

Disability Stigma Reduction Interventions Study Report

October 2023



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Acronyms

BNGh	Basic Needs Ghana
CALID	Centre for Active Learning and Integrated Development
CHRAJ	Commission on Human Rights and Administrative Justice
CPRI	Centre for People's Empowerment and Rights Initiatives
CV	Community volunteer
DC	Disability champion
DMHCP	District Mental Health Care Plan
DSW	Department of Social Welfare
FGD	Focus group discussion
FOCEP	Foundation for Community Empowerment Programme
GFD	Ghana Federation of Disability Organisations
GLOWA	Global Action for Women Empowerment
GNAD	Ghana National Association of the Deaf
IA	Inclusion ambassador
IDI	In-depth interview
KAP	Knowledge, Attitude and Practices
KCL	Kings College London
MEHSOG	Mental Health Society of Ghana
MEL	Monitoring, evaluation and learning

MHA	Mental health authority
MMDAs	Metropolitan, municipal and district assemblies
NCCE	National Commission on Civic Education
NE	North east
OPDs	Organisation of People with Disabilities
SBC	Social behaviour change
SHG	Self-help group
ToC	Theory of change
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VOICE	Voice of People with Disability, Ghana (grantee)
WHO	World Health Organization
WODAO	Women with Disability, Development and Advocacy Organization

Definitions and terminology

Collaborating partners: this term is used in the report to identify the wide range of other 'external' partners, both governmental and non-governmental, who work in partnership with different elements of the programme.

Implementing partners: this term in the report is used to identify the five implementing consortium partners. These partners are detailed in Section 1.3.

'Leadership' of people with disabilities and mental health: used to describe those who have leadership roles within their SHG or OPDs, such as a chairperson, secretary and gender lead. They might also be given dedicated project roles such as inclusion ambassador or disability champion.

Mental health: 'A state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes. Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm' (World Health Organization, June 2022).

People with disabilities: the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) defines people with disabilities as those who have: "Long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." (UNCRPD 2006).

Self-help groups: this term is used to explain both the self-help groups established by Basic Needs Ghana (BNGh), and the different types of self-help groups established at community level, supported by organisations of people with disabilities (OPD) and grantees.

Stigma: a complex term, which can mean different things in different settings. It results from strong social disapproval; an 'attribute that is deeply discrediting' and marks out individuals 'less than' (Goffman, E. 1963; Pescosolido, B. A. et al. 2008). The different dimensions of stigma are explored in more detail in the [introduction](#) section.

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Executive summary

Ghana Somubi Dwumadie is a four-year disability programme with a specific focus on mental health. One of the output areas was reducing stigma and discrimination against people with disabilities, including people with mental health conditions, implemented primarily through its grants programme, which consisted of grants for social behaviour change (SBC) interventions and grants for advocacy interventions.

The study aimed to explore how Ghana Somubi Dwumadie interventions have been designed, delivered, and monitored, and to identify what went well and what could have been improved in the implementation of a programme to address disability and mental health stigma reduction.

Study methodology

A mixed methods design was adopted. This included a document review of programme reports and evaluations, in-depth interviews (IDIs), focus group discussions (FGDs), and a final participatory workshop at the end of the fieldwork, with key stakeholders to validate and probe further on findings.

There were two stages to sampling: a purposeful selection of Ghana Somubi Dwumadie sites, and then purposeful sampling within sites, to include geographical spread, a spread of implementing partners but with greater weight to SBC grantees, and stigma work that targets people with different types of disabilities and mental health conditions.

This study received ethical clearance from the University of Ghana's Committee for Humanities Ethics, and fieldwork was conducted from 17 to 27 June 2023.

In total, we conducted 26 IDIs and 14 FGDs. These included: 16 Ghana Somubi Dwumadie implementing staff and partners, 37 grantee staff, seven government collaborating partners, 12 OPD collaborating partners, 10 traditional and religious leaders, 62 SHG members, and 22 inclusion ambassadors/disability champions/community volunteers.

