Pan-African Psychiatric Hospital in Pantang to provide a Pan-African Mental Health Village for research and mental disease treatment and care. However, this hospital was finally completed in 1975. In the 1970s the lunatic asylum Act of 1888 was revised and modernized into the mental health law of 1972 which emphasized institutional care as well as incorporated innovations in mental health care delivery at the time.

In the mid-1980s the concept of a chief psychiatrist as an advisor to the Minister of Health was introduced. Moreover, a policy aimed at sending mental health care to the doorstep of every community was put in place in 1991. The implementation of this policy has, however, been hampered by manpower and logistical problems. Efforts to revise the 1972 health law in 1992 had been unsuccessful. However, new efforts to revise the law were started again in 2004 and a new mental health strategic plan for the nation is also being put together.

Policy framework for Mental Health

The mental health policy of Ghana is embedded in the overall health policy framework of the country, which has the overarching general objective to provide health care for all Ghanaians, using the PHC as the strategy. The policy framework is made up of various strategies, policies and guidelines, which have over the years been enacted into laws and strategy documents. Indeed there are about 19 health related laws, most of which are outmoded. These include the Mental Health Law that was last reviewed in 1972. Of importance among the laws is the Ghana Health Service and Teaching Hospitals Act 525, 1996, which repealed the Hospital Administration Law, 1988 (PNDL 209). Other important strategy documents include the Medium Term Health Strategy (MTHS) and the rolling five-year Programme of Work (I and II) that guide health development in Ghana. The MTHS commits the government in the medium term towards improving health outcomes and achieving the health policy objective of ‘health for all’ by 2020. The programme of work, however, seeks to improve efficiency, quality of care and geographical and financial access to basic services.

The MOH, as the supervisory body for the health sector, has the objective to maximize the potential health life years of all individuals resident in Ghana by reducing the incidence and prevalence of illness, injury and disability, and the prevention of premature deaths. This is derived from the ministry's specific mandate to monitor and evaluate the country's health status, advise central government on health policies and legislation, formulate policies and strategies, design and coordinate programmes to address health problems of the country, and implement, monitor and evaluate (in collaboration with other related sectors and agencies) all health programmes and activities in the country. All these different roles and responsibilities are supposed to be implemented by the different implementing agencies including the Ghana Health Service (GHS), tertiary institutions, specialised institutions, statutory and regulatory bodies.
Since 1997 the Ministry of Health has adopted a sector-wide approach (SWAp) that integrates government and donor efforts to achieve defined goals and includes joint systems to monitor sector performance. The (SWAp) seeks to rationalise donor inputs, encourage efficiency of service delivery and promote private sector involvement and community empowerment and participation.

Ghana has experienced several attempts at health policy reforms since independence in 1957. The latest round of reforms started in 1996 with the enactment of the new Ghana Health Service Act (525) of 1996 which decentralised service delivery, policy, and regulatory components of the overall health sector to separate responsibilities. It appears, however, that most of these reforms have not touched the mental health sub-sector. Apart from the revision of the Lunatic Asylum Act of 1888 into the Mental Health Law 1972, which emphasized on the policy of institutional care for mental patients, nothing much has happened in the sub-sector.

In 1994 a National Mental Health Policy was formulated and revised in 2000. The components of this policy include advocacy, promotion, treatment and rehabilitation. The policy, which was drafted along the lines of WHO Mental Health Policy and Service Guidance package, is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It defines a vision for the future, as expressed in a mission statement, and seeks to establish a model for action. The policy also states the level of priority that the country has assigned to mental health in relation to other health and social policies. Basing on the policy thrust of decentralization the policy proposed a mental health system which offers psychiatric care to all those who present themselves or are referred and promote good mental health for the psychological wellbeing of people living in Ghana. The policy document begins with a mission statement and is organised in 14 set of values expressed in problem statements and objectives (table 4).

Table 4 Policy Statements in Ghana Mental Health Policy

POLICY 1	Decentralization of Mental Health Services Mission Statement:
POLICY 2:	National Mental Health Co-ordinating Group
POLICY 3:	Technical Coordinating Committee
POLICY 4:	Facilities for Management of Substance Abuse
POLICY 5:	Training

POLICY 6:	Conditions of Service in the Mental Health Services
POLICY 7:	Mental Health Awareness
POLICY 8:	Position of Mental Health Personnel in the Regional and Districts Health Management Teams (RHMT/DHMT)
POLICY 9:	Transportation for Community Mental Health Services
POLICY 10:	Quarterly and Annual Reports on Mental Health Activities at Regional and District Levels
POLICY 11:	Annual Mental Health Services Review and Planning Meetings
POLICY 12:	Qualification of Community Mental Health Unit Workers at Various Levels
POLICY 13:	Rehabilitation of the Mentally ill in the Community
POLICY 14:	Treatment of Mental Patient (see Box 2)

The mental health policy though very fine on paper is far from achieving its set objectives. The decentralization of mental health services, which the policy sets to bring about is far from achieving reality. A top clearly defined decentralization goal in the policy document was the setting up of psychiatric wings in all the ten regional and tertiary hospitals with at least ten beds for psychiatric patients. However, fifteen years down the line, only five tertiary and regional hospitals have psychiatric units in Ghana, with many of them having less than ten beds for psychiatric patients. Moreover, the policy appears to be institutional based oriented with no consideration towards community mental health and rehabilitation of the mentally ill people. The gray area of human rights abuse by others and the many faith and traditional healers, who presumably handle a great proportion of mental patients, has not been considered at all in the document and appears to still be unregulated by any law. This might be due to the fact that the policies do not specify the standards that need to be applied across all programmes and services, linking them all with a common vision, objectives and purpose. Provision of standard facilities in general hospitals was also not considered and these policies were not backed by any specific law.

A serious shortfall of the policy framework is its sole use of a health/clinical approach to tackle all challenges confronting mental health in Ghana. This is in spite of the prevailing consensus among experts that mental health is also a development issue owing to its enormous social and economic burden everywhere. As a result the policy document provides little explanation of the fundamental role of mental health or its importance in relation to inequalities in health or risk behaviour. Thus the concentration on clinical approach suggests that the policy framework is limited in perception as it takes into account only the clinical needs of mentally ill people and not their socio-economics.

The difficulties in implementing the policy objectives are compounded by inconsistencies between physical and mental health care, introduced by the health reforms that accompanied the introduction of the Medium Term Health Strategy and the GHS Act introduced in 1996. The inconsistencies can be attributed to the fact that the reforms failed to develop a framework for integrating mental health into the primary health care. These reforms even reduced the status of mental health sub-sector, despite its importance, by placing mental health administratively under institutional care as a unit of the Ghana Health Services and not even a division of the

Ministry of Health with no direct access to the top hierarchy of the sector. On the one hand whilst the GHS has developed a medium term strategy and a series of Programmes of Work, POW I & II, a sort of multi-year rolling roadmap of activities since 1996 for physical health, a similar thing is yet to be developed for mental health care. For this reason there exists no indicators for monitoring mental health care (MOH 2005) and GHS annual review reports include nothing on mental health service delivery. Attempts to revise its archaic law of 1972 and consequently its status have proved futile in spite of having gone through 10 drafts.

National Therapeutic Drug Policy.

A national therapeutic drug policy has been formulated since 1986. This drug policy contains an essential list, i.e. necessary drugs for the treatment of widespread diseases, including psychotropic drugs. In Ghana in order to reap the advantages of bulk purchases and ensure availability, accessibility and proper use of drugs the GHS is the sole purchaser of these essential drugs. The GHS withholds at source budgetary allocations for the pur-

Box 2
Mental Health Care and Free Treatment

Mental health care in Ghana is very expensive. Apart from the high indirect costs emanating from the restricted ability of patients and/or care givers to earn regular income, stigma and discrimination, mental diseases are associated with very high direct treatment costs. Moreover, research in many countries has reliably confirmed a high correlation between mental disorders and high rates of physical illness, which usually go untreated and very often result in increased rates of chronic morbidity and mortality (Lawrence et al 2001, Koran et al 1998, Makikyro et al 1998) among mental patients[1]. All these add up to raise the total financial costs of treatment and care of mental diseases immensely. It is probably in the light of this that the Mental Health Policy makes mental health care free of charge and indeed treatment of mental illness is by the government's exemption policy free in Ghana. However, a number of factors, including ignorance, administrative and managerial expediency, have bedevilled its implementation. Free treatment appears to exist only in a psychiatric hospital. The provision of basic preventive and curative health at the first level of the primary health care system is not totally free, particularly, when mental ill persons are treated against physical illnesses. In most cases the mentally ill people themselves are not aware that they are exempt from payment. For instance, in 2001 a study by SAPRI of exemption awareness revealed that only 6% of urban and 12% of rural people who visited a public health facility when sick or when a member of the household was sick in the previous two weeks knew that they were not expected to pay. On the part of hospital authorities either ignorance or administrative expediency always drive them to charge mental patients fees.

[1] *Mental ill people are prone to a range of physical illnesses, including coronary heart disease, diabetes, infections and respiratory disease. It is estimated that they are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease (Phelan et al 2001, Barr 2001 Brown et al 2000).*

chase of these drugs. As mentioned earlier, in 2004 about 16% of the budgetary allocations from the Ministry of Health to the psychiatric hospital were withheld for drugs. It must, however, be pointed out that the lack of reliable data about the overall

lists of drugs and amount withheld from psychiatric hospitals does not permit accurate estimates of the proportionate share drugs costs to the total mental health budget.

Alcohol and substance abuse constitutes a major cause of mental disorders in Ghana and the situation has assumed larger dimension during the last two decades. For this reason a Substance Abuse Policy was formulated in 1990 to stem the increasing tide drug addiction. Two additional new laws on substance abuse (Narcotic Drugs Control, Enforcement and Sanctions Law (1990), and PNDC Law 236) have also been added to the old Pharmacy & Drugs Act (1961) during the nineties. However, due to lack of resources that hamper proper implementation of the law their impact on mental health are yet to be felt in the country. Prevention and control of substance abuse is centralized through the Narcotic Control Board, whilst the activities of dem-and reduction are undertaken by the ministries of health, social welfare and education. Management and treatment of substance abuse addiction continues to be done in psychiatric hospitals.

Human Resources and Training

The importance of human resource development and, particularly, training of mental health personnel cannot be over-emphasized, given the severe manpower shortage, and poor service delivery. There exists in Ghana no formal strategy of meeting the human resource needs of mental health care. Psychiatric consultants and nurses are either trained on the job or sent outside the country for training. Local training of psychiatric nurses, for instance, started in the country in 1973 when Registered Mental Nurses (RMN) were trained for a period of three years in community psychiatry whilst the State Registered Nurses (SRN) underwent the same training for one and half years. In addition experienced nurses are also trained on the job for a period of three months without the award of formal or accredited certificates to become psychiatric nurses.

Limited facilities for training psychiatric nurses are now available in Ankaful and Pantang. However, these institutions have hitherto not been able to formalise their training curriculum to secure formal accreditation from the Ministry of Education to run courses and award recognised certificates in psychiatric nursing. Thus the training centres in the psychiatric hospitals train mostly non-psychiatric nurses. According to the Acting Chief Psychiatrist, Dr. Osei, the Ankaful Nursing Training Centre, for instance, had, until recently, trained on the average, about five psychiatric nurses annually. Also, for more than 30 years, a West African Programme to train more psy-chiatrists has been able to train only one psychiatrist. Lack of interest among potential trainees, strategy, resources, stigma, discrimination and bleak and gloomy prospects for career development for psychiatric experts have been the possible causes for the sad state of affairs. Consequently the psychiatric care in Ghana has become permanently under-resourced in terms of human resources.

