



GHANA



A VERY PROGRESSIVE MENTAL HEALTH LAW

KEY ACHIEVEMENTS

A very progressive mental health law that:

1. Reflects international human rights and best practice standards, while at the same time takes into consideration local conditions and requirements:

- ✦ It contains specific clauses related to the rights of people with mental disorders,
- ✦ It also has provisions for the protection of vulnerable groups, and
- ✦ It provides for a visiting committee to monitor human rights conditions in mental health facilities and
- ✦ It sets up a tribunal with the authority to investigate complaints and review involuntary admission and treatment in mental health facilities

2. Emphasises community based treatment and discourages institutionalisation;

3. Acknowledges and regulates informal mental health facilities (traditional and faith-based healers). The law takes into account the significant role of traditional healers in providing care while at the same time putting in safeguards against inhuman and degrading treatment practices.

NEXT STEPS

1. Official adoption of the mental health law

2. Drafting regulations

3. Implementation of the mental health law

Potential partners and donors interested in supporting the **WHO MIND Project 'Mental Improvement for Nations Development'** or any aspects of the implementation of the mental health legislation in Ghana should contact the World Health Organization:

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THE PROJECT



OVERVIEW

It is estimated that of the 21.6 million people living in Ghana, 650,000 are suffering from a severe mental disorder and a further 2,166, 000 are suffering from a moderate to mild mental disorder. Like in many other parts of the world treatment rates are low. In Ghana, statistics from the health information system indicate a treatment rate for the whole country of only 32,283 people contributing to a treatment gap of 98% of the total population expected to have a mental disorder.

There remains an over reliance on institutional treatment and care – largely a hangover of colonial days. Great efforts are being made however to change the model of service provision to one which emphasizes care in the community. Great efforts are also being made to fight stigma, discrimination and human rights violations. To this end the reform of the existing mental health law was identified as a priority action to improve the situation for people with mental disorders.

While the 1972 law was certainly a major improvement over its predecessor, it strongly emphasized institutional care to the detriment of providing mental health care in primary health care settings. This is contradictory to both national and international policy directives. Furthermore, procedures for involuntary admission in the 1972 law did not sufficiently protect people against unnecessary admission. Indeed, serious mistreatments of people with mental disorders - some have been involuntarily locked away in institutions for decades – have persisted under this legislation. It is in this context that Ghana has been working to draft and implement new mental health legislation to promote best practice in treatment and care and to protect the human rights of people with mental disorders.

Specifically, the new law will aim to:

- Improve access to in-patient and out-patient mental health care in the communities in which people live
- Regulate mental health practitioners in both the public and private sectors
- Combat discrimination and stigmatization against people with mental disorders and promote the human rights of people with mental disorders.
- Promote voluntary treatment and, if necessary, admission, in mental health facilities.
- To clearly define and limit the circumstances under which treatment may be given to people with mental disorders without their informed consent



MAJOR MILESTONES

■ **January 2004: Established drafting committee.** Ghana established a multi-sectoral drafting committee, encompassing key national stakeholders (representatives of professional groups, human rights commission, psychiatrists, traditional healers and attorney generals office).

■ **Feb-March 2004: Review of the 1972 mental health decree.** The drafting committee compiled all domestic laws that made reference to mental health issues and critically examined and analysed these laws as well as the existing mental health law, using the WHO Resource Book and WHO Legislation Checklist, in order to identify its weaknesses, in particular where it failed to promote and protect human rights in accordance with international human rights standards.

The drafting committee also prepared a plan of action for the development, adoption and implementation of the law using the WHO's Guidance instrument.

■ **14-17 June 2004: Joint workshop with the drafting committee, MOH Ghana and WHO.**

- ✦ Presentations were made to improve knowledge of technical issues and WHO framework for developing and implementing a mental health law–
- ✦ The 1972 Mental Health Decree was systematically reviewed and discussion with the help of the WHO checklist for analysing the adequacy of a mental health law
- ✦ The action plan for developing the law was discussed and elaborated using the WHO Guidance Instrument for developing and implementing a mental health law.

■ **29 September 2004: Inauguration of the drafting committee.** (including Dr Samuel Allotey, Dr J. B. Asare, Dr Akwasi Osei, Dr Kofi Ahmed, Prof. C.C. Adomako, Dr. Sammy Ohene, Mr. David Macauley and Ms Estelle Appiah).

■ **Oct-Nov 2004: Broad consultation** with a number of key stakeholders was undertaken to understand their vision and ideas for a new mental health law. The consultation included: traditional and spiritual healers (25 Oct), advocacy groups and human rights NGOs (27 Oct), professional groups (3 Nov), and the press (5 Nov).

■ **Nov 2004-Dec 2006: Ten drafts of the mental health law produced and commented** on by WHO and main stakeholders in Ghana.

■ **January 2006: Last draft of the new mental health law** (in line with most international standards) put into consistent legal language by the Attorney General's office. Previously six drafts had been produced by the attorney general's office and discussed with the Technical Drafting Committee.

■ **4-6 April 2006: 2nd joint workshop with drafting committee, MOH Ghana and WHO.** Review of some outstanding content issues for the Draft Mental Health Bill and discussion of key technical, procedural and political considerations for the adoption and



implementation of the mental health law. Participants at the workshop included members of the drafting team, the Head of the Attorney Generals Office, the Chief Medical Officer, National mental health coordinator, other MOH staff Ghana, WHO consultant and WHO AFRO Regional Adviser for Mental Health and WHO coordinator for Mental Health Policy and Service Development, HQ.

■ **May 2006: Drafting of regulations and forms** to accompany the law

■ **June 2006: Final draft law** produced, ready for submission to Parliament.

The bill has been submitted to the Minister of Health. The Minister has sent back comments on two occasions for response. Meanwhile the Minister has met with his technical committee on the bill and other health-related bills being prepared.

NEXT STEPS

- Consultation with the Chief Justice to discuss the implications of the law for Court workload
- Submission of the Mental Health Bill to Parliament.
- Finalization of the regulations and required forms/proforma
- Holding of a Sensitization workshop for Parliamentarians, awaiting the forwarding of to Cabinet and thence to Parliament before discussions with parliamentarians.
- Workshops for deliberations on the law (Parliamentarians and key technical staff)
- Preparation of training materials and guides for different stakeholders on the law
- Stakeholder workshop on the Draft Mental Health Bill, their role and implications for practice
- Holding of training workshops on the implementation of the new law, once law is enacted.



MAIN PARTNERS

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Dr Dixon Chibanda (University of Zimbabwe, Harare); and
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LINKS TO OFFICIAL DOCUMENTS

Situational Analysis

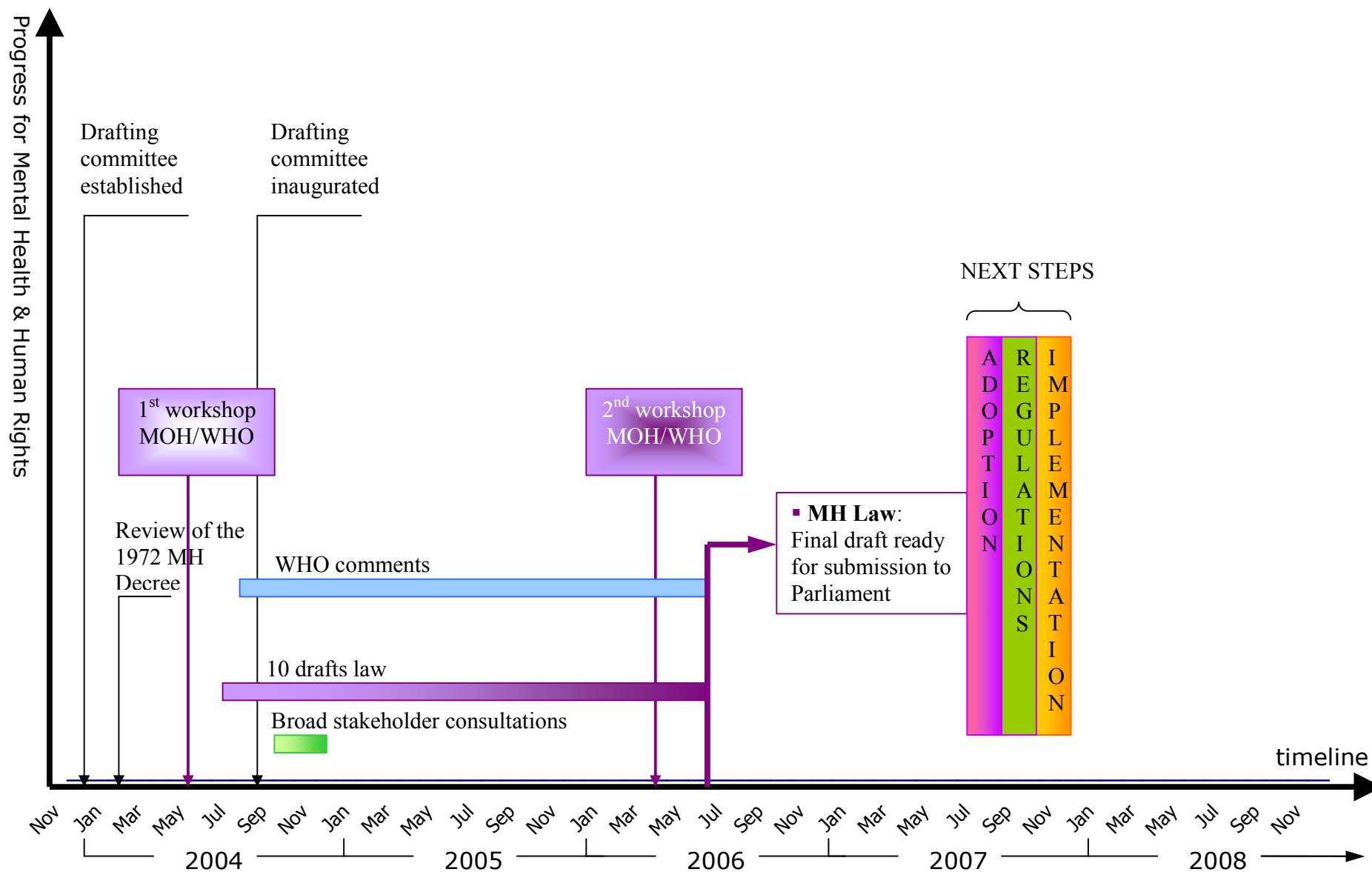
- Situational Analysis (Mental Health Profile, Asare, 2003)