For this reason the mental health policy of 1994 placed training, among others, at the centre stage of its main policy objectives: i.e. to train adequate number of staff for effective functioning of the mental health services. For the medium term, i.e. within

the next 5 years (beginning from 2000) the revised policy sets out to achieve the following goals through recruitment and training

A. Train sufficient Experts
   i. 10 psychiatrists
   ii. 20 one-year diplomates in psychiatry
   iii. 40 clinical psychologists
   iv. 10 occupational therapists
   v. 200 mental health nurses.
   vi. 15 psychiatric social workers.

B. Develop adequate training facilities for all grades of staff of the mental health services.

However, at the end of the five years, all these did not materialise. Presently it can be said that both Ankaful and Pantang have improved their facilities and increased intake of trainee psychiatric nurses. However, planned expansion of training schools to allow increased intake is behind schedule because of delays and lack of resources. For instance, a government sponsored programme to train 10 doctors to obtain diploma in mental health outside the country to assist in the management of psychiatric cases in the Regions, has been suspended barely after it took off. Various reasons have been assigned to the suspension including shortage of doctors, and resources.

The number of mental health experts in the country's mental institutions has never been fewer relative to the number of mental disorders than present (GSS 2003). In 2005 the number of psychiatric consultants and nurses in active service was estimated at three and 156 respectively. Despite the existence of the West African Programme to train psychiatrists it is estimated that only one person has so far gone through the programme in Ghana to become a psychiatrist since its 30 years of existence. About 17 psychiatrists have, however passed through the Accra Psychiatric Hospital in the last fifteen years to be trained abroad but many have refused to return. Thus the precarious human resource situation is also being compounded by a high attrition of psychiatric experts for greener pastures abroad. It appears, however, that the problem is a lack of a mental human resources and training strategy that clearly defines the responsibilities for human resource management between MOH, GHS and training hospitals.

Access to Health Services

Access to health services in Ghana, is defined as living within thirty minute travel time (by any available means) from a health facility. According to this definition it is estimated that only 80% and 37% of the urban and rural population respectively live close to a health facility (Canagarajah and Ye 2002). This compares unfavourably, for instance, to access ratios in Botswana, where about 100% of urban and about 90% of rural dwellers live within a walking distance of about 30 minutes to a health facility (World Bank, 2001). The proportion of the total population without access increases to a little below 50% when the travel time is doubled.

Various reasons account for the relatively low level of access to health care in Ghana. The major reason can be attributed to the low density of health facilities in Ghana. On the whole there are about 2,262 health facilities in Ghana which care for a total

population of about 20 million (table 3). Besides, there is a high level of inequality in the geographical distribution of health facilities, which gives rise to inequality of access to health services. The distribution of health facilities favours mostly the more affluent regions in southern Ghana, including Greater Accra, Ashanti, and Volta Regions, with the Ashanti alone having about 30% of the total number of government run hospitals and the Volta Region also with a population share of about 10% of total population of the nation harbouring about 26% of the total number of sub-district health centres and clinics.

Just as with the distribution of health facilities, access to modern health care services as reflected in population density per facility appears to favour the more affluent regions (table 5), which are more or less, at or below the national average of 11 persons per facility. Another indicator of service availability as measured by population per physician shows a skewed picture. In 2002 the only two teaching hospitals of the country, located in Accra, the national capital, and Kumasi, the regional capital of Ashanti Region, for instance, employed about 503 or more than 40% of the 1,204 publicly funded physicians in Ghana (MOH 1999a).
Apart from availability of health services, affordability of the services also limits access considerably. This is no wonder given that about 40% of the total population of Ghana

Table 5: Selected health indicators on potential access to health facilities

Regions	District and other hospitals	Sub-district health centres/clinics	Total no of health facilities	% of population with access to health services		Poverty incidence
				Urban	Rural	
Greater Accra	22	249	271	94	63	7.3
Western	19	180	199	85	31	24.9
Ashanti	64	226	290	75	48	35.7
Volta	26	450	476	75	51	37.4
Brong Ahafo	23	179	202	76	38	38.8
Eastern	25	128	153	76	45	48.4
Central	14	104	118	75	42	49.7
Northern	13	116	129	50	16	69.1
Upper West	4	51	55	83	14	88.3
Upper East	5	75	80	22	16	89.3
Ghana	215	1758	1973	80	37	42.1

Source: MOH (1999b) CWIQ survey and GLSS4, The Health Sector in Ghana, Facts and Figures.

are poor and cannot afford their daily bread and some few basic needs. This contributes to limit access as was confirmed in a study by SAPRI (2001) which found that as high as 71% and 34% of rural and urban households respectively visit the health facility only “occasionally” or never at all because of high cost of services and lack of money.

Source of care for people with mental health problems

Mental health care, unlike physical health service, is free in Ghana. However, many people in Ghana are said to suffer from mental disorders, but only a few get the necessary treatment. This is due to, apart from the factors adduced earlier, the fact that the mental health system in Ghana is highly fragmented, under-resourced, and chiefly organized around the needs of people with severe mental disorders. Moreover, mental patients can seek formal treatment mainly in three government psychiatric institutions comprising the Accra Psychiatry, Pantang Psychiatry and the Ankaful Psychiatry Hospitals. Following the introduction of the new efforts to decentralise mental health care, all the regional hospitals are supposed to have psychiatry wings with at least 10 beds allocated to the treatment of mental disorders while all district hospitals are supposed to have OPDs for psychiatry patients. However, due to resource constraints, most of the identified hospitals have not been able to fulfil this new directive. Only five regional hospitals including Ho, Kumasi, Sunyani, Wa and Koforidua have established some beds in their respective hospitals with the others providing some beds in medical wards for psychiatric patients.

The biggest and most well equipped hospital of the country, the Korle-Bu Teaching Hospital in Accra, for instance, has no psychiatric wing. It however, houses a psychiatry department, purposely for the teaching of medical students who opt for the psychiatry course. The students and full time lecturers have their clinical training at the Accra Psy-

Box 3
The Community Mental Health Care

Apart from institutional mental health care Ghana also practises a community mental health care at the primary health care level. The community mental health care is run by community psychiatric nurses (CPNS) through community visits and outreach programmes. The CPNs assess new cases, review old ones and refer as appropriate. They also receive patients, trace them to their homes, educate the families of people with mental illness, the general public, and the security agencies on mental health. Presently there are about 156 community psychiatry nurses practising psychiatry nursing in about 53 communities where the resources are available. The activities of community mental health care are co-ordinated by a Community Psychiatric Unit headed by the Ghana Psychiatrist. The community psychiatry is placed under the public health services and hence, community psychiatry belongs to the Budget Management Centre (BMC) of the public health service. The community psychiatry in Ghana, however, faces a myriad of problems that range from lack of transportation means, drugs, human resources, etc. Below is a transcription of a short interview the study conducted with the national co-ordinator of the Community Psychiatric Unit of Ministry of Health:

"We do not have enough vehicles. This results in denial and lack of access to the vehicles. Some times community psychiatry nurses go to the field together with public health nurses. This puts a limitation on how far the community psychiatry nurses can go. We cannot readily move. Mobility is a problem because "ours and mine are different". Thanks to BasicNeeds Northern Ghana that we are able to carry out most of our activities. When a mentally ill person needs confinement in the northern part of Ghana for instance, because of the lack of vehicle for the CPNs, families of clients are advised to hire a vehicle and a CPN is released to travel with them to the Psychiatry Hospitals in the South. This is not the best but the situation is beyond the control of the community psychiatry services.

"Drugs supply is insufficient and irregular especially the anti-convulsants such as tegretol. However, most of the patients do very well on tegretol. The modern psychotropic drugs such as mocicate (depo) are very expensive. The government is unable to provide enough. Meanwhile it is slow in acting.

"We have a very big problem with human resources. The community psychiatry unit has its fair share of the brain drain which has affected the country. Nurses are not interested in community psychiatry because the community psychiatry nursing course is not certificated. Moreover, there are no regular refresher programmes for community psychiatry nurses. Hence we have resorted to the use of focal[1] persons and volunteers.

"Stationary is insufficient because of lack of money. We were relying on donor funds from DANIDA, UNICEF, CRS, ISODEC etc paid to public health. However, most of these supports have been withdrawn".

chiatric Hospital. There is also a handful of private clinics which offer mental health services in Kumasi and Accra but only to a very few patients who can afford the high costs of treatment. Community based psychosocial interventions are limited in Ghana, and when available, have been addressed on ad hoc basis. There is also an outreach programme which radiates from nearest district facilities for the districts without community psychiatric personnel. However, due to problems faced by the community psychiatry nursing unit (see box 3), the districts are witnessing a rapid decline in psychiatric services. The situation is acute in the northern sector of Ghana, where health care facilities are severely affected by lack of competent psychiatric experts (see table 6). As can be deduced from table 6, the Wa regional hospital, for instance, has only one psychiatric nurse and no trained Psychiatrist.

It discerns from the above sections that the mental health care system in Ghana is less organised and this makes it difficult for one to derive a good picture of the mental health situation and sources of care. Indeed there is even a considerable uncertainty in the estimates of prevalence of mental disorders in many regions. These limitations can be attributed to inadequacies in hospital data capturing and self-reporting instruments for classifying mental health symptoms in a comparable way across populations, and limitations in the information available to classify the severity of disabling symptoms of mental health conditions.

Table 6: MENTAL HEALTH FACILITIES AND PERSONNEL IN THE THREE NORTHERN REGIONS

REGION	DISTRICT	LOCATION	NO. OF PSYCHIATRIC STAFF/Volunteers
Northern	Tamale	Ti Sampaa (Old Hospital)	3 Psychiatric Nurses
	Karaga		1 Psychiatric Nurse
	West Mamprusi		1 Psychiatric Nurse
	Yendi	Yendi Hospital	1 Psychiatric Nurse
	Saboba/Chereponi	Saboba Hospital	1 Psychiatric Nurse (Saboba)
	East Gonja	Salaga Hospital	1 Psychiatric Nurse (General Nurse Volunteer)
Upper East[6]	Bolgatanga	Bolga Hospital	2 Psychiatric Nurses[7]
	Bawku	Bawku Hospital	4 Psychiatric Nurses
	Zebilla		1 psychiatric Nurse
	Garu/Tempane	Garu	1 Psychiatric Nurse
	Kassena-Nankana	Navrongo Hospital	1 Psychiatric Nurses
Upper West	Wa	Wa hospital	1 Psychiatric Nurse
	Lawra[8]	Lawra Hospital	1 Psychiatric Nurse

[6] There are 26 health centres in the region. None operate mental health services except outreaches done by the psychiatric nurses in those regions or districts.
[7] One is due for retirement in two years time

	Nadowli	Nadowli Hospital	1 Psychiatric Nurse

Source: Yaro et.al, 2005

We present a list of the top ten causes of admission into the Accra Psychiatric Hospital in table 7. Using the relative shares of causes of admissions as proxies for prevalence rates of mental disorders in Ghana, it can thus be said that schizophrenia is the leading cause of mental disorders in Ghana. This is in contrast with the major causes of mental disorders in developed countries (WHO 2001).