Legislations

- 1972 Ghana Mental Health Decree
- WHO Legislation checklist applied on the 1972 Ghana Mental Health Decree.
- Ghana draft new Mental Health Law (to be adopted)
- WHO Legislation checklist applied on draft mental health bill
- The Narcotic Drugs (Control, Enforcement and Sanctions) Law 1990 -PNDC Law 236
- Pharmacy and Drugs Act (1961)

Health and Mental Health Policies, Plans and Programmes

- Previous mental health policies, adopted but not implemented:
 - ✦ Substance Abuse Policy (formulated 1990);
 - ✦ Mental Health Policy and Programmes (1994 & 2000 revision)
- MOH Ghana, 2002. The Second Health Sector. *5 year programme of work, 2002-2006. Partnerships for Health: Bridging the Inequalities Gap*. Ministry of Health, Government of Ghana, January 2002. MOH7PD/005/03/GD. 63 pages. url: <http://www.danida-health-ghana.org/publications/pdf/powII.pdf> (last accessed on 01/02/2007).
- MOH Ghana, 2004. The Ghana Health Sector Annual Programme of Work 2004. Ministry of Health, Government of Ghana, January 2004.
- MOH Ghana, 2005. The Ghana Health Sector 2005 Programme of Work. Bridging the Inequality gap: Addressing Emerging Challenges with Child Survival. Ministry of Health, January 2005. 90 pages.
url:
<http://www.ghanahealthservice.org/includes/upload/publications/2005%20Programme%20of%20work.pdf> (last accessed on 01/02/2007).
- MOH Ghana, 2007. Five-year Programme of Work for Health 2007-2011 (in preparation)
- National Drug Policy, 2nd Edition (2004).
url:
http://www.who.int/countries/gha/publications/Ghana_National_DrugPolicy_2nd_Edition.pdf
- Essential List of Drugs, 5th Edition (2004).
http://www.who.int/countries/gha/publications/Ghana_Essential_Medicine_List_5th_Edition2004.pdf





THE CONTEXT



① COUNTRY DEMOGRAPHIC AND SOCIOECONOMIC PROFILE

Ghana is located in West Africa with a population of **21.664 million people (46% urban)**: World Bank 2006), an average density of 77 people per km² with large geographical disparities (from 897 in Greater Accra to 31 in the Upper West region; MoH Ghana, 2002) and annual population growth of 2.3% (2004 data; WHO, 2006b).

Its capital is Accra. Ghana is divided into 10 administrative regions and 138 decentralized districts constituting the lower level of political administration.

(Sources: http://www.who.int/whr/2006/annex/06_annex1_en.pdf and <http://devdata.worldbank.org/wdi2006/contents/toc.htm>)

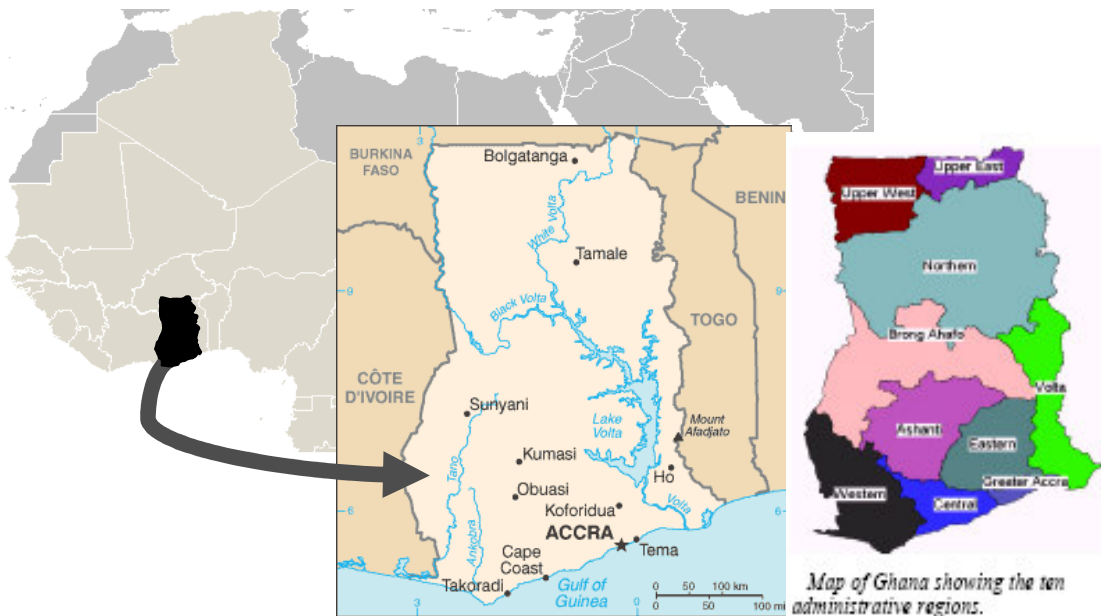


Figure 1: Geographical location and map of Ghana

(Source/adapted from: <http://intranet.who.int/features/icp/?cc=gha> , <http://www.who.int/globalatlas/default.asp> and http://www.who.int/countries/gha/publications/RED_approach_in_Ghana.pdf , page 6)

The principal religions in Ghana are Christianity, Islam and African traditional religions. The main language used in the country is English. (WHO, 2005b)

The **adult literacy rate** is **66.4%** for men and **49.8%** for women (2000 data; UNESCO, 2006).

The proportion of the population under the age of 15 years is 39.5% (UNDP, 2006), and the proportion of population above the age of 60 years is 5.6% (WHO, 2006b).

The **life expectancy at birth** is **56** years for males and **58** years for females (WHO, 2006b).

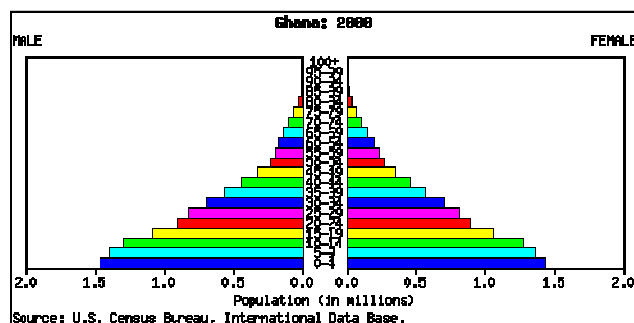


Figure 2: Age pyramid (Ghana, 2000)

(Source: <http://www.census.gov/cgi-bin/ipc/idbpyrs.pl?cty=GH&out=s&ymin=250>)

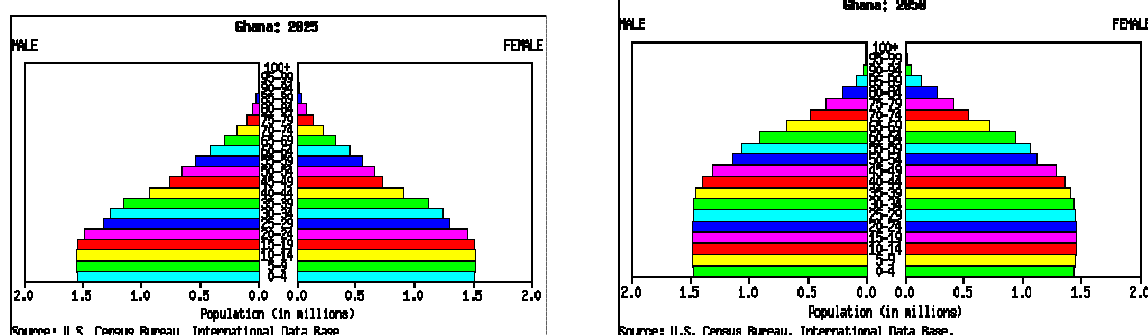


Figure 3: Age pyramids (Ghana, Projections for 2025 & 2050)