Just like in many developing countries traditional and faith healers also form another major source of care for people with mental health problems in Ghana. The country does not have reliable data to facilitate a good estimate of the proportion of mental health patients handled by them. However, given the widespread nature of prayer and healer camps, spiritual sanctuaries, etc., in the country, their high patronage by especially women and those with little education coupled with the widespread believe that mental

Table 7

Top Ten Causes of Admissions into Accra Psychiatry Hospital

No	Diseases	Male	Female	Total	Percent
1	Schizophrenia	366	283	649	19.70
2	Depression	114	238	352	10.68
	Manic Dep.				
3	Pshchiatry	134	151	285	8.65
4	Sustance Abuse	256	19	275	8.35
5	Acute Org'. Psych.	159	115	274	8.32
6	Schizo. Aff. Dis.	149	120	269	8.16
7	Alcoholism	200	20	220	6.68
8	Hypomania	123	95	218	6.62
9	Epilepsy	95	104	199	6.04
10	Dementia	47	69	116	3.52
	Sub-total	1,643	1,214	2,857	86.71
	Others	222	216	438	13.29
	Total	1,865	1,430	3,295	100.00

Source: *Accra Psychiatric Hospital*

illness is a spiritual curse, it can be said that the traditional and faith healers cater for the largest proportion of the mentally ill in the country. This observation is empirically confirmed by Saeed et al (2000), who found 61% of attendants at faith healers in Pakistan to suffer a mental disorder. This may be another explanation for low treatment rates in some medical settings, and the view of many that the majority of persons with mental disorders in developing countries go untreated (e.g. Andrews et al, 2001).

Access to Mental health Service

As mentioned above there are only three psychiatric hospitals in Ghana. These are, however, concentrated only in the South of Ghana in only three regions of the ten

[8] There are 10 clinics. 8 of these give out only anti epileptic drugs because they are not trained psychiatric nurses.

regions in Ghana. Also, only five of the regional hospitals have psychiatric wings. There are also a few private clinics in a few urban centres which offer out-patient neurological services in the country. For most people living in about 80% of Ghana's geographical space, they may have to travel not less than five hours and also incur high economic costs in order to access orthodox and proper psychiatric care. The majority of mental health care services are offered by traditional and faith healers.

The few treatment places for mental disorders in Ghana puts a considerable stress on the mental health care system in Ghana. The Accra Mental Hospital, for instance, was originally built to cater for only 200 inmates and was later expanded to 600, but now houses over 1000 patients. Pantang Hospital presently caters for over 500 patients. In spite of the paucity of data in the country, which does not permit a reliable estimate of mental health care access rates, it can be said that access to mental health care in Ghana, like in most developing countries, remains unacceptably low.

The relatively low access rates to mental health care in Ghana are reflected in the psychiatric beds/patients ratios in the psychiatric hospitals or general hospitals per 10,000 population as in table 8. Another indicator of the low access ratios to mental health care in Ghana is underscored by the relatively high mental patient-mental-doctor ratio.

Table 8 Psychiatric Beds and Professionals

	Ghana	South Africa	USA	Netherlands
Total Psychiatric Beds per 10,000 population	1.03	4.5	7.7	18.7
Psychiatric Beds in mental hospitals per 10,000 population	1	4	3.1	15.4
Psychiatric Beds in general hospitals per 10,000 population	0.01	0.38	1.3	1
Psychiatric Beds in other settings per 10,000 population	0.2	0.12	3.3	2.3
Number of Psychiatrists per 100,000 population	0.08	1.2	13.7	9
Number of Neurosurgeons per 100,000 population	0.01	0.3	1.6	1
Number of Psychiatric Nurses per 100,000 population	2	7.5	6.5	99
Number of Neurologists per 100,000 population	0.01	0.3	4.5	3.7
Number of Psychologists per 100,000 population	0.04	4	31.1	28
Number of Social Workers per 100,000 population	0.03	20	35.5	176

Source: WHO, Mental Health Atlas 2005, Geneva, 2005

According to a publication in the Peoples Daily Graphic of May 22, 2006 edition, out of the five consultant psychiatrists for the Accra Psychiatric Hospital, only one is in active service. Three of them had already retired and were offering only supporting services on contract on part time basis, whilst one of them had gone for further studies.

According to the WHO estimates, the ratios of psychiatrists and neurosurgeons per 100,000 population are about 0.08 or 0.01 respectively (WHO 2005). The situation seems to be compounded by serious shortage of paramedics and nurses in the mental health institutions. According to latest WHO estimates the ratios of psychiatric nurses, social workers and psychologists to 100,000 population are about 2, 0.04 and 0.04 respectively. The situation seems to have worsened in the face of the recent increased out migration of Ghanaian nurses into the industrialised countries. According to a recent outcry of the Acting Ghana Chief Psychiatrist, Dr. Akwasi Osei, as published in the People Daily Graphic of May 22, 2006 edition, the country presently is able to meet only 25% of its required need of 2000 psychiatric nurses. Even the Accra Psychiatry Hospital, which has a better labour attraction because of its location in the capital city of Ghana, has only 41.67% of its 600 required nursing staff fulfilled.

In summary it can be said that access to mental health services in Ghana is not only considerably limited by the limited number of service delivery points, but also by the very limited number of treating experts including psychiatric doctors and nurses.

Treatment Gap

The relationship between mental and physical health is very close, even though these two vital strands of life are likely to be the result of a complex interaction between biological, psychological and social factors. However, there exists a large treatment gap for most mental disorders as compared to physical health in most countries. Despite the fact that mental disorders affect all societies and individuals at all ages and have a very high negative socio-economic impact on the quality of life of individuals and families, only a small minority of all those presently affected receive any treatment.

World wide it is estimated that some 450 million people suffer from a mental or behavioural disorder with around 0.3-1.5% of the adult population suffering from a severe and enduring mental illness, yet only a small minority of them receive even the most basic treatment producing a large treatment gap. In Ghana, similar to many other developing countries, mental health care programmes have a low priority with service provision available in only a small number of institutions that are usually overcrowded, understaffed, financially under-resourced and inefficient. The treatment gap is particularly high for the poor in the population and also women who carry the burden of responsibility associated with being wives, mothers, educators and carers of others.

The treatment gap manifests itself in various shapes, including discrimination in the allocation of human and material resources, drugs and infrastructure by the MOH. The Psychiatric Hospitals in the country, for instance, do not have proper outpatient department and any recovery ward at all. All the institutions face serious congestion of patients. The few available beds do not have adequate beddings – mattresses, blankets and bed sheets, leaving many patients to sleep on the bare floor (see plate 1).

They also lack modern and adequate equipment to deliver the quality service. Electro-encephalograph (EEG) machines for tests on the brain and electro-convulsive therapy machines for treating cases of severe depression are inadequate, old or non-existing. A major concern remains the lack of adequate and properly trained psychiatric human resources. A recent baseline study of the mental health sector by 'BasicNeeds' (Yaro et al., 2005) counted a total of 15 Consultant Psychiatrists[9] out of which only 4 are in active service and 156 community psychiatric nurses in the whole country.

In the view of health experts a public health approach to mental health care appears to be the most appropriate method of response to mental disorders (Box 4), considering the sheer magnitude of its problem, its multifaceted aetiology, its widespread stigma and discrimination (WHO 2001). Yet the Ministry of Health has separated mental health care from public health and placed it in its organizational chart under institutional care and at a level below public health, suggesting an apparent lower priority and status as compared to public health.

Box 4 Appropriate Care for Mental disorders

Appropriate care for mental and behavioural disorders should normally consist of interventions in the areas of prevention, treatment and rehabilitation. In this direction prevention and early intervention efforts for children and adolescents can be critical for promoting social and emotional development and preventing mental disorders. In fact, the precursors for many adult mental disorders can be found in childhood. For this reason mental health care in developed countries has developed new approaches like the System of Care in the US, which is a widely accepted framework with more emphasis on implementing mental health services and supports for children, youth and their families.

Burden of Mental Disorders

Available data shows that morbidity pattern or prevalence of diseases has remained fairly constant over the years in Ghana, in spite of improvements in health care, with the country demonstrating a high preponderance of communicable preventable diseases, under-nutrition, and poor reproductive health. Adams and others (2001) report the top ten causes of out-patient morbidity in 2000 as 1) malaria; 2) upper respiratory tract infection; 3) diarrhoea diseases; 4) skin diseases; 5) accidents; 6) pregnancy related complications; 7) eye infections; 8) intestinal worms; 9) hypertension; and 10) anaemia. Other epidemics such as cerebrospinal meningitis (CSM), guinea worm, buruli ulcer, yellow fever and cholera still occur. Although there have been improvements in the control and the eradication of diseases like

[9] BasicNeeds found in their study (2005) that doctors and nurses are not interested in working with psychiatric hospitals. "This is because they see psychiatry not financially attractive, there are no incentives, it is full of risks, it is very stressful, and it is scorned with stigmatization and discrimination from all angles. Besides, there seems to be no prospect of progression, particularly among the nursing groups. While other disciplines are always getting opportunities for self development, such programmes of self development seems to be alien to mental health. Donors and philanthropists are always pumping money into other disciplines except mental health."

Oncocerciasis, polio, leprosy, chicken pox, etc., in recent years the emergence and/or re-emergence of diseases such as the HIV/AIDS menace, tuberculosis, buruli ulcer and filariasis as well as some non-communicable diseases including cardiovascular diseases (CVDs), cancers and diabetes are increasingly threatening the gains in life expectancy.

In terms of disease burden by mortality and DALY, prior estimates for Ghana show HIV/ AIDS, prenatal conditions and malaria to be among the top list reported diseases (see table 9). Mental disorders despite its high prevalence in Ghana do not feature in the list of reported diseases at all. This evidence brings to the fore, the biases in favour of physical diseases in the monitoring of health indicators in health information and reporting systems in Ghana. This thus makes mental health one of the silent but growing illnesses and one of the least talked about health issues in Ghana.

However, neuropsychiatric disorders are slowly becoming leading causes of disease burden worldwide (see table 10). It is estimated that five of the ten leading causes of disability worldwide are mental disorders, comprising major depression, alcohol use, bipolar disorder, schizophrenia and obsessive compulsive disorder. By 2020 depression, as predicted by Murray and Lopez (1996), would become the second most important cause of disability in the world and probably also in Ghana. Worldwide about 12% of the global burden of disease in 1998 was attributable to neuropsychiatric conditions, with these conditions accounting for about 4.3% of the African continent's total disease

Table 9; Burden of disease in terms of DALY and Mortality: prior estimates for Ghana, 2000

Rank	Mortality (deaths)	% total deaths	Rank	Burden (DALYs)	% Total DALYs
1	HIV/AIDS	13.7	**1**	HIV/AIDS	12.5
2	Perinatal conditions	8.3	2	Perinatal conditions	9.5
3	Malaria	6.9	3	Malaria	7.7
4	Measles	6.2	4	Measles	6.8
5	Lower respiratory infections	5.7	5	Lower respiratory infections	4.5
6	Ischaemic heart disease	5.6	6	Tuberculosis	4.0
7	Tuberculosis	5.1	7	Diarrhoeal diseases	3.1
8	Cerebrovascular disease	4.7	**8**	Unipolar depressive disorders	2.0
9	Diarrhoeal diseases	3.6	**9**	Road traffic accidents	1.9
10	Road traffic accidents	1.9	**10**	Violence	1.8

Source: Global Programme on Evidence for Health Policy (WHO 2002)

burden (WHO 1999). This total burden in terms of disability-adjusted life-years lost to

mental illness is expected to rise to 15% by 2020 (WHO 2003).These identified mental disorders accounted for 28.5% of all disabilities worldwide ranging from 47% in established market economies, such as the United States, to 16% in low income African countries such as Ghana in 1998. Particularly, young adults seem to be very much afflicted by neuro-psychiatric disorders which account for four of the ten leading causes of