(Source: <http://www.census.gov/cgi-bin/ipc/idbpyrs.pl?cty=GH&out=s&ymin=250>)

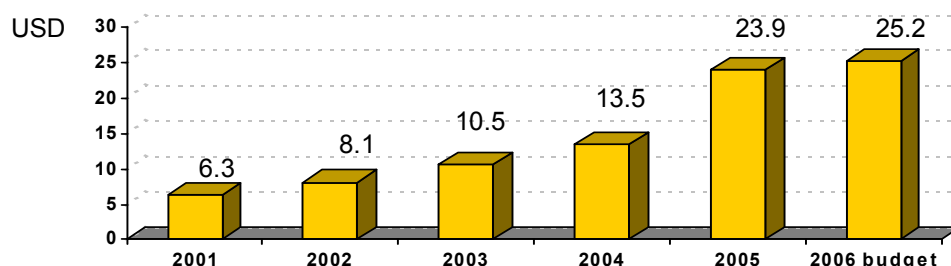
The country is a **low income group country** (based on World Bank 2004 criteria¹). The primary sector of employment and revenue is agriculture (WHO, 2006c).

The **health budget** represents **1.4% of the GDP** and 31.8% of the total health expenditures, 100% of private health expenditures being paid by the users (out of pocket) (World Bank, 2006). It was the 3rd largest share of the government budget for 2006, after education and economic affairs (17% of GoG budget; MOH, 2006, p. 11²).

The **per capita total expenditure on health** (at international dollar rate³) is **98\$**, which represents **4.5% of GDP** (2003; WHO, 2006b).

The **per capita government expenditure on health** is **31 international \$** (2003; WHO, 2006b) [ratio 0.32], with the gap filled in by external resources (IGF and Donors: 15.8% of total expenditures in 2003) and user fees (see MOH Review 2005, p. 10).

Table 1: Per capita expenditure on health (USD), Ghana 2001-2006



Source: Ghana MOH, 2006, p. 10

¹ Classification available on:

http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0_contentMDK:20421402~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html (last accessed: 09/01/2007).

² Health sector revenue shares are detailed by sources for the period 2000-2006 in this document (MOH, 2006, p.11)

³ "Purchasing power parity (PPP) conversion factors take into account differences in the relative prices of goods and services—particularly non-tradables—and therefore provide a better overall measure of the real value of output produced by an economy compared to other economies. PPP GNI is measured in current *international* dollars which, in principal, have the same purchasing power as a dollar spent on GNI in the U.S. economy. (...) PPPs provide a better measure of the standard of living of residents of an economy (source:

http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0_contentMDK:20399244~menuPK:1504474~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html)



② CONTEXTUAL FACTORS INFLUENCING MENTAL HEALTH NEEDS AND SERVICES

► The **population living below the poverty line** has fallen from about 54% in 1991-1992 to just fewer than 40% in 1998-1999 (Ghana statistical services, 2000) (WHO, 2005b). There are vast geographic disparities especially for the Northern, Upper West, Upper East and Central regions (MOH Ghana, 2002; p.61)

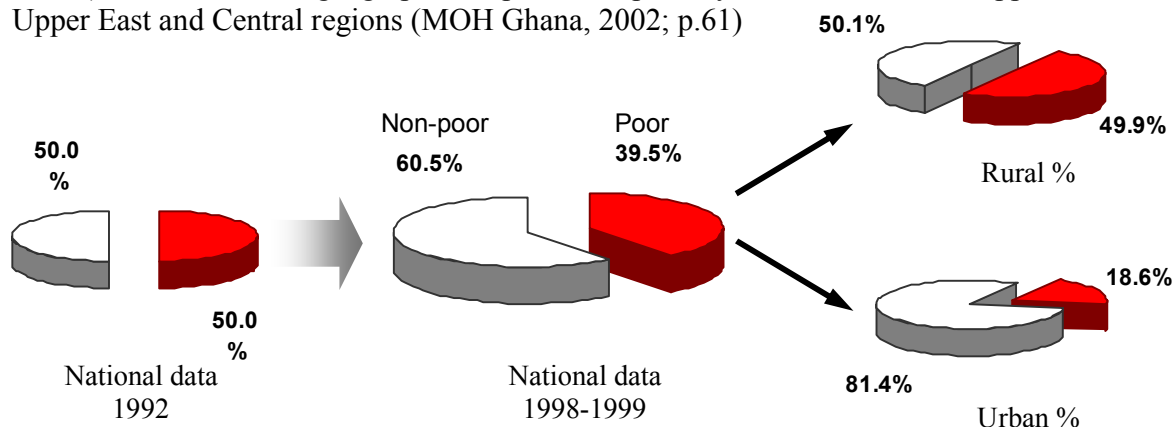


Figure 4: Population living below the national poverty line (in red) in Ghana (World Development Indicators, 2006).

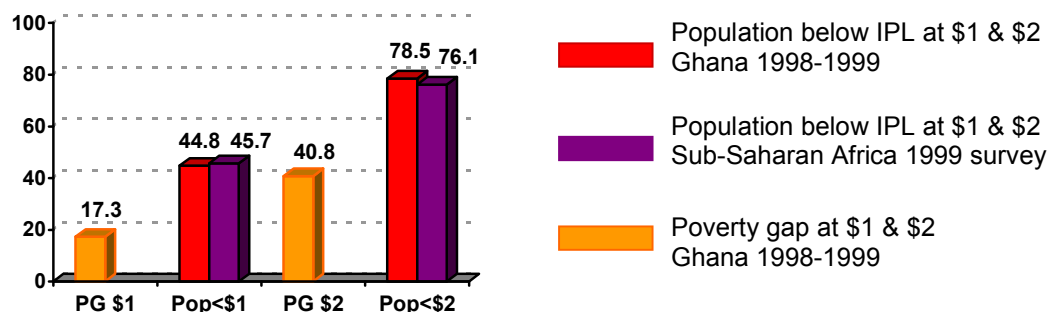


Figure 5: Poverty levels and poverty gaps⁴ in Ghana (1998-1999) and Sub-Saharan Africa (1999), international poverty lines (IPL) at \$1 and \$2 (World Development Indicators, 2006).

(Source: <http://devdata.worldbank.org/wdi2006/contents/Section2.htm> [table 2.7.: Poverty]).

⁴ The poverty gap is the mean shortfall from the poverty line (counting the nonpoor as having zero shortfall), expressed as a percentage of the poverty line. This measure reflects the depth of poverty as well as its incidence.



Human Development Index (HDI)⁵ (Country HDI 2004 = 0.532, ranking 136/177):

While figure 6 shows HDI trends over time, figure 7 shows how, in this specific national context, GDI relates to health and social indicators of development (how much economic wealth is transformed into development at the population level).

While doing slightly better than other Sub-Saharan countries in terms of HDI (21.5% increase, compared to 12.7% regionally), Ghana is achieving about the same level of development with a slightly lower GNI per capita than the average low income country group.

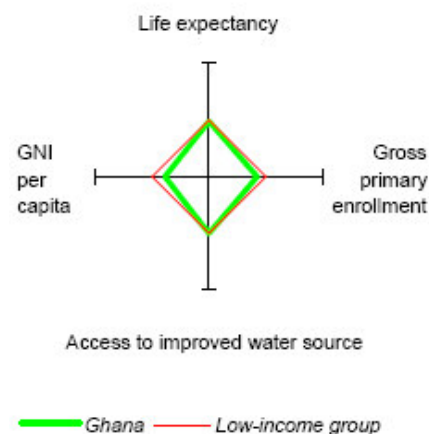
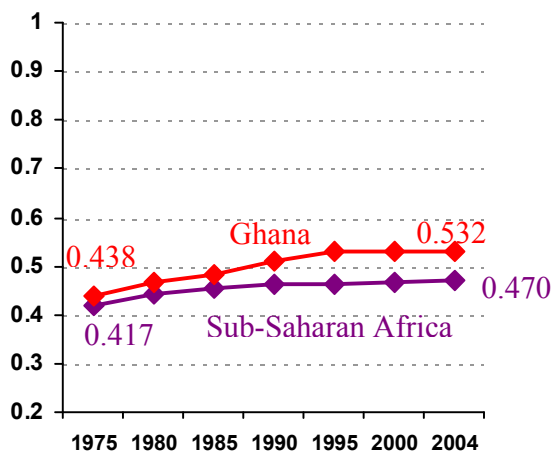


Figure 6: Human Development Trends (1975-2004)

(Source: UN Development report 2006, url:

http://hdr.undp.org/hdr2006/statistics/flash/statistics_trends.cfm)

Figure 7: The development Diamond (2005)

(Source: World Bank, 2006b, url:

http://devdata.worldbank.org/AAG/gha_aag.pdf)

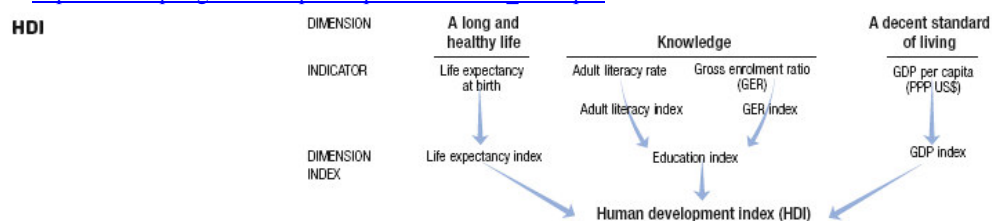
► In terms of general **health status**, there are very **large inequalities** across geographical areas and socio-economic groups. The epidemiological situation of Ghana is similar to other sub-Saharan countries, i.e. a predominance of communicable disease conditions, under nutrition and poor reproductive health with **emerging importance of noncommunicable diseases**, including mental and alcohol/substance use related disorders (WHO, 2005b).

► **Brain drain**: there is an important migration of locally trained staff to more lucrative work abroad.

⁵ The Human Development Index (HDI) is an indicator, developed by UNDP, combining 3 dimensions of development: a long and healthy life, knowledge, and a decent standard of living (see figure below).

Source: Human Development Report 2006 (UNDP), Technical Note 1.

url: http://hdr.undp.org/hdr2006/pdfs/report/Technical_notes.pdf





- ▶ There is a growing trend in **rural-urban migration** (MoH Ghana, 2002): the proportion of people living in urban areas has increased from 36% in 1990 to 46% in 2004 (WDI 2006, table 3.1.).
- ▶ The key policies of the **2002-2006 health programme** (WHO, 2005c) include:
 - ✦ a shift from facility-based services by emphasizing **community-based care**⁶
 - ✦ 10 priority health interventions⁷, one of which is "specialist services, including psychiatric care (community, secondary and tertiary) (MOH Ghana, 2002; p. 15);
 - ✦ staff motivation and health workers **incentives**;
 - ✦ replacement of user-fees for **prepayments and insurance** arrangements⁸, introducing new social insurance and health insurance schemes and clarifying exemption policy; and
 - ✦ increased emphasis on the use of **NGOs and private health providers** (currently accounting for about 42% of the health care services nationally; target set for 2006: 50% of non essential services contracted out and 10% of private facilities at district level).
- ▶ "There has been a **substantial increase of nearly 400%** in the **financial resources available for health care** since the beginning of the PoW from 2002-2006 and this is attributable to a number of factors. The first is the **generally positive macroeconomic climate**, including real GDP growth of 5-6% per annum over 2003-5 the second important factor is the **proportion of government expenditure** which has been allocated to health, which was increased dramatically in 2005, such that health now has the third largest share of the government budget for 2006 (after education and economic affairs)" (MOH, 2006, p. 10)

⁶ The Community-based Health Planning and Services Strategy (CHPS) being the main initiative to achieve the strategic objective (MoH Ghana, 2002, p. 18).

⁷ Other priority health interventions are: HIV/AIDS/STI; malaria; tuberculosis; guinea worm; poliomyelitis; reproductive, maternal and child health; accidents and emergencies; non-communicable diseases; oral and eye care.

⁸ Abolishment of the cash and carry system in order to ensure that no one lacking funds at the time of need is denied essential health care (MoH Ghana, 2002; p.5). The NHIS (National Health Insurance System) has been established in 2003 by Act 650 "to ensure universal access to health care services for all residents in Ghana" (GHS, 2005, p. 46). The NHIS coverage was at 15.8% nationally in 2005, varying from 7.1 (Upper East region) to 26.7 (Brong Ahafo region (GHS, 2005).



③ BURDEN OF MENTAL DISORDERS AND TREATMENT GAP

➡ Burden of Disease

Based on prevalence rates from the World Mental Health Survey 2004, it is estimated that **at least 2,816,000 people** in Ghana (or **13%** of the adult population) are likely to be affected by mental disorders which require varying degrees of treatment and care: approximately 650,000 people (3%) are suffering from a severe mental disorder and a further 2,166,000 (10% of the adult population) from a moderate to mild mental disorder⁹.

➡ Treatment gap

In the annual report of the Ghana Health Services 2005, **estimates of the number of people receiving treatment** for mental disorders including substance abuse and neurological disorders is based on an annual figure of 6,316 individual cases of hospitalization and 26,559 cases receiving outpatient consultations (OPD cases) = **32,875 cases**¹⁰

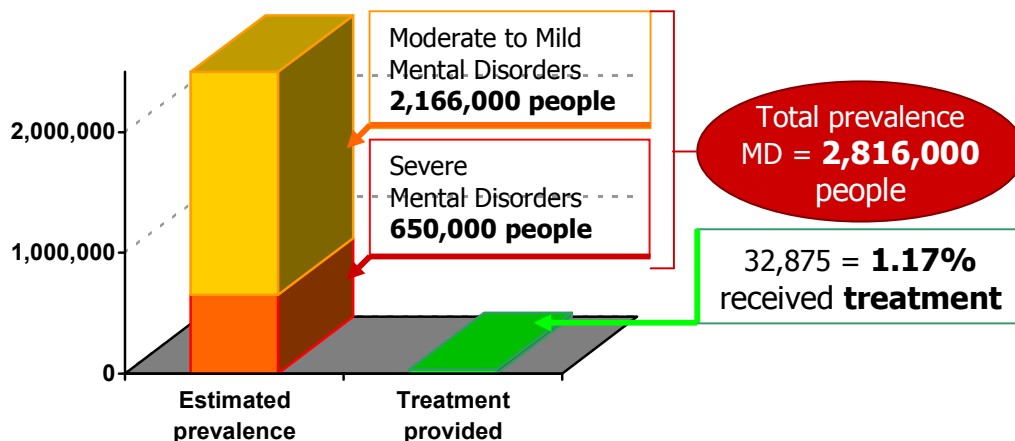


Figure 8: Treatment gap for people with mental disorders in Ghana

The **ratio of outpatient attendance to admission** is 14.6 (GHS, 2005) for all health conditions. For mental health, it is only **4.64**, showing the rather high level of institutionalization for the treatment and care of people with mental disorders.

Total number of OPD cases for neurological and mental disorders is estimated to represent 0.3% of the total OPD new cases reported (for all medical conditions), which is disproportionate with the estimated relative burden of disease (13%).

⁹ These estimates of numbers treated are based on inpatient & outpatient consultations in the 3 major psychiatric hospitals and outpatient departments.

¹⁰ According to an informal report of Joe Asare, Chief Psychiatrist up until 2003, the total number of people receiving treatment was estimated to be 89,135 - giving an overall treatment rate of 4.1%. OPD attendance was estimated to be 82,819 in 2002 and inpatient admissions was estimated for 6,316 people. These rates are higher than that reported in the official statistics from the Ghana Health Service Report 2005 (GHS, 2005). The discrepancy in figures may come from the fact that Asare has included in his estimation mental health care provided at all levels (including secondary and primary levels) whereas Ghana Health Services would have only reported on the tertiary level (3 main psychiatric hospitals and teaching hospital). This hypothesis would mean that mental health care is very decentralized/deinstitutionalized in Ghana as it would bring the ratio of outpatient attendance to admission up to 13.11 and only 32% of OPD care would be provided in specialized psychiatric hospitals.



➡ Breakdown of diagnosis for inpatient & outpatient treatment

■ Inpatients

Table 1: Top 10 cases of admission to psychiatric hospitals in Ghana (2002; from: Asare, 2003)

Rank	Diagnosis / Cause of admission	Number of Cases	%
1	Schizophrenia	1,599	25.32
2	Substance Abuse	1,101	17.43
3	Depression	736	11.65
4	Hypomania	629	9.96
5	Acute Organic Brain Syndrome	495	7.84
6	Manic Depressive Psychosis	343	5.43
7	Schizo-affective Psychosis	284	4.50
8	Alcohol Dependency Syndrome	215	3.40
9	Epilepsy	191	3.02
10	Dementia	131	2.07
Other cases of admission		592	9.37
Total		6,316	100.00

■ Outpatients

Table 2: Reported cases of Neurological & Mental Disorders (NMD) at outpatients departments in Ghana (2005; from: GHS, 2005)

Neurological & Mental Disorders (NMD)	♂	♀	Total	% of OPD cases for NMD	% of all OPD new cases
Epilepsy	4,397	3,264	7,661	28.8	0.09
Acute psychosis	3,639	3,811	7,450	28.0	0.09
Neurosis	2,538	4,589	7,127	26.8	0.08
Substance Abuse	2,692	1,629	4,321	16.3	0.05
Total OPD Cases for NMD	13,266	13,293	26,559	100	0.3