Table 10; Ranks of selected conditions among causes of disease burden, 1998

Disease or injury	Rank in cause-list		
	World	High income countries	Low and middle income countries
Unipolar major depression	4	2	4
Alcohol dependence	17	4	20
Bipolar disorder	18	14	19
Psychoses	22	12	24
Obsessive-compulsive disorder	28	18	27
Dementia	33	9	41
Drug dependence	41	17	45
Panic disorder	44	29	48
Epilepsy	47	34	46

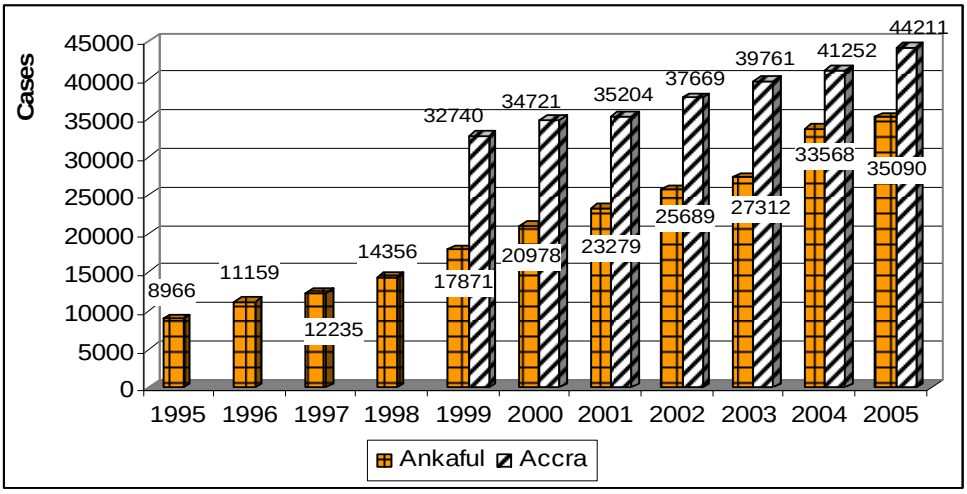
Source: WHO 2001

disease burden of the group aged between 15–44 years (Murray and Lopez 1996; Ustun 1999). In low and middle income countries, in which Ghana finds itself, one out of every ten DALYs is estimated to be lost to a neuropsychiatric condition. Latest available data, which uses much improved classificatory systems, estimates a 12 month prevalence rate in the order of 20-25% of total DALYs (Whiteford et al., 2001).

In 1998, 10.5% of DALYs, lost in low/medium income countries, were estimated to be due to neuropsychiatric conditions (WHO 1999). Lack of reliable data does not permit an accurate estimation of the DALY for Ghana but anecdotal evidence suggests a high prevalence rate of mental disorders, which constitute a major cause of disability in the country. Available statistics at the three psychiatric hospitals in the country, for instance, show very high OPD attendance of mental health related disorders, comparable to malaria OPD attendance[10] reports at the biggest and best equipped hospitals in the country, such as the Korlebu Teaching Hospital. Figure 2, for instance, shows the rapid increases in OPD case loads at the Accra and Ankaful Psychiatric Hospitals. Between 1995 - 2005 total number of OPD cases in Ankaful, for example, rose by more than 291%, whilst that of Accra rose by more than 35% between 1999 – 2005.

Fig. 2
OPD Attendances at Accra and Ankaful Psychiatric Hospitals, 1995 - 2005

[10] Malaria is estimated to account for almost 44% of all OPD visits in Ghana's health facilities (Appiah-Kubi 2003).



Even though the number of reported new cases of mental disorders at the OPD in the three psychiatry hospitals appears to stagnate between 2003 and 2005, the long-run picture depicts an upward increasing trend. From table 11, for instance, it can be calculated that total number of admissions in these hospitals increased from 6,008 in 2003 to 9,558 in 2004 before dropping to 6,454 in 2005. There have not been any scientific studies yet to estimate the proportion of the Ghanaian population that suffer from mental disorders. However, using world wide estimates of people suffering from mental disorders of the World Health Organization (WHO) in 2001, it is possible to estimate the total number of people suffering from various mental illnesses in Ghana with

Table 11 Annual Reported Mental Health Cases at Psychiatric Hospitals in Ghana

	Accra			Ankaful			Pantang		
OPD Visits	2003	2004	2005	2003	2004	2005	2003	2004	2005
New Cases	5,584	5,345	4,154	5,784	6,042	6,316	2,528	2,559	2,409
Old Cases	34,177	35,907	40,057	22,526	27,526	28,774	9,850	11,154	10,476
Total Admissions	3,295	6,551	3,597	1,783	1,917	1,743	1107	1,090	1,114
Total OPD Visits	39,761	41,252	44,211	27,312	33,568	35,090	12,378	13,713	12,885

Source: Ministry of Health: Institutional Care Unit

a population of 20,000,000 to be approximately 2,000,000 including about 200,000 severe mental ill patients.

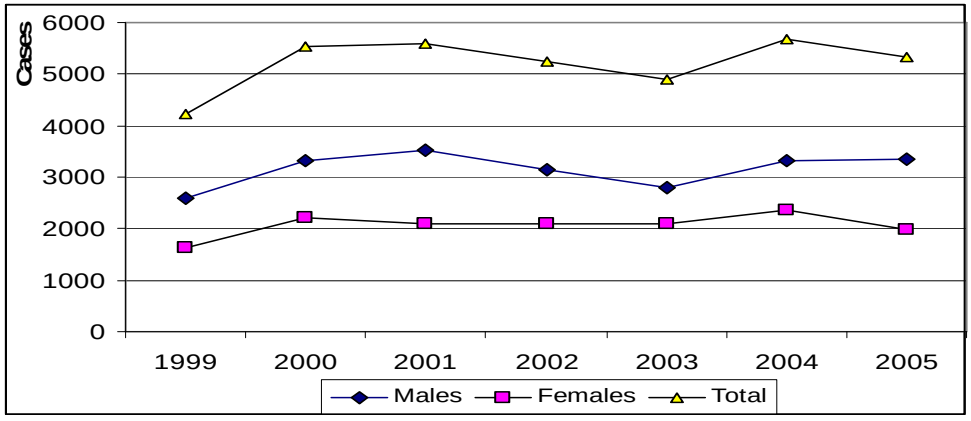
The consequences of mental illness on the individual, family and community as a whole have social and economic aspects. Information documented by BasicNeeds Accra[11] in the forms of life stories and community psychiatry nurses/volunteers field visit reports reveal that, though treatment for people with mental illness is free at the psychiatry hospitals and poly-clinics, constant transport cost to these facilities is a problem to many since some of them cannot use the normal public transport system but have to charter taxis. In addition, the expensive psychotropic drugs are not provided in these health institutions. When a patient is put on such drugs, it brings

[11] *From BasicNeeds Life Story Files, September 2006*

untold hardships on their families. Some carers have to reduce their scale of work and in extreme cases, stop it all together in order to provide care for mentally ill relatives. Because of the stigma associated with mental illness, some mentally ill people loss their spouses and this worsens their burdens.

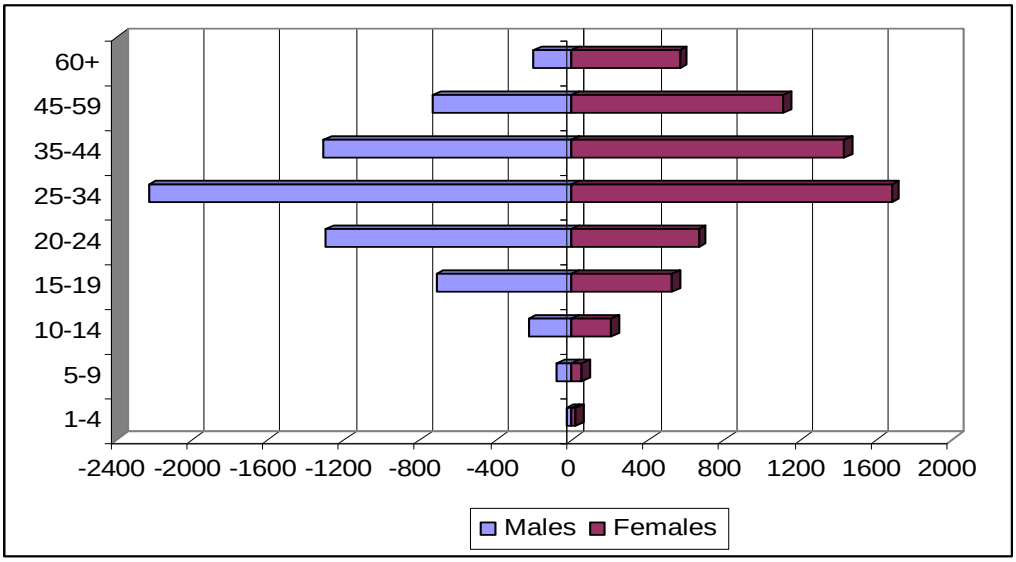
Contrary to the situation prevailing in the developed countries more males than females seem to suffer from mental disorders in Ghana (WHO 2004). Thus the number of male admissions in the psychiatric institutions in the country tends to be considerably higher than that of females (figure 3). A close look at the available data reveals that males tend to suffer more from schizophrenia, substance and alcohol abuse, and mania, whilst females tend to suffer more from depression, epilepsy, and affective disorder. This aspect seems to conform with world wide trends of gender disparities in mental diseases (Piccinelli & Homen 1997).

Fig. 3 Admissions in Accra and Ankaful Psychiatric Hospitals according to Sex, 1999-2005



In terms of age, the majority of psychiatric patients tend to be between the prime age of 15 and 44 years. As can be seen in figure 4 about 75.3% of the psychological cases seen in the OPD of Pantang Hospital, including new and old cases, during 2005 were between 15 and 44. Indeed the age group of 25 and 34 years appears to be highly vulnerable to mental diseases in Ghana. Almost 30% of the OPD patients seen in 2005, for instance, were between 25 and 34 years. However, there appears to be recorded increases in mental illness, especially, among older female groups aged above 35 years. This phenomenon has been attributed to various factors including rising gains in life expectancies, which may increase the number of older persons suffering from depression. Rapid urbanization, conflicts, disasters and stressful macroeconomic adjustments have also been seen to play a major role for the increasing numbers of the aged who suffer from mental illness.

Fig. 4 Age Composition of Admitted Patients at Pantang Psychiatric Hospital, 2005


60+
45-59
35-44
25-34
20-24
15-19
10-14
5-9
1-4
-2400 -2000 -1600 -1200 -800 -400 0 400 800 1200 1600 2000
Males
Females

Chapter 3

FINANCING MENTAL HEALTH CARE IN GHANA

Patterns of Health Care Finance

This section provides a conceptual introduction to key issues related to mental health care financing. It begins by describing the health care financing context in which mental health care is embedded, so as to illustrate the level of current available resources and how they are utilised. The main sources of health care financing in Ghana include largely public resources, financial credits, internally generated funds, foreign and donor funding Other sources of funding that have emerged over the last two years include also HIPC and health insurance.

In 2003 the Ministry of Health recorded a total of about ¢2,115.87 billion cedis in gross revenue for the financing of health care services in Ghana. This shows a massive nominal increase of about 55% compared to that of ¢1,365.2 billion cedis for 2002. Out of the total available finance for the health sector in 2003, government budgetary allocations accounted for about 47% (see table 12), which represents the greatest share of total money that go to finance health care spending in Ghana. The second largest source of health care finance comes from contributions from donors and NGOs, which accounted for about 26.95% of total revenue for health care spending in 2003. User fees and other internally generated funds from the sale of drugs and other charges produced about 13% of total health care finance in 2003.

Table 12 Health Sector Revenue (1999-2003) (in billion cedis)

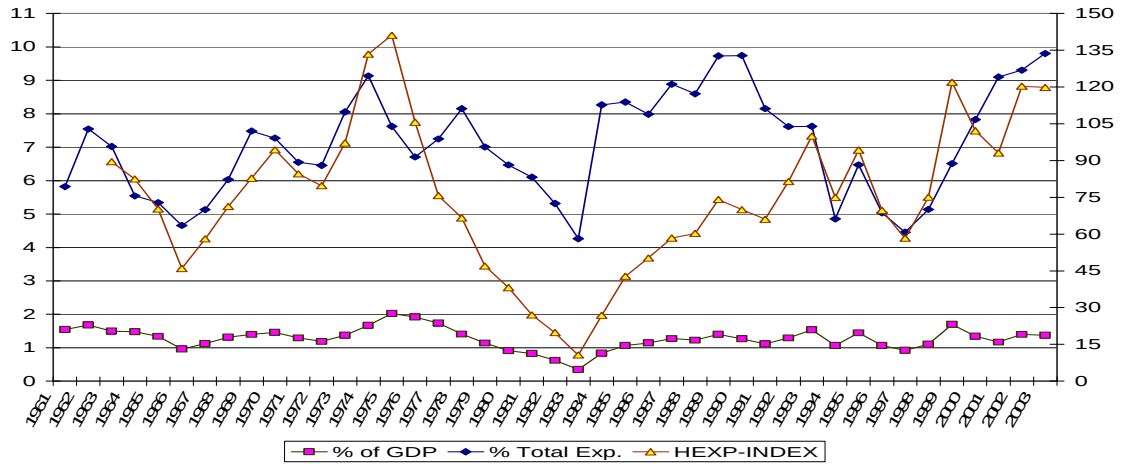
	1999		2000		2001		2002		2003	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Government	238.20	55.59	366.58	49.14	444.57	48.35	662.26	48.51	986.00	46.60
Financial Credits	27.80	6.49	31.70	4.25	13.42	1.46	142.95	10.47	166.08	7.85
IGF	50.70	11.83	81.70	10.95	135.85	14.77	196.90	14.42	264.70	12.51
Donors	104.90	24.48	230.40	30.89	325.64	35.42	363.07	26.60	570.30	26.95
HIPC Funds	n/a	0.00	n/a	0.00	n/a	0.00	n/a	0.00	68.80	3.25
Others/DACF	6.90	1.61	35.60	4.77	n/a	0.00	n/a	0.00	60.00	2.84
Total	428.5	100	745.98	100	919.48	100	1,365.2	100	2115.87	100

Source: MoH financial statement and 2003 annual review (main) report.

It appears that government budgetary allocations to the health sector has enjoyed tremendous increases in nominal terms, increasing by 115,621 times from ¢18.3 million in 1961 to ¢2,115.87 billion in 2003 in nominal terms. However, these allocations appear to have stagnated relative to total government expenditure as well as in real terms over the years (see also SAPRI 2001, Lavy et. al 1995). As can be deduced from figure 5, after rising successively in the sixties to reach a peak level of 9.13% of total government health expenditure in 1974, the government health

expenditure ratio experienced downward trend to hit a low level of 4.26% in 1983 before increasing to a level of 9.80% in 2003.

Fig. 5 Comparison of Selected Health Indicators over time, 1961-2003



HEXP-Index = Health Index = Government Budgetary Health Allocations or Health Expenditure, 1993=100
% Total Expenditure = Ratio of Government Budgetary Health Allocations or Health Expenditure to Total Government Expenditure

In real terms government allocations to the health sector appear to have fallen successively since independence. Using a time series deflation to measure the real value of fiscal resource allocations to the health sector, with 1993 as the base, the real value of budgetary allocations has over the period declined from an index of over 141 in 1975 to 119.80 in 2004. This underscores not only the inadequacy of funding health care in Ghana, but also the fact that the available inadequate resources have also declined in real terms over time. This decline can also be seen in the large fall in per capita government allocation to the health sector in the last decade from $10.16 in 1978 to about $7.4 in 2003 (MOH 2003). It is within this context of declining availability of real resources that mental health care financing in Ghana should be situated.

Resources and Funding for Mental Health in Ghana

Mental health care financing in Ghana is embedded in overall Ghana government's health care financing system. Resources and funding for mental health come from sources similar to overall health care financing and consist of government allocations, financial credits, internally generated funds, foreign and donor funding and others. Foreign and donor pooled funds account for the largest share of resources available to the three psychiatric institutions in Ghana, and their relative share ranged between 68% and 91% of resources available to the mental hospitals between 2001 and 2005 respectively. In 2005, for instance, this source of funding for the mental health institutions accounted for over 91% of all resources available to these institutions.

Following this with a wide distance are government budgetary allocations. Internally generated funds (IGF) account for an insignificant (about 5%) portion of all resources available to mental health institutions in the country, unlike the other health facilities in Ghana where IGF accounts for almost 12% on average since 2000. This is due to

the fact that mental health care is free in Ghana, and only out-patients who utilise services other than mental health related medical services pay for consultation and drugs received. This occurs mostly in Pantang and Ankaful institutions, where out-patient services to the surrounding villagers who suffer from illness other than mental disorders are also offered.

In nominal terms the resources available to finance mental health care have risen substantially but appear to have declined in real terms just like the overall budgetary allocation at the disposal of the whole health sector in Ghana. This decline is partly due to the declining total real resources available to finance general health care in Ghana. Also the decline can be attributed to the fact that government has virtually stopped any capital repair and expansion works in the Accra Psychiatric hospital, on grounds that it intends to relocate it to a different place. Another source of finance which does not feature in table 13 but can be expected to play a major role in mental health care financing in Ghana in the near future, is the risk pooling health insurance system, which has been introduced in Ghana since 2005.

Table 13 Sources of Funding to the Health sector and the Mental Health Sector

	2001		2002		2003		2004		2005	
	Total	Mental	Total	Mental	Total	Mental	Total	Mental	Total	Mental
GOG	48.35	11.122	48.51	27.34	46.6	19.8132	46.1	8.3	47.82	6.72
Financial Credits	1.46	n/a	10.47	n/a	7.85	n/a	3.2	n/a	1.1	n/a
IGF	14.77	5.2	14.42	4.39	12.51	4.52	14.09	5.3	15.02	4.22
Donors	35.42	83.68	26.6	68.27	26.95	75.67	31.02	86.6	29.87	89.08
HIPC Funds*	n/a	n/a	n/a	n/a	3.25	n/a	4.2	n/a	5.1	n/a
Others/DACF	n/a	n/a	n/a	n/a	2.84	n/a	1.39	n/a	1.09	n/a
Total	100	100	100	100	100	100	100	100	100	100.02

* = HIPC Funds for Mental Hospitals are included in GOG

Source: The Three Psychiatric Hospitals

A close look at the projected budgetary ceilings[12] of the Ministry of Health for the year 2004 as represented in table 14 shows that the psychiatric hospitals received about ¢42.55 billion, or a little below 3% of the total budget ceilings of the Ministry of Health[13]. In terms of line items the ceilings for the psychiatric hospitals for expenditure on salaries, administration, and investment accounted for about 1.07%, 5.07% and 3.48% respectively, whilst services accounted for about 6.2% of the total budget of the Ministry of Health in the same year. It must be pointed out that the actual finances released for spending are also always lower than these budgetary ceilings used in preparing the annual budget. Thus according to estimates of WHO

[12] The total budgetary allocations available to the Ministry of Health and thus mental health care can be analysed using the total resource envelope. In 2004 the projections for the resource envelope of ¢2.434.84 billion was larger than the budget ceiling of ¢1,449 billion because the budget ceiling excluded expected inflows from IGF, HIPC and earmarked funds from Development Partners to be paid into the Health Fund.

[13] The percentage of the Ministry of Health resources allocated to mental health care falls to 1.75% if the allocations are based on available resource envelope.

(2005) the country spent about 0.5% of its total health budget on institutional mental health care in 2004[14].

The psychiatric care is under the Ghana Health Services (GHS). Relative to the projected total budget ceilings of the GHS, the psychiatric hospitals received an equivalence of about 7% of the total budget ceiling of the GHS (table 15). However for policy and

Table 14 Allocation of Health Budget Ceilings by Level and Line Items - (Per cent, 2004)

TOTAL HEALTH	Total	Items 2&3	Salaries	Admin	Service	Invest-ment
		2 & 3	*1*	*2*	*3*	*4*
Ministry of Health HQ	39.69	11.13	58.01	15.59	8.61	27.71
Training Institutions total	4.70	5.91	2.67	5.44	6.17	13.65
Ghana Health Service -GHS	44.10	68.89	31.77	62.07	72.75	30.48
G.H.S. Head Quarters	3.14	7.46	0.69	9.70	6.20	2.77
Psychiatric Hospitals	2.94	5.95	1.07	5.07	6.45	3.69
Regional Health Service	6.48	9.02	5.16	8.57	9.27	5.42
District Health Service	31.55	46.45	24.83	38.73	50.82	18.59
Subvented organizations	1.86	2.81	1.04	3.60	2.37	3.66
Innovations' Fund	0.10	0.29	0.00	0.27	0.30	0.00
Civil Servants' Exemption	0.48	1.44	0.00	3.99	0.00	0.00
Teaching Hospitals	9.07	9.53	6.51	9.05	9.80	24.50
TOTAL HEALTH	**100**	**100**	**100**	**100**	**100**	**100**

Source: Ministry of Health, The Ghana Health Sector 2005 POW 2005

management considerations, a number of allocations, termed special components, have been centralized to facilitate budget implementation. These special components include allocations for exemptions, deprivation, fellowships, ADHA, training and conferences,

Table 15 Budgetary Allocation of Ghana Health Services by Level and Line Items - (Per cent, 2004)

TOTAL HEALTH	Total	Items 2&3	Salaries	Admin	Service	Invest-ment
		2 & 3	*1*	*2*	*3*	*4*
Ghana Health Service – Percent of MOH	44.10	68.89	31.77	62.07	72.75	30.48
G.H.S. Head Quarters	7.13	10.84	2.19	15.63	8.52	9.09
Psychiatric Hospitals	6.66	8.64	3.38	8.17	8.87	12.12
Regional Health Service	14.69	13.09	16.25	13.80	12.75	17.79
District Health Service	71.53	67.43	78.18	62.40	69.86	61.00
TOTAL GHS	100.00	100.00	100.00	100.00	100.00	100.00

Source: Ministry of Health, the Ghana Health Sector 2005 POW 2005

and psychotropic drugs. Table 16 shows the provisions for special components of the budget, which include withheld provisions for psychotropic drug supplies. On the

[14] It must, however, be pointed out that the actual total operational budget of the GHS for mental health care is very difficult to estimate, since some of the functions of mental health care are now integrated into the primary care system.

basis of these provisions it can be estimated that psychotropic drug supplies from the GHS account for about 16% of the total budget of the psychiatric hospitals.