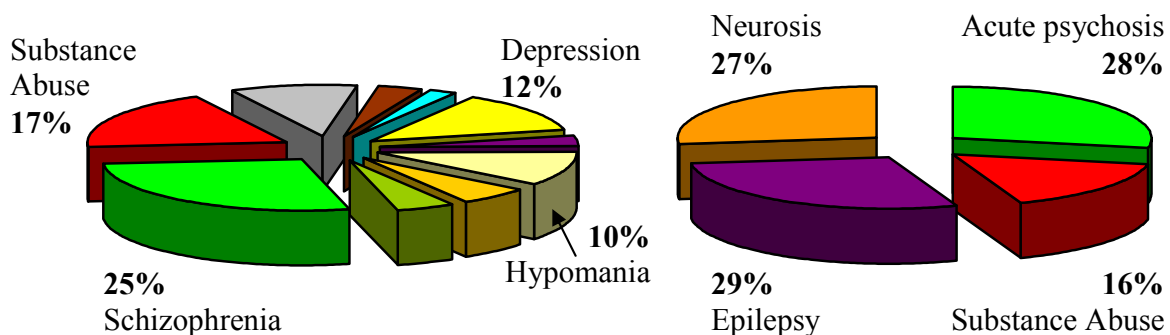


Figure 9: Main diagnosis for inpatients (left pie chart) and outpatients care (right pie chart)



④ THE MENTAL HEALTH SYSTEM

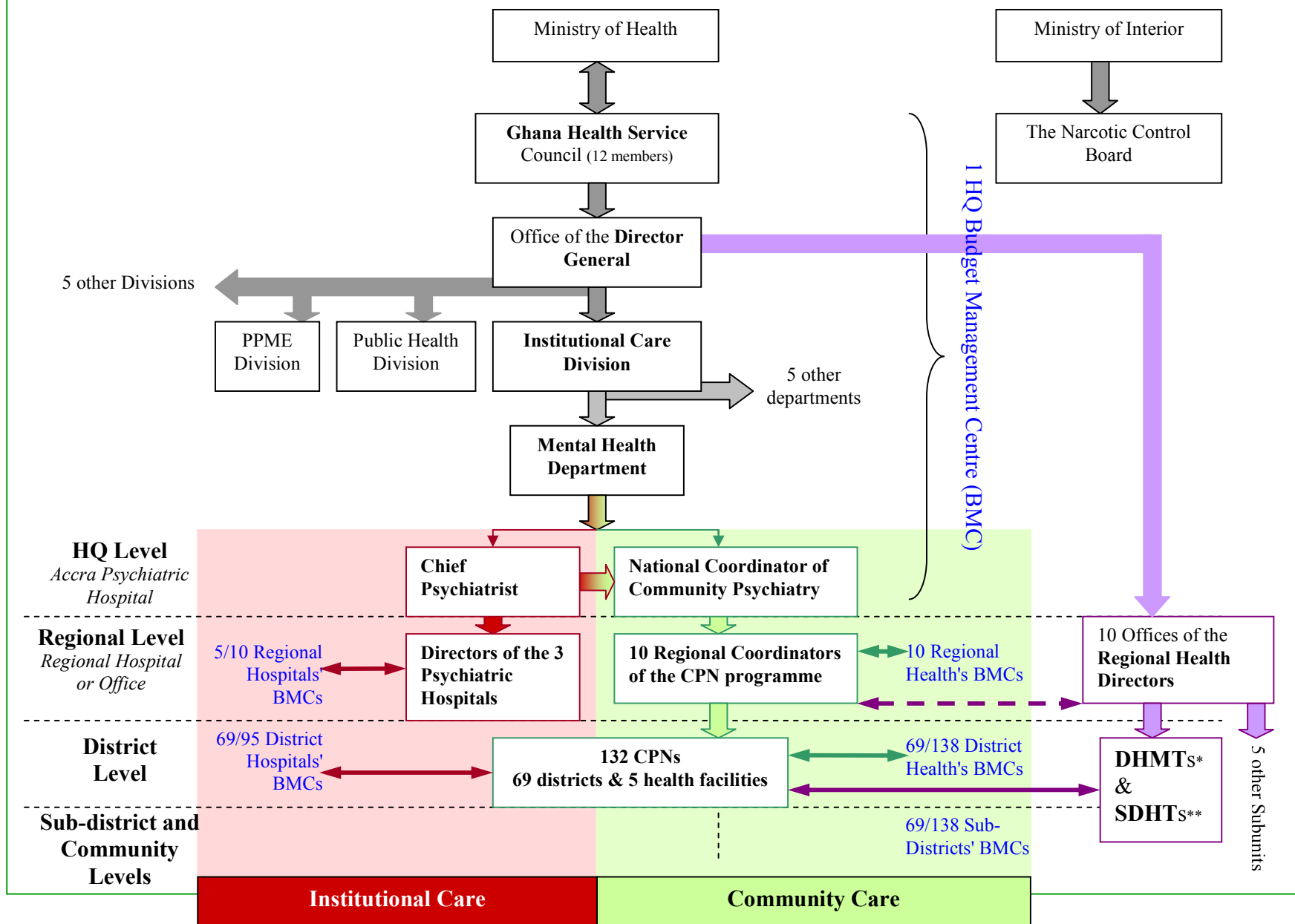
Mental health services in Ghana are available at most levels of care. However, the majority of care is provided through specialized psychiatric hospitals, with relatively less government provision and funding for general hospital and primary health care based services. The few community based services being provided are private. In summary most treatment and care is being provided by specialist hospitals, close to the capital, Accra, and servicing a small proportion of the population in need.

The health system overall is decentralized from national, through to regional and district level. Districts have a reasonable degree of autonomy in providing mental health services and relate both horizontally to the district level health director and Budget Management Centre (BMC), and vertically. For vertical reporting, the psychiatric hospitals report to the chief psychiatrist while the district community nurses report to the national coordinator of community psychiatry who liaises with the Chief Psychiatrist.

Figure 10: Organizational structure of the current mental health system in the general health system in Ghana (2005). Ghana Health Service¹¹ [Next page]

¹¹ "The Ghana Health Service (GHS) is a Public Service body established under Act 525 of 1996 as required by the 1992 constitution. It is an autonomous Executive Agency responsible for implementation of national policies under the control of the Minister for Health through its governing Council - the Ghana Health Service Council. The establishment of the Ghana Health Service is an essential part of the key strategies identified in the Health Sector Reform process, as outlined in the Medium Term Health Strategy (MTHS), which are necessary steps in establishing a more equitable, efficient, accessible and responsive health care system".

(Source: <http://www.ghanahealthservice.org/aboutus.php?inf=GHana%20Health%20Service>)





► Coordination

The Mental Health Unit is currently working as a separate unit within the Institutional Care Division of the Ghana Health Service. Unit headquarters are located at the Accra Psychiatric Hospital and represented by the chief psychiatrist [Dr Osei, since July 2005] and the national co-coordinator of community psychiatry [Ms. Amina Bukari since January 2007] (Asare, 2003, p. 15; Ghana Health Service website).

Coordination is very decentralized. At regional level, coordinators of the community psychiatric nursing programmes, based in regional capitals, head community mental health staff/nurses. BMCs¹² (Budget Management Centres) (GHS website)

► Legal framework, policies and programmes

Ghana's current law, the Mental Health Decree of 1972, is more than 30 years old, outdated and serves to take away the rights of people with mental disorders. The focus of the law is on institutional care and how to keep 'sick' individuals off the streets as well as how to protect their belongings and assets. Patients under the law are not seen as having any human rights or capacity to make decisions. Indeed, serious mistreatments of people with mental disorders - some have been involuntarily locked away in institutions for decades - have persisted under this legislation.

There is an official mental health policy which was never implemented due to a lack of commitment on the part of policy makers and ownership by stakeholders. There is no mental health plan for Ghana at the moment but a draft five-year programme of work for health (2007-2011) of which mental health is a component.

► **Financing:** According to the Ghana Health Services 2005 Report 5.74% of the health budget for administration and services (3.4% of total health budget) is dedicated to psychiatric hospitals (GHS, 2005; table 13, p.67). No data on public and private health care expenditure is available for mental health.

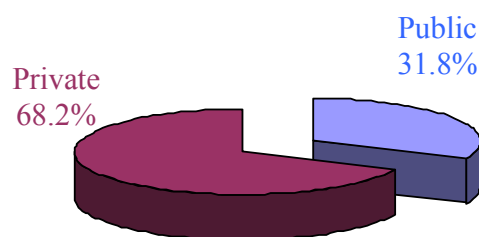


Figure 11: Share of public and private expenditure on (general) health in Ghana, as percentage of total expenditure on health (WHO 2006, annex2).

¹² "There are a total of 223 functional BMC's and 110 Sub-Districts BMC's of Record. A break down of the BMC's are as follows: Currently, the headquarters of the GHS is managed as one BMC; 10 Regional Health Administration, 8 Regional Hospitals, 110 District Health Administrations and 95 District Hospitals" (Source: <http://www.ghanahealthservice.org/aboutus.php?inf=Organisational%20Structure>).



The primary source of mental health financing is **tax based** (WHO, 2005a).