By various indications, mental health care remains one of the under-funded areas in Ghana's social sector, because it does not receive the necessary attention in terms of resources that is commensurate to the relative burden of the illness on the economy and society as a whole. This can be evidenced by the regular cries for help in the media and newspapers since the beginning of the year. Despite the high socio-economic costs of mental disorders in countries like Ghana, equivalent to 1-4% of GDP in lost productivity

Table 16 Special Pooled Components of the Budget Ceilings

Special area	Amount (billion cedi)	Percent	Where lodged
Recruitment into the sector	8.53	1.35	Office of Minister
Overseas conferences	6	0.95	Office of Minister
ADHA	464.39	73.70	Office of the C.D.
Trainees (NTCs etc.)	20	3.17	HRD of MoH
Cuban Doctors (Travel & hotel)	11	1.75	Office of CD
Cuban Doctors (subsistence)	0.5	0.08	Office of D. G, GHS
Fellowships (all sector)	20	3.17	HRD of MoH
Procurement	4	0.63	Procurement directorate
Sch of Allied Health Sc	0.7	0.11	Training Institutions
Post Grad. College	0.2	0.03	Training Institutions
"Various initiatives"	0.15	0.02	Office of D. G, GHS
Deprived area incentives	36	5.71	Office of D. G, GHS
Emergency preparedness	0.5	0.08	PHD, GHS
Emergency preparedness	4.6	0.73	Off. of the Minister
Dental and Eye Specialist outreach	1	0.16	ICD, GHS
Contraceptive initiative	2.5	0.40	PHD, GHS
HIV/AIDS	0.5	0.08	PHD, GHS
For EPI	9.65	1.53	PHD, GHS
For EPI	6.85	1.09	PHD, GHS
Exemptions	26	4.13	Office of DG,GHS
Specialist outreach services	0.4	0.06	I.C.D, GHS
For deprivation	1.85	0.29	Accra Psych. hosp
For deprivation	1	0.16	Pantang Psych. hosp
For deprivation	0.8	0.13	Ankaful Psych. hosp
Psychotropic drugs	1.2	0.19	Accra Psych. hosp
Psychotropic drugs	1	0.16	Pantang Psych. hosp
Psychotropic drugs	0.8	0.13	Ankaful Psych. hosp
Total	**630.12**	100.00	

Source: Ministry of Health, the Ghana Health Sector 2005 POW 2005

and other social costs[15] the country spends probably less than 0.02% of its annual total output on it.

Poverty, Mental Health and Access to Treatment

Poverty influences mental illness through its impact on the social, psychological and biological factors of mental disorders. Life events such as threat of loss or actual loss, such as the death of a family member, marital separation, maternal deprivation, or loss of employment, have been shown to cluster before the onset of mental illness and also to influence the course of illness in both developed and developing countries (e.g. Hussain et al 2000). In terms of access to treatment poverty poses the biggest challenge. Worldwide access of the poor to social services like health care, particularly, in developing countries, is relatively lower than the less poor. Hence this section attempts to provide evidence of the influence of poverty on mental health.

There appears to be a direct link between poverty, mental disorder and low level access to treatment particularly in developing countries (Saraceno and Barbui, 1997; Jenkins *et al* 2004). Surveys in Brazil, Zimbabwe, India and Chile reveal a consistent relationship between poverty and common mental disorders (Patel et al 1999). The surveys also show close associations of high the prevalence of common mental disorders with indicators of impoverishment as measured by hunger, level of debt and education. Similarly in Indonesia, lower rates of depression and other common mental disorders are found to be related to higher levels of education and access to amenities such as electricity. For instance, in Pakistan poverty has been found to be firmly related with mental illness (Mumford et al 1997). This association applied to communities as well as individuals. A study by Bahar *et al* (1992) also found close associations as applied to communities, with least poor villages having common mental disorder rates of 28% compared with 13% in the less developed villages.

The above mentioned evidence of a direct relationship between poverty and mental disorders are consistent with available information from Ghana (GLSS 4) that the proportion of people who consult a doctor or visit the hospital when sick or injured increases overall with the standard of living. The proportions of people who consult a doctor or pharmacist when ill or injured are much higher in urban areas than rural areas, even within the same quintile groups. In the rural areas, for instance, the proportions consulting a doctor or pharmacist in the highest quintile (27%) are more than three times higher than those in the lowest quintile (8%), whilst in the urban areas the highest quintile (52%) are twice as high as the lowest quintile (27%) (GSS 2000). These findings also seem to be confirmed by empirical evidence in Ghana that the poor and the deprived have a higher prevalence of mental and behavioural disorders, including substance use disorders. Turkson and Dua (1996), for instance, in a study of female mental patients found the majority of patients to be between 20-40 years of age, married with 5-8 children but with poor financial support from husbands, limited education and limited employment opportunities. According to WHO these conditions tend to produce high causation of disorders among the poor

[15] http://www.euractiv.com/en/health/health-expenditure-economy/article-153271

and the drift of the mentally ill into poverty. The inter-linkages between gender, mental health, social position and barely sustainable income levels despite heavy work have been illustrated in a study in the Volta region of Ghana. Avotri & Walters, (1999) found that the combination of financial insecurity and financial and emotional responsibility for children, together with heavy workloads, a sense of work being compulsory and a gender division of labour exacted a heavy toll on women's emotional health.

Economic and Social Costs of Mental Disorders

Mental health is embedded within social and socio-economic relationships and so also are the risk factors such as unemployment, bereavement, financial strain and long -term caring across the life cycle and especially in later life. The enormity and prolonged treatment nature of mental disorders make their economic and social costs staggeringly high[16]. These costs, consisting of direct and indirect burdens, fall on individual patients and their carers or families, the government, and/or the whole society. In fact, recent studies conducted in industrialized countries show that the aggregate social cost of adverse consequences of mental disorders is enormous, ranging from 1% to 4% of gross domestic product (GDP). For instance, the economic costs of direct treatment of mental disorders range from the equivalence of US$148 billion annually or 2.5% of GDP in the USA and about £77 billion annually in England (NIAMH 2004). These direct economic costs are mostly driven by service utilisation. For the UK and US, Berto *et al* (2000) have found for depression that hospitalisation accounts for around half the total in the UK and three-quarters in the US. The few available studies such as that from Chile reveals high direct economic treatment costs (US$74 million) equivalent to half of the mental health budget (Araya *et al* 2001). In Ghana, a cursory ballpark estimate of the potential direct resource needs for treatment of mental health patients could be put at about 0.05% of the total GDP of the country.

In addition to the direct treatment costs are the indirect economic costs which emanate from lost earnings and productivity of mental patients, their carers or family members' inability to work. Studies in the USA and the UK, for instance, put the indirect costs three times and nearly six times respectively higher than the direct

[16] WHO lists some of the specific economic and social costs to include:

1. lost production from premature deaths caused by suicide (generally equivalent to, and in some countries greater, than deaths from road traffic accidents);
2. lost production from people with mental illness who are unable to work, in the short, medium or long term;
3. lost productivity from family members caring for the mentally-ill person;
4. reduced productivity from people being ill while at work;
5. cost of accidents by people who are psychologically disturbed, especially dangerous in people like train drivers, airline pilots, factory workers;
6. supporting dependents of the mentally ill person;
7. direct and indirect financial costs for families caring for the mentally-ill person;
8. unemployment, alienation, and crime in young people whose childhood problems, e.g., depression, behaviour disorder, were not sufficiently well addressed for them to benefit fully from the education available;
9. poor cognitive development in the children of mentally ill parents, and the emotional burden and diminished quality of life for family members.

costs. Estimates of indirect costs may appear to be relatively higher in developing countries like Ghana, where many family members traditionally take care of the sick. Information from life-stories collected by BasicNeeds, an NGO working with mental patients, put the corresponding indirect economic costs of mental health as high as 15 times that of the direct treatment costs of mental illness.

There are also the social costs, which come from the stigma and negative stereotyping suffered by mental patients, their carers and their family members. Thus mental illness pushes patients and their dependants more into poverty, alienation and a diminished quality of life. These burdens affect disproportionately certain societal groups belonging to low income classes, women, slum dwellers, people living in conflict, disaster, and war prone areas. In developing countries these social classes of people constitute the majority of the population, and thus contribute to raise the social costs of mental disorders staggering high.

Chapter 4

HEALTH AND MACRO-ECONOMICS

Health outcomes are now widely recognized as highly relevant to rapid economic growth and poverty reduction, due to the fact that the benefits of good health are shared by all sectors. Hence improved health outcomes account for a great number of the MDGs. In the view of WHO's Commission on Macro-economics and Health (2001) "…good population health is a critical input into poverty reduction, economic growth and long term economic development at the scale of whole societies"[17]. Empirically the links between health and the economy has been documented by many studies, (Schultz, 1997, 1999), which show that low population health impedes economic well-being and economic development directly through economic losses to society arising from low years of healthy life expectancy[18]. In addition low health is said to result in a combination of depressing effects on parental investments in children and on returns to business and infrastructure investments (WHO 2001). Cross-country regressions for the 1965-90 period by Gallup and Sachs (2001), for example, revealed that poor countries like Ghana with serious disease conditions such as malaria grew 1.3% less per person per year, controlling for initial poverty, economic policy, tropical location, and life expectancy among other factors.

The negative effects of poor health on productivity and economic development in most Sub-Sahara African countries including Ghana have also been widely documented. The Commission on Macroeconomics and Health, for instance, assigns the heavy burden of disease, and its multiple effects on productivity, demography, and education to be partly responsible for Africa's chronic poor economic performance. In its estimation the high prevalence of malaria, for instance, costs Africa about 1 percent annually in lost economic growth. Hence experts assert that more than half of Africa's growth shortfall relative to high growth countries in East Asia can be attributed to its relatively high burden of diseases, demography and geography rather than traditional variables of macro-economic policy and political governance (Bloom and Sachs 1998).

The losses from poor population health manifest themselves quantitatively in reductions in market income[19], longevity, and psychological well being caused by illness (Cutler *and* Richardson, 1997). Therefore any evaluations of economic development that do not take into account the direct and indirect linkages of health status and economic well-being will tend to understate the economic benefits of good health. The burden of disease thus appears to stand as a stark barrier to economic

[17] For a critique of this apparent virtuous circle hypothesis see *Legge et al.*, (2002) Globalisation on trial: world health warning. In: http://users.bigpond.net.au/sanguileggi/Blum#Blum (19.11.2004)

[18] A typical statistical estimate suggests that each 10 percent improvement in life expectancy at birth is associated with a rise in economic growth of at least 0.3 to 0.4 percentage points per year, holding other growth factors constant (WHO 2001).

[19] The reductions in market income can take the form of 1) costs of medical treatment; 2) the loss of labour-market income from a episode of illness; 3) the loss of adult earning power from episodes of disease in childhood; 4) the loss of future earnings from premature mortality (WHO 2001).

growth and therefore must be addressed frontally in any comprehensive development strategy[20]. However, isolating the causal effect of health on economic prosperity has over the period proved to be very controversial.

Macro-Economics and Mental Health in Ghana

Even though good health is an input into rapid economic growth, development and poverty reduction, government's efforts to achieve rapid economic growth can also endanger health and more, particularly, mental health. That is to say that every government policy that put stress on people has the likelihood of generating mental disorders in people[21]. This is particularly the case in developing countries, which due to their low level of development, high level of poverty and stagnation in their respective economies, are constantly implementing various forms of reforms, austerity and structural adjustment programmes. Ghana is a country that has implemented various forms of structural adjustment and other macro-economic reform programmes since independence in 1957. Particularly, under its current structural adjustment programme, introduced in 1983, the economy has witnessed massive changes, which covered a broad spectrum of macro-economic policy variables including exchange rate, fiscal and monetary, privatization, and trade policy variables as well as changes in institutions and practices. These changes have produced various shocks and have caused economic displacements in the social Ghanaian set ups.

This explains probably why social stress accounts for one major cause of neurological disorders in Ghana. Turkson and Dua (1996), for instance, found in 1996 that social stress is a major cause for the onset of depression, which occupies the second position on the list of causes of mental diseases in Ghana. A potent by-product of economic shocks and their resulting social stresses is unemployment and drift into poverty, and substance and alcohol abuse. Thus hard drugs such as heroin and cocaine, which were entirely unknown up to the end of the 70s had by 2000 become common drugs of abuse, as found by Affinnih (1999) in 1999. Several other studies (Turkson and Asante 1997, Turkson 1996, 1998) seem to confirm the increase in psychological illness due to alcohol abuse. Apparently the economic shocks and the resultant social stresses seem to have contributed to the increased number of mental patients since the introduction of the latest economic reforms in 1983, even though, there exists presently no empirical evidence to confirm the causality between the increasing number of mental patients and negative effects of structural adjustment programme. In the following section we explore possible deleterious impacts of these policy measures on mental health care through effects on government health expenditures.

[20] This can also be seen against the background of the fact several of the great "takeoffs" in economic history – such as the rapid growth of Britain during the Industrial Revolution,; the takeoff of the US South and the rapid growth of Japan in the early 20th century; and the dynamic development of Southern Europe and East Asia beginning in the 1950s and 1960s – were supported by important breakthroughs in public health, disease control, and improved nutritional intake (Fogel 1997, 2000).

[21] This follows from the WHO definition of mental health as "…a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community." (see WHO 2002a)

The Impact of Structural Adjustment on Mental Health Care Delivery

Between 1970 and 1983 the economy suffered dramatic declines which entailed a decline in GDP *per capita* by more than 3% a year. This culminated in the introduction of a market oriented stabilization programme, dubbed Economic Recovery Programme (ERP) in 1983, and a subsequent structural adjustment programme (SAP) with the view to (Kapur, 1991; Leechor, 1994; Appiah-Kubi 2003):

1. correct the imbalances in government finances,
2. reduce the state's involvement in the economy,
3. remove fiscal controls on trade, savings, investment and maintain fiscal and monetary discipline, and
4. rehabilitate basic social and economic infrastructure.

The measures undertaken to achieve these objectives included among other things devaluation of the local currency, massive government expenditure cuts in social spending (health, education, infrastructures, and food), trade liberalization, restrictions on government borrowing, deregulation of goods and financial markets and the state-owned enterprise sector, etc. Even though these measures were able to halt the downward decline in the economy as witnessed in the seventies and early eighties, they had not been adequate to generate any large increase in real incomes or to transform the economy. The increases in average real per capita income of about 2% of GDP since the eighties would not allow, in the face of the high level of prevailing poverty in the country, any high private out-of-pocket expenditures of poor people in mental health care.

On the other hand, like all structural adjustment measures which always have negative short-term effects (Huq 2004), the implementation of the SAP measures resulted in negative social consequences on the people of Ghana, which most likely created high level social stress and possibly also increased neurological disorders in the country. With government expenditure cuts, as normally demanded by structural adjustment programmes, government allocations to the health sector did not only suffer initially under the SAP, but could also not increase in real terms as would have been without SAP instigated spending cuts. Consequently the marginalised health sub-sectors like the mental health sector suffered most under the government spending cuts.

Connected with public health spending cuts was also the SAP induced reduction in private health spending, brought about by declines in income due to increases in unemployment, withdrawal of government health subsidies and the introduction of cost-sharing measures through user fees in Ghana health systems (GSS 2000). As a result Ghana recorded a reduction in utilization rates of health services and thus worsened the already precarious situation of mental health patients. Since most mental health patients in Ghana are found to be poor structural adjustment measures made it difficult for them to acquire the necessary drugs and treatment. Other consequences of government spending cuts resulted in cutbacks in preventive social

programmes and interruptions in supply of pharmaceuticals to public health care facilities as well as the weakening of disease control programmes[22].

The Impact of the Oil Price Shocks on Ghana's Mental Health Care Delivery

The country has over time experienced several oil price shocks, which may have also played a role in the worsening mental health problems in Ghana, insofar as they negatively affected the country's ability to import needed drugs. For instance, the first oil price hike in 1973-1974, increased the oil import bill of Ghana by more than three fold, from US $41 million in 1973 to US $155 million in 1974. A similar situation occurred in 2005 – 2006 when the price of a barrel of crude oil rose by more than 100% and thereby increased the country's oil import bill by almost threefolds. The increase in the oil import bill was among the factors which caused the balance of trade to change from surplus of US $126.7 million in 1973 to a deficit of US $171.5 million in 1974, (Siebold,1988:143) or deteriorate from –US$1,558.1 million in 2004 to –US$2,037 million in 2005. Particularly, the oil-price shocks of 1973/74, 1979/80 and 2004-2006 coupled with the high prices increases of other imports, drought, macro-economic distortions and falling export volumes, led to sharp declines in the terms of trade at the beginning of the eighties. With declining foreign exchange earning as the consequence, it became increasingly difficult for Ghana to meet its deficit food imports with the likely negative consequences on mental health related vital imports.

Budgetary Deficits and Mental Health

In Ghana government budget balance has for most part since independence been in the negative. Even the much acclaimed budget surpluses realised during 1986-1991 turn into deficits that range from about 2% to 3% of GDP when the budget is defined in its broader terms to include foreign financed project expenditures (Islam and Wetzel, 1994). According to the World Bank these budget deficits (including grants), which were equivalent to about 2.3% of the GDP annually between 1975-1984, rose slightly to an annual average of 2.7% during 1985-1989 but jumped to 7.3% during 1990-1996 (World Bank, 1997:189) before falling to 4.3% of the GDP in 2001-2005. During this period health expenditure in real terms as measured by the health expenditure index (1993) declined from 141 in 1975 to below 15 in 1983 before rising successively to 119.8 in 2004, a level still far below the 1975 level. An increasing substantial portion of these deficits was, however, used to finance increases in public wage bill, debt servicing and increasing deficits of parastatals. In the 1992, for instance, when the government granted election bonuses in the form of

[22] Even though data limitations and methodological difficulties make it difficult to attribute health changes specifica-lly to SAPs, general evidence from other countries supports SAP's negative impact on various health indicators such as infant and child mortality and mental health. For instance, ample evidence confirms that non-adjusting countries with low levels of debt in Sub-Saharan Africa have succeeded in accelerating the rate of improvement of their infant morta-lity rates during the 1980s; that the rate of progress in severely indebted, non-adjusting countries has remained broadly unchanged; and that progress in severely indebted, intensively-adjusting countries has slowed markedly. Some analysts have also attributed these negative effects on health indicators to SAP induced income declines of the poor; increases in food prices; and reductions in health sector spending and its resultant imposition of user charges for health care, cut-backs in preventive programmes' budgets and interruptions in supply of pharmaceuticals to public health care facilities (TWN 2006 http://www.twnside.org.sg/title/sap-ch.htm).

massive wage increases of about 300% (ISSER, 1992), fiscal deficit rose from a surplus of 0.9% in 1991 to a deficit of about 5% of GDP in 1992 (ISSER 1994). In such situations not much of government resources remain for marginalised sectors like the mental health.

Debt Burden and Mental Health

It is widely acknowledged that a country that is crippled by debt cannot afford to provide its people with medical services or other social services, leaving its population vulnerable to pressures of life. Ample evidence confirms that every $1 earned in exports or received in aid by a very poor indebted developing country is repaid many times over or deducted at source to service foreign debt (UNAIDS 2004). Debt servicing in most indebted developing countries takes a much larger slice of their budgets than public health, and this condition contribute to deepen the marginalisation of such already neglected health problems as mental health. For instance, according to estimates Ghana spends between 20% -25% of its export earnings and about 20% of its tax revenue on servicing debts incurred almost decades ago (Ampaw 2001). All these expenditures could be used to provide needed inputs or vital drug imports for the mental health services.

Debt Relief and Mental Health

Ghana belongs to the group of countries classified by the World Bank as 'heavily burdened' by debt (UNAIDS 2004). This has caused it to apply for debt relief under the World Bank HIPC debt relief facility in 2001. Under this facility Ghana shall enjoy debt-cancellations of about US$4.429 billion (ARB 2006) and equivalent to over 71.09% of total outstanding debts of US$6.23 billion as at 2006 over a twenty year period (ROG 2005). However, to qualify for debt relief under HIPC, countries like Ghana are required to adopt economic reforms and open up their economy to “free” trade with “closed” economies in the developed world. Many restrictions or tariffs on imports or subsidies to farmers are required to be removed or lowered, and foreign companies are to be allowed access to markets of these poor countries. Wealthy nations, however, are not required to do the same, giving their industries an additional advantage over those of poor countries. Even though empirical evidence about its impact on mental health in Ghana is not available, the negative impact in the short-run on poverty and the ability of such agriculturally oriented communities like Ghana to earn hard foreign exchange to import vital mental health inputs like drugs cannot be denied.

Mental Health Care and Foreign Aid

Since long the health sector in Ghana has remained one of the few sectors that have benefited a lot from foreign aid inflows into the country. However, for some time now a decline in aid inflows worldwide can be observed in the face of rising demand for health services on the part of health care consumers, including mental health. On the other hand attached to these aid inflows in many cases are specific spending

conditionalities for utilization of these transfers on receiving countries. Since mental health care is not high on the development assistance agenda of many of these donor agencies and countries the mental health sector does not receive foreign assistance that is commensurate with its importance. This is also against the background of the fact that most donors prefer to support projects that in their opinion are sustainable in the long-run and this contributes to further marginalization of social sectors like the mental health sector that do not generate revenue directly.

Price Controls

Price controls, despite its inherent allocative and distortionary consequences, has in the past enjoyed high popularity among governments in Ghana. Price controls for consumer goods have been used as a means to protect urban consumers and control socio political discontent. In the past, price controls had involved the tying-down of prices of particular consumer goods irrespective of their production costs. The seventies and early eighties saw the increasing use of this measure in Ghana. Up to the early eighties, for instance, about 6000 prices or more than the prices of 825 product categories were regulated by the government (Appiah-Kubi 1995). The scope of product categories and the intensity of regulation widened with mounting scarcity and inflation till the mid eighties. When inflation jumped from 9.2% in 1972 to 116.3% in 1977 the government instituted strict price controls with stiff sanctions.

This was intensified under the Armed Forces Revolutionary Council (AFRC) and the Peoples National Defence Council (PNDC) governments in 1979 and 1982 (Haynes 1989). The consequences of this distortion were a rapid decline in overall output, because the producers could not cover costs at the prices at which they were compelled to sell their products. During 1979 and 1982, for example, those producers who could not adhere to the controls were either physically abused or imprisoned. All these resulted in physical and mental torture as well as social stress (possibly depression, alcohol abuse, etc) for especially the poverty stricken farmers and producers, who were pushed into more poverty when they were forced to subsidise the living standard of the relatively well off urban colleagues.

Another form of resource transfers from the rural poor to the urban rich takes place through the marketing of cocoa through the Cocoa Marketing Board (CMB), sole marketing agency for cocoa. High degree of mismanagement and corruption at the CMB combined with increasing tax on cocoa income and high marketing costs usually results in transfers of income from the poverty stricken sections of the population who are highly susceptible to social stress. In 1980, for example, the CMB was paying the Ghanaian cocoa farmer only about 28% of the export price it was receiving on the international market. This contributed to a sharp decline in the index of real farmers' income from 100 in 1957 to 18.6 in 1983 (Appiah-Kubi, 1995). Even though successive increases in the producer prices by the government since the introduction of structural adjustment programme have brought about some tangible improvement in the real income of farmers and consequently production to 700,000 tonnes (2004), the proportion of the producer price to fob export prices of cocoa still lingers around 70% (ISSER 1997, 2005).