The **National Health Insurance Scheme (NHIS)** passed in parliament in 2003 (MOH, 2004, p. 26), ensured universal healthcare services for all residents in Ghana (GHS, 2005, p. 46). However, while it says mental illness is exempt from the Insurance Scheme, it implies that patients with mental illness do not qualify to register with the Insurance Scheme. That means when a mentally ill patient has a physical illness he will have to pay upfront for the cost of that physical illness¹³. There are special regulations in the new NHIS for very poor people (registered as 'indigent') but for the time being people receiving mental health care, even very poor, cannot be registered as 'indigent'.

■ **Private providers** (including Christian Health Association of Ghana - CHAG¹⁴ - and NGOs):

The important role of the private sector in health care delivery is clearly recognized in Ghana. Since 2002, the government established a Ministry of Private Sector, and in the Ministry of Health there is a Directorate of Private Practice. A private sector policy has been developed and approved by cabinet (in 2002¹⁵) as well as a draft strategic plan which aimed at increasing the contribution of private sector to health care delivery (MOH, 2004, p. 17-18). In 2004, the MOH developed a Policy and Strategic Framework to guide private sector development and promote public-private partnership in health care delivery (MOH, 2005, p. 20).

However, it is difficult to know their real contribution to health care delivery as **private sector expenditure** is **currently un- or underreported** (MOH, 2006, p. 13).

➡ Information System

■ Community Mental Health Care

At the micro/community level, the Community Psychiatric Nurse collects the data and sends them through two channels:

Horizontally to the district director of health services (ie as part of total health information collected in the district, and this is where integration is firmly established). The district director forwards this information to the Regional Director, who in turn forwards it to the Director-General of Ghana Health Services, at the national level.

Vertically, to the Regional Coordinator of Community Psychiatry nursing, who in turn sends it to the National Coordinator of Community Psychiatric Nursing. The National Coordinator then shares this information with the Chief Psychiatrist who coordinates all the information on mental health in the country.

This system is however not very effective. One of the major problems is the risk of double counting, for the cases collected in the districts and in the regions may have already been seen and captured in the psychiatric hospitals (which also refer to the chief psychiatrist). As a consequence information from the national coordinator has often not been included in the statistics collected.

¹³ Anyone having received care for a mental disorder is registered in Ghana. Those people are excluded from receiving for free any other care than psychiatric care.

¹⁴ <http://www.chagghana.org/>



■ Institutional Mental Health Care

The psychiatric hospitals report to the Chief Psychiatrist who then reports to the Institutional Care Division who also reports to the Director General.

■ Information Reporting System:

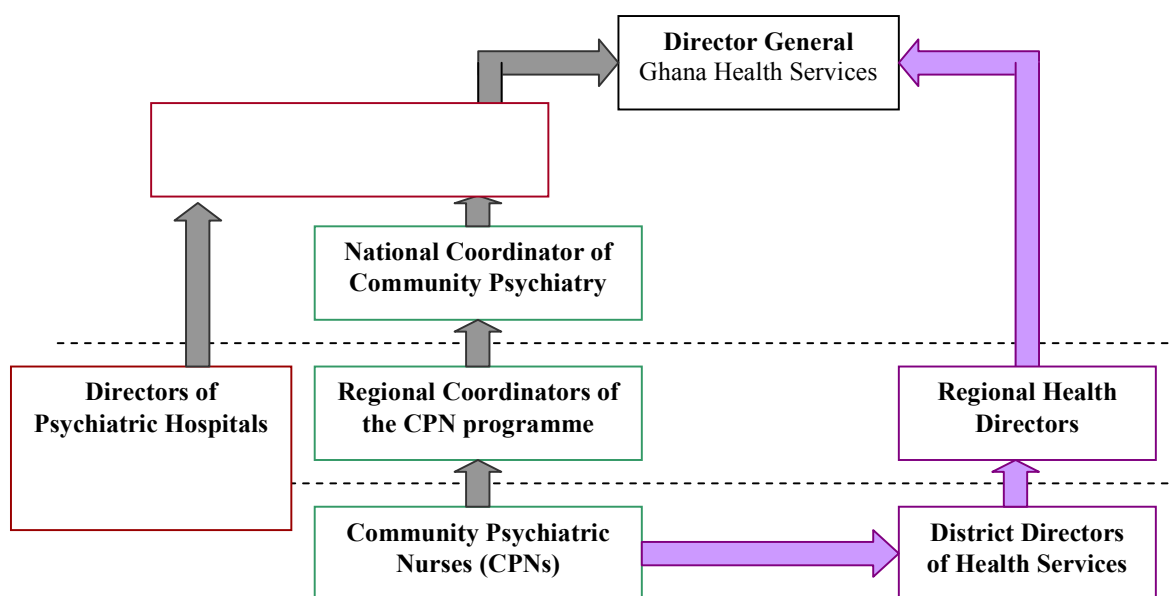


Figure 12: Mental Health Information System in Ghana – organizational chart (2006)



Human Resources for Mental and General Health (WHO Mental Health Atlas, 2005; WHO Global Atlas of the Health Workforce, 2006)

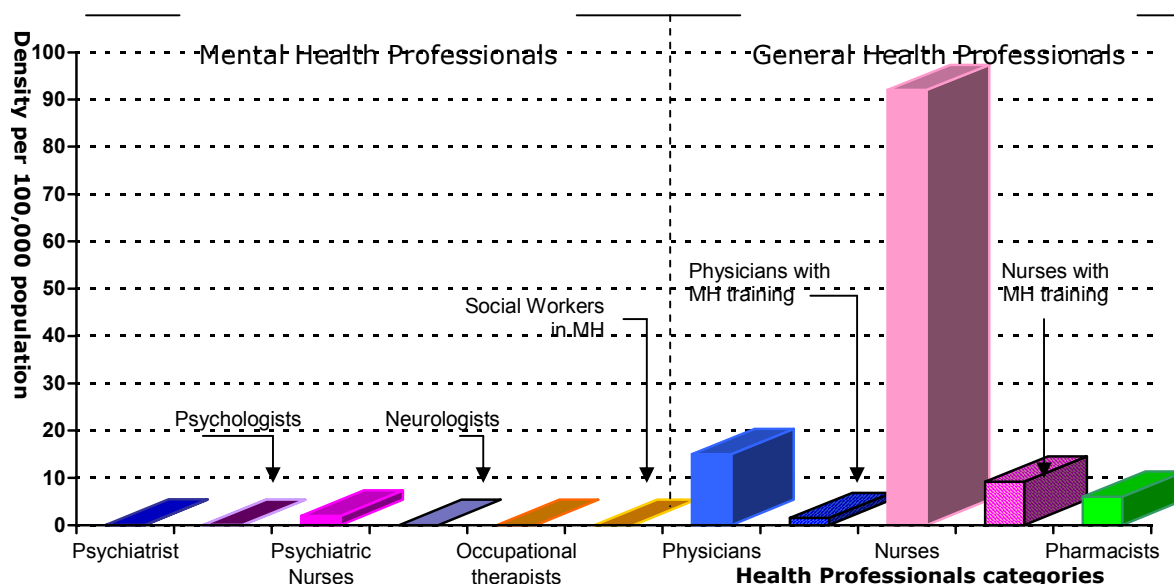


Figure 13: Human Resources for Mental (2005) and General (2004) Health in Ghana.

(Sources: World Mental Health Atlas 2005, url: www.who.int/mental_health/evidence/atlas/index.htm (last accessed 09/01/2007) & WHO Global Atlas of the Work Health Force., url: http://www3.who.int/whosis/core/core_select_process.cfm?country=gmb&indicators=healthpersonnel&intYear_select=all&language=en (last accessed 09/01/2007).

- **3.9%** of Human Resources for health in Ghana were **working in psychiatric institutions** in 2005. The shortfall in health workers is estimated to be 339 for mental health, representing 2.98% of the total estimated deficit of human resources for health at national level (GHS, 2005).
- **Brain drain** and **regional disparities** are preoccupying problems for the MOH, affecting both general health and mental health workers¹⁶.
- **Deprived areas incentives**, were instituted for general health workers in 2005, e.g. the policy of serving for 4 years instead of 5 years - or the topping up of salaries - in the 3 Northern regions of Ghana (GHS, 2005), however these incentives are no longer being used. Four to five years ago **deprived services incentives** were being used as part of an overall effort to recruit and retain mental health workers, however, they were discontinued due to funding difficulties.

¹⁶ Data on doctor population ratios and nurse population ratios by region are available for general health for 2003-2005 (GHS, 2005; p. 53-54).



■ Training and Work in Mental Health

Table 3: Training and Work for mental health professionals in Ghana

Human Resources	Training available in Ghana		Currently working in Ghana	
	Degree courses	MH CPD ¹⁷ (number/training years)	Density (per 100,000 population) ¹⁸	Number currently working in mental health ¹⁹
Mental Health Professionals				
■ Psychiatrists	3 to 5 years	✓	0.08	4 ²⁰
■ Neurosurgeons	6 years	✓	0	None in Mental Health
■ Neurologists	3 to 5 years	✓	0.01	None in Mental Health
■ Psychiatric nurses	3 years ²¹	Log Book	2.00	169
■ Psychologists	3 years, MPhil programme	No	0.04	4
■ Occupational therapists	N/A in Ghana	No	0	Only one, retired even
■ Social workers MH	N/A in Ghana	No	0.03	4 ²²
■ Traditional healers	Informal apprenticeship training for about 5 years ²³	No	23.08	5,000
■ Faith-based healers	N/A	No	23.08	5,000
General Health Professionals				
▶ Physicians / GP	7 years	No	15	N/A ²⁴
▶ Nurses	3 years	No	92	N/A
▶ Pharmacists	4 years	No	6	N/A

➡ **Postgraduate and undergraduate medical training** takes place mainly at the Accra Psychiatric Hospital. However, the **Department of Psychiatry** has been relocated to Korle-Bu -the main teaching hospital in Accra. Both Ankaful and Pantang Hospitals have nursing training schools attached, producing Registered Mental Health Nurses (Asare, 2003). Both are accredited to provide a **Diploma in Mental Health Training**.

Ghana Medical School: <http://www.ug.edu.gh/chs/Medical1.htm>

¹⁷ Continuing Professional Development in Mental Health.

¹⁸ Source: WHO Mental Health Atlas, 2005 (for mental health workers); WHO Global Atlas of the Health Workforce (for general health workers).

¹⁹ National Source (to cite): The information gathered for the mental health policy/other national information source and for WHO Atlas comes from different sources and at different points in time, and can therefore differ.

²⁰ 15 working in Ghana, out of whom only four are in active service, the rest retired officially.

²¹ Meaning: either three years of general nursing plus one and a half years of further training as psychiatric nurse, or three years of psychiatric nursing training for those without general nursing background.

²² No mental health social workers are available, but 4 generic social workers are working in mental health.

²³ Now there is a three year degree programme in herbal medicine but not specifically in mental health.

²⁴ The number of general health professionals working in mental health is not available but it is estimated to be about 10% for GP and nurses (by Dr Osei, current chief psychiatrist in Ghana).



■ (General) Health Professionals:

- **General practitioners (GP)** have 6 years of general medical curriculum plus 1 year of intensive training before graduating. All GPs receive 8 weeks of mental health training as part of their medical curriculum.

- **General nurses** have 3 years of initial curriculum, this being currently upgraded from a certificate course to a 4 years university diploma. All nurses receive 6 to 8 weeks of mental health training as part of their nursing curriculum.

■ Mental Health Professionals:

- **Psychiatrists and Neurologists** have 3 years of specialization and 2 additional years to become consultant on top of the 6 years of general medical curriculum.

- **Psychiatric Nurses** have 18 months of specialization after general nursing training, or 3 years for straight psychiatric nursing training.

➡ **In Service Training (Continuing Professional Development - CPD)** for health in general is the function of the Human resource Development Division (in MOH). The existing **Mental Health Care curriculum** was reviewed in 2005 to make it more skill-based (GHS, 2005, p. 55).

- **Psychiatrists and Neurologists** have the obligation to take 2 professional courses every year. They are registered and are provided with a certificate for each course, processed by the national professional accreditation body (Medical and Dental Council).

- **Psychiatric Nurses** only have to keep a log book of the professional courses taken for CPD.

Fellowship programmes: The 3 psychiatric hospitals have been authorized to provide one long course and 6 short courses in 2005, (instead of one long course and 2 short courses for other national directorates), showing the importance given to psychiatry in Ghana.

➡ **Mental Health Facilities and Services**

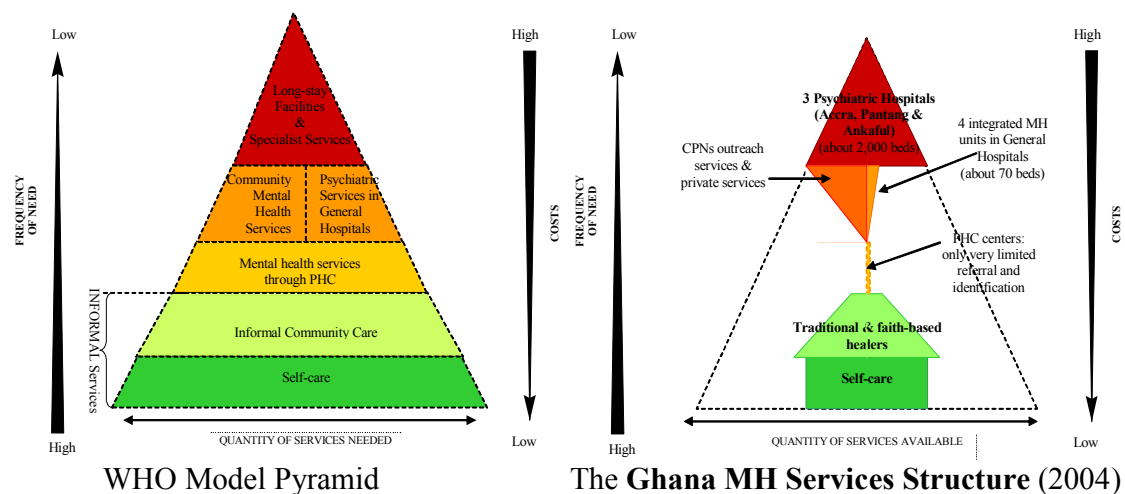


Figure 14: The global shape of mental health services: WHO Model versus Ghana

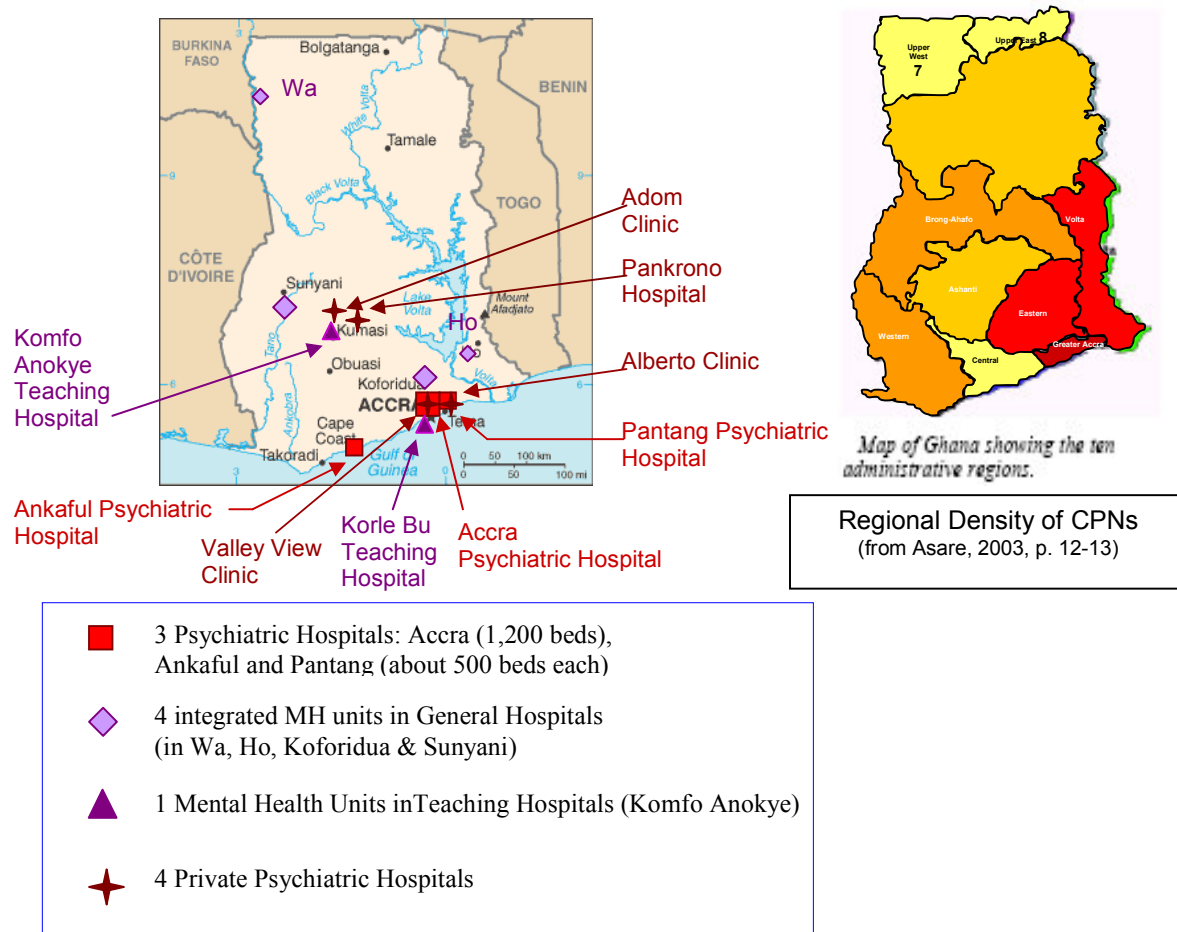


Figure 15: Mapping of the main Mental Health Facilities and Services in Ghana

(Sources: WHO Country Page Ghana, url: <http://intranet.who.int/features/icp/?cc=gha> ; NAM Project Report, 2003)

➡ Description of Mental Health Services at each level of care

■ Long Stay Facilities & Specialist Services

➤ There are **3** psychiatric **public** hospitals (in Accra, Ankaful and Pantang) in the country.