The combined effects of these transfers have been massive declines in production and consequently export earnings, particularly in the mid seventies and early eighties. Merchandise exports during 1975-1985, for instance, declined almost by 3.8% annually (World Bank, 1997). With it came also a decline of about 50% in imports of merchandise necessities during the same period. Since most of the drugs and other medical necessities for mental health care are imported, it was no wonder that mental health suffered seriously during that time.

Exchange Rate Policy

Another factor which had in the past played an important role in the nation's ability to import necessary medical inputs for the mental health system has been the exchange rate system of the Ghanaian Cedi. Up to the early eighties the country practised a fixed exchange rate system (Kapur 1991) that led to a massive over-valuation of the cedi and thus made exports highly uncompetitive. This seriously affected the country's ability to earn foreign exchange to import essential raw materials and other capital inputs for its production units and increase output. This situation on the one hand contributed to rising unemployment and social stress (depression, alcohol abuse, etc) and probably an increased pressure on the limited mental health care resources. The lack of foreign exchange, the stagnation in output affected not only government revenue but also its budgetary allocation to the health sector. This partly contributed the steep decline in the government health expenditure both in real terms from an index of 141 in the mid seventies to below 14 in 1983 and in relative terms from about 9% to 4% of total government expenditure during the same period. With declining resources available to the whole health sector it became increasingly difficult for such marginalised areas as mental health care to run efficiently and so cater for the increasing numbers of clients.

Beginning from the mid eighties the country adopted a flexible exchange rate system, which resulted in a massive depreciation of the cedi of more 10.000% between 1984 and 2005. This substantial depreciation meant that Ghanaians now needs to exchange more cedi for the same foreign currency. This situation consequently made imported essential drugs almost out of reach of the average mental health patient on the free market.

Poverty Reduction Programmes and Mental Health Care in Ghana

The Ghana Poverty Reduction Strategy (Govt. of Ghana, 2003: GPRS I) 2003-2005 proposed to develop and implement special programmes for the poor and the vulnerable in society. The GPRS, the GLSS 4 and Participatory Poverty Assessment (NDPC 2006) identify the extreme poor, the vulnerable and the excluded to include: rural agricultural producers, children in difficult circumstances, people living with HIV/AIDS, displaced communities, disadvantaged women, residents of urban slums, the elderly who have no access to family care, physically challenged persons especially those with no employable skills, people suffering from chronic diseases (tuberculosis, buruli ulcer, guinea worm, trachoma bilharzias and breast cancer), drug addicts, victims of harmful traditional practices and the unemployed. These groups

include people who are susceptible to stress and mental disorders. As much as tackling the poverty of these groups will indirectly manage their stress (and thereby addressing the possible causes of mental disorders), with the exception of drug addicts, the issue of people with mental illness is conspicuously missing in the Ghana Poverty Reduction Strategy document. This in a way underscores the argument that significant benefits are being denied to mentally ill people and their families by their exclusion/absence in poverty reduction strategies and related policy discussions.

Chapter 5

Recommendations

It discerns from the foregoing that the mental health system in Ghana, whilst still in its developing stages, is inundated with many problems. The major single barrier to effective mental health care in Ghana, however, lies in the apparent lack of recognition of the seriousness of mental illness and lack of appreciation of the socio-economic benefits of good mental health. These problems have combined to reduce access to mental health care to very low levels in Ghana. In order to increase access levels and close the gap between what is needed and what is currently available to reduce the burden of mental disorders and to promote mental health it is important for Ghana to implement the following measures:

- correcting the fault or inadequacy of the current policy framework for MH in Ghana – which limits mental health care solely to health and health related issues rather than approaching it also as a development issue. For an effective mental health care it is important for the country to award it specific considerations in poverty reduction strategies and other development strategies and policies. This requires the recognition by development and mental health policy planners that mental health like physical health is a development issue owing to its enormous social and economic burden on the economy of Ghana. It therefore should warrant the attention in terms of financial and technical resources that is commensurate with its burden. In other words, more resources should be made available to mental health care to enable the psychiatric institutions to undertake the badly needed infrastructural rehabilitation and expansion works.

- In order to widen access to mental health care in Ghana it is also recommended that the country gives the decentralization process as enshrined in its mental health policy the needed boost to integrate mental health care in the country's primary health care. Indeed the management and treatment of mental disorders in primary care is a fundamental step to facilitate increasing number of people to easier and faster access to services. This requires the effective absorption of mental illness's clinical aspects into health policies and systems, especially in the decentralised and community based contexts.

- Increasing access implies bringing mental health care closer to the people in need. This also means moving away from institutionalised specialised treatment and care of mentally ill persons to less expensive community-based treatment and rehabilitation services. This approach to mental health care should also include community interventions which focus on building social capital or policy level interventions which widen participation in education and skills training. Evidence as to how community based mental health care can contribute towards improving mental health care in Ghana can be provided by the work of BasicNeeds, an NGO which has been working with CPNS in the Northern sector and Accra to provide organized specialist outreach clinics in remote parts of the Northern Region. The group has also been involved in helping families of discharged patients and discharged patients through counselling and home visits as well as assisting them

in securing sustainable livelihoods.

- Ghana started a community mental health and development programme in the nineties, which for various reasons have been stalled. This was meant to provide appropriate mental health care and treatment to mentally ill people living in the community. It is highly recommended to revive this programme to allow the country to reap the many associated advantages, among them to offer cost effective treatments and to support mentally ill people and their families to earn an income either through work or by involvement in income generation schemes. For this to happen it is important to do the following:

  - to reallocate staff from hospital to community-based service settings;
  - a new set of competencies for work in community-based settings must be developed, and a change in emphasis on recovery and rehabilitation in hospital settings to community-based care;
  - to train a wider range of workers (for informal community care and primary care) in mental health; and

- The country can reap the full benefits of decentralization and integration of mental health care into the primary health care if enough mental health experts are made available to the health institutions. For this to happen, however, general health personnel need to be trained in the essential skills of mental health care and the capacity of all personnel in the various institutions must be continuously upgraded. Mental health should therefore be included in training curricula of medical personnel, with refresher courses to improve the effectiveness of the management of mental disorders in general health services. Another way to meeting the rising of human resource need would be to introduce public mental health alongside public health in Ghana's tertiary institutions. As an emerging discipline public mental health can help propagate the art, science and politics of protection and enhancement of mental health and well-being and the prevention of mental health problems, as well as improving opportunities for recovery and quality of life for people with existing mental health problems. More scientific research should be devoted to strengthening mental health resources so as to improve the quality and quantity mental health information as well as better understanding of mental health issues.

- Another important thing that also needs urgent attention is to get the Mental Health Act of 1972, whose review has gone through 10 drafts, amended immediately. The new legislation can play a vital role in promoting human rights and access to quality care and prevent violations, discrimination and stigmatization against people with mental disorders. Legislation can promote human rights and encourage the autonomy and liberty of people with mental disorders. It can also support access to quality mental health care and help people to integrate into the community.

- The planned expansion of training schools to allow increased intake, which is behind schedule should be revisited. For more mental health experts to be trained it is recommended to decentralize mental health care to District Hospitals and

facilitate follow-up after training. Training and recruitment should move in tandem with strong staff retention programmes. In recent times Ghana is one country that has experienced an extremely high staff attrition, which has seriously affected negatively the country's health human resource base. Table 17 presents brain drain situation in the country over the last decade.

Table 17 Brain Drain in Ghana 1993 - 2004

Cadres	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Totals
Doctors	68	44	58	71	62	61	72	52	62	105	117	40	812
Nurses	207	236	195	182	174	161	215	207	235	246	252	82	2,392
Pharmacists	28	30	29	27	35	53	49	24	58	84	95	30	542
Allied staff	12	9	8	9	4	6	9	16	14	0	NA	NA	NA

Source: Ministry of Health

- Compounding the international brain drain is the internal distribution of health personnel that is skewed towards urban and more developed areas and illnesses with less stigma and discrimination and less favourable to mental health care. To be able to stem the tide added efforts on the part of government should be made towards addressing the problem of low salaries as well as the negative factors influencing the retention of health workers in deprived areas. According to a DFID-funded study in 2002 these factors included the following:

  1. Staff accommodation.
  2. Water and sanitation
  3. Electricity
  4. Access to good schools and qualified teachers for children
  5. Transport for work
  6. Road access
  7. Availability of working materials and equipment
  8. Availability of good transport links to and from the districts.

- In the short to medium term the status of psychiatric hospitals should be raised to the level of tertiary hospitals in terms changing the organizational structure of Ministry of Health to enable the psychiatric hospitals attain the appropriate attention it warrants. In any case it offers already training not only to community nurses in general including psychiatric nurses, but also in-service training to medical professionals. In the long-run it is recommended to do away with these large psychiatric hospitals in a decentralised mental health system.

- Mental health promotion in a wider perspective covers a variety of strategies, all aimed at having a positive effect on mental health. This includes the encouragement of individual resources and skill improvements in the socio-economic environment. In Ghana mental health promotion constitutes a big missing link in the country's mental health care system. Even the existing mental health policy is silent on mental health care promotion. However, mental health promotion can contribute significantly to health improvement for people living with mental health problems, challenge discrimination and increase understanding

of mental health issues. An effective mental health promotion requires a strong state-civil society partnership. In order not to make the health promotion limited purely to high risk groups, it is important that the programmes and interventions are as broad-based as possible using a multi-sectoral approach, encompassing various government sectors such as health, employment/industry, education, environment, transport and social and community services as well as non-governmental or community-based organisations such as health support groups, churches, clubs and other bodies. This may also require a close collaboration among MOH, GHS, TH and District Assemblies the private sector[23], and community.

- Most health care resources are spent on the specialised treatment and care of the mentally ill persons, and to a lesser extent on community-based treatment and rehabilitation services. Even less funding is available for promoting behavioural health. Studies in the US, for instance have found that overall medical care costs decrease for those using behavioural healthcare services, particularly, when the community including employers are involved.

- It has already been pointed out that mental health promotion involves a multi-sectoral collaboration of a number of government sectors such as health, employment/ industry, and more especially social and community services as well as non-governmental or community-based organisations such as health support groups, churches, clubs and other bodies.

- A major problem that also needs immediate attention is lack of effective discharge planning of cured or previous mental patients. Since there appears to be no pre-release discharge planning for the psychiatric hospitals a lot of discharged inmates of psychiatric hospitals continue to live in the hospitals because they have been abandoned by relatives or do not have anywhere to go or due to fear of stigma and discrimination are afraid to integrate themselves into the larger society. We recommend a 'special action plan' to integrate these former patients into the society by offering them sustainable livelihoods. Since these discharged inmates over-burden the limited resources of the psychiatric hospital it lies in the interest of the hospital authorities to liaise with the Ministry or Department of Social Welfare to develop an effective discharge plan, Where these inmates are given 'special treatment' to participate in the various employment and sustainable livelihoods programmes in the country, like Youth in Agriculture, Poverty Alleviation Fund, Skills Training and Employment Programme (STEP), Women in Development programmes, etc. There is also the need for an effective supervision of mentally disordered post-release to cut down the high rate of relapses that inundate the hospitals. In both instances it is recommended for the

[23] A study at Chevron Corp shows that the company saves seven dollars for every dollar it spends on promoting their employees behavioural health care. Similarly companies like Campbell Soup Company and Virginia Power realized a 28% or 23% drop in medical claims after investing in behavioural healthcare of their employees. The involvement in promotion of such behavioural health care can be replicated in Ghana. Healthcare Reform Advocacy Resource Center at 1-800-969-NMHA (6642)

government to enlist the services of local NGOs who together with community-based service centres can perform such various outreach services.

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