■ **Accra Psychiatric Hospital**, built in 1906, has a capacity of 800 beds but accommodates 1,200 patients (Asare, 2003).

■ **Pantang Psychiatric Hospital**, 25 kms outside Accra, is a "vast land with a number of uncompleted wards, bungalows", accommodating 450 patients for a capacity of 500 beds (Asare, 2003).

■ **Ankaful Mental Hospital**: It has 300 patients for a capacity of 500 beds, the restricted number of patients being due to the insufficient number of health workers.



➤ There are **4 private** psychiatric hospitals in Ghana:

- **Pankrono neuro-psychiatric hospital** and **Adom Clinic**, both in Kumasi, in the Ashanti region.
- **Valley View Clinic** in Accra
- **The Alberto clinic** in Tema (30 km east of Accra, on the coast)

The Adom Clinic is staffed with an experienced nurse but all the other private clinics in Ghana have psychiatric specialists (Asare, 2003).

Both public and private hospitals provide both inpatient and outpatient services (Asare, 2003).

▪ **Psychiatric Services in General Hospitals**

There has been a policy of creating mental health units/or provision of beds in the regional hospitals. Since this policy was formulated, some units have been created in **5 of the 10 regions (10 general hospitals)** of Ghana even though each of the other 5 regions provides beds in medical wards for psychiatric cases (Asare, 2003). The mental health units are manned largely by Community Psychiatric Nurses who relate horizontally with the regional hospital administration and vertically with the National Coordinator of Community Psychiatric Nurses and the Chief Psychiatrist. The unit provides OPD care and in some cases inpatient facilities. CPNs go to the communities from the unit to give follow up care to patient.

➤ **Inpatient**: It is planned that each of the 10 **regional hospitals** will eventually have a psychiatric wing with 20 beds.

As of now:

- 10 beds have been provided in **Ho** regional general hospital (Volta region).
- 10 beds have been also provided in **Wa** (Upper West region)
- A ward with 22 beds has been completed to accommodate psychiatric patients at the **Sunyani** regional hospital (Brong Ahafo region).
- 20 beds for psychiatric patients have been provided in **Koforidua** regional hospital (Eastern region) The OPD component is functioning now, but the inpatient section has not started yet because there is no resident doctor.
- 12 beds are available in **Kumasi** at the main general hospital (**Komfo Anokye Teaching Hospital**, Ashanti region).

➤ **Outpatient**: All the psychiatric hospitals and regional units also serve OPD purposes.



■ **Community Mental Health Services**

➤ Public services:

69 out of the 138 districts have at least one or more **Community Psychiatric Nurses** (CPN). CPNs are mental health nurses who have received further training in community care. CPNs are based in the main district health facility (major health centre or hospital) and travel around the district to provide specialized OPD services at primary health care level, in sub districts health centres. The districts that have no CPN are covered on outreach by the nearest district with CPN (Asare, 2003, page 13). Their functions are to follow up cases from hospital, follow-up on psychotropic medications and identify new cases of mental disorders.

Three 'psychiatric diplomates' (general doctors with 18 months training in psychiatry) work in 3 regions²⁵. They are based in general hospitals and assist the Community Psychiatric Nurses in primary health care activities (Asare, 2003, page 10)

➤ Private services:

Apart from these public services, there are private sector facilities: Damien Centre at Takoradi, (serving as day-care centre for patients who live around the centre), Cheshire Home in Kumasi (serving as rehabilitation centre for patients who have been treated from the psychiatric hospitals and require some handywork training), Remar Centre in Accra and Kumasi (serving as drug rehabilitation centre, faith-based), Mercy Centre at Brafo Yaw near Cape Coast (serving as Drug Abuse Treatment Centre), Tisampaa Club House by Basic Needs NGO at Tamale which serve as day care club house for the patients on treatment in the community, Sakina Club House by a private Medical Practitioner (non-psychiatric) at Tamale which serves as club house for the vagrant psychotics

■ **Mental Health Services through Primary Health Care**

➤ **District Health Centers:** Some primary health care workers in Ghana have received on site mental health training thanks to the '**Nations for Mental Health Project**'²⁶. The project's goal was to improve the detection and treatment of people suffering from psychosis and epilepsy in Ghana. Starting with the 2 neighboring districts of Manya Krobo and Yilo Krobo, the project has:

- Sensitized and involved opinion leaders to the issue of mental illness in the communities,

²⁵ Psychiatric diplomates are general doctors with eighteen months training in psychiatry, as against consultant psychiatrists with full training in psychiatry. There were 5 of such psychiatric diplomates located in 5 regions apart from the regions with the psychiatric hospitals. Now the distribution has changed, with only 3 of these regions having the services of this category of doctors.

²⁶ For more information on the 'Nations for Mental Health Project', go to:
http://www.who.int/mental_health/media/en/400.pdf (final report, last accessed 25/05/2007).



- provided support (including further clinical training²⁷) to community psychiatric nurses to extend care within the community,
- provided training to general health providers to be able to give basic care to mentally ill people in their daily practice,
- supported districts with the aim of integrating mental health in primary care and creating a network of support systems for care providers.

As for now, the project is not running anymore. This is because the WHO programme had a time period after which the communities were to take over. This did not happen and there is a gap. Ghana now want to revive the concept using local funds and as part of the community mental care.

■ Informal Community Care

➤ **Traditional Healers:** "Ghana has **about 45,000 traditional healers**. Many churches also offer spiritual healing, which often involves a blend of traditional medicine and Christianity" (Roberts, 2001, p. 1859)

According to the MOH Ghana itself, "traditional medicine is a major source of healthcare for many Ghanaians. It is currently estimated that about **70-80% of Ghanaians** use traditional medicine as their front line health service. However the quality of traditional medicine has been difficult to assure" (MOH, 2005, p. 22). The government strategic choice in Ghana is "to promote the integration of traditional and alternative medicine practice into the formal health system and support strategies to improve the quality of care provided" by these practitioners, developing a tool for accreditation of practitioners and clinics, and an essential traditional medicine list with standard treatment guidelines and establishing a separate administrative structure for Traditional Medicine (regional offices and Secretariat of the TM Practice Council) (MOH, 2005, p. 22).

"In February **2000**, the **Traditional Medicine Practice Act** was passed to regulate and codify the practice of traditional medicine. (...) there is certainly scope to expand this code of practice to include mental health care" (Roberts, 2001, p. 1859).

➤ **NGOs:**

■ **Basic Needs Ghana** (<http://www.basicneeds.org>), "which is based in the Northern part of Ghana. BasicNeeds has been working with CPNS in the Northern sector and has also organized specialist outreach clinics to remote parts of the Northern Region. A specialist from Accra has been involved with these outreach clinics since 2002" (Asare, 2003).

■ **Friends of the psychiatric hospital**", an NGO was established in the middle eighties of the last century. They are a group of women from churches and voluntary organizations who have come together to help the psychiatric hospital. Each of these groups has adopted a particular ward in the hospital which they visit and help in diverse ways. They came to help the hospital when there was famine in the country leading to

²⁷ Training was provided to coalition teams, general health care providers, and community psychiatric nurses to assist them in carrying out their functions.



malnutrition and high rate of deaths in the hospital. This NGO raises funds for some projects in the hospital annually.

- An NGO, “**Family Support group**” was established in the year 2002 through the efforts of the chief psychiatrist with support from **V.S.O.** The group has been helping families of discharged patients through counseling and home visits” (Asare, 2003).

- One Mental Health **Consumers/Users or Family associations** in Ghana: **Mind Freedom Ghana** (<http://www.mindfreedom.org/affspo/act/inter/mfghana>), 15 members, based in Accra.



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[Tables used for this country summary: 2.3: Employment by economic activity; 2.7: Poverty; 2.14: Health expenditures, services and use; 3.10: Urbanization]

Country WHO website: <http://www.who.int/countries/gha/en/>

Some official websites:

<http://www.moh-ghana.org/moh/default.asp>

<http://www.ghana.gov.gh/governing/ministries/social/health.php>

<http://www.ghanadistricts.com/home/> (if we go to region and then districts, there is a link to 'health sector')

<http://www.chagghana.org/>

2005 programme of work:

<http://www.ghanahealthservice.org/includes/upload/publications/2005%20Programme%20of%20work.pdf>

SWAP II:

<http://www.ghanahealthservice.org/includes/upload/publications/GHANAPLAN.pdf>

Organizational chart of Ghana Health Services:

http://www.ghanahealthservice.org/ghs_organogram.pdf