Summary of key findings

Objective 1a, participation design: to explore lessons learnt from adopting participatory approaches in the design of stigma reduction strategies and activities, with particular attention to the role of people with disabilities.

Objective 1b, participation delivery: to explore participatory approaches to the delivery of disability stigma reduction strategies and activities, with particular attention to the role of people with disabilities.

- The value of a participatory and user-led approach is core to the programme and permeates through the design and delivery phases and programme guidance notes. There are a variety of roles that people with disabilities, including people with mental health conditions, play at community level in addressing stigma in their role as disability champions, inclusion ambassadors, community volunteers, and/or leaders of SHGs.
- Where disability champions, inclusion ambassadors and community volunteers were well supported and drew on strong networks and relationships (social capital), they were able to utilise and mobilise these connections for their work on stigma. In contrast, when people with disabilities are selected, and there are issues related to their capacity, combined with limited support, they have struggled more to implement stigma reduction activities.
- The model of intervention approaches, which includes both people with disabilities and community members, appears to work well. The latter are able to utilise their positions of power, and access to resources, to implement activities. And where traditional leaders are involved in the selection, they can provide valuable additional support for implementation.
- As a result of their engagement, people with disabilities were empowered in various ways, which facilitated their engagement on stigma reduction activities. That said, internalised/felt stigma was identified as an issue that needed to be better addressed in supporting the work with people with disabilities.
- It was clear that adopting a participatory collaborative approach with a wider range of partners and community stakeholders was also key to success. This was more evident in some study sites than others, and attributed to a range of factors, including a history of engagement in the area of disability, with an existing strong relationship and shared values. This offered greater synergy in stigma reduction activities.
- The importance of being able to engage with ‘people of power’ to effect change in stigma was a consistent theme.

Objective 2, coherence: to investigate whether and how a diversity of intervention approaches can complement each other to improve implementation of stigma reduction interventions in Ghana.

- Within the SBC component, there was strong coherence in the approach. This was facilitated by having one SBC strategy, including alignment of indicators and outcomes. In a similar vein, whilst not specific to stigma, there was coherence within the work on the District Mental Health Care Plan, specifically in the development processes for the plans, supported by an overarching theory of change.
- There was no one single conceptual and articulated approach to understanding stigma, or of stigma reduction interventions, across the various elements of the programme. Overall, cohesion could have been improved between grantees and different Ghana Somubi Dwumadie workstreams. Greater engagement with the SBC strategy and learning from the formative research conducted on stigma could have benefited other programme elements.
- There was scope for greater shared learning and opportunities for synergy across different components of the stigma work. At an operational level, some of the excellent resources and training materials produced, for example, could have been more widely adopted and adapted as necessary.
- Learning meetings and exchanges were valued by participants but, in practice, it was less clear how this translated into take-up of stigma approaches and resources. The guidelines and learning briefs were seen as valuable, but the evidence also indicated they were not used to their maximum. Their use could be enhanced with a stronger, more cohesive approach to dissemination of resources and enhanced opportunities for learning.

Objective 3, acceptability: to understand the acceptability of different disability stigma reduction interventions in Ghana.

- Several approaches were seen to strengthen the acceptability and adoption of materials. This included a user-led approach, combined with wider participation of other key stakeholders. This also clearly fostered ownership and widespread use of the materials.
- The pre-testing of materials and quality assurance processes worked well with one grantee and resulted in various adaptations to suit the cultural context. However, there was an identified need to streamline this process to avoid delays.

- There were documented examples of adaptations for people with different types of disability, but this is an area where more work was needed. For example, more materials in braille or easy read versions.

Objective 4, early effect: to contribute to understanding of the early effects of direct or indirect stigma reduction interventions on attitudes, perceptions and stigmatising behaviours in Ghana.

- There was evidence of an early effect on knowledge and attitudinal change for individuals, families, and communities. A common change identified was more positive use of language, with examples of how this was an important stepping stone towards greater disability inclusion.
- Ghana National Association of the Deaf identified their research on mental health for deaf people as ‘groundbreaking’, although more was needed to disseminate findings.
- There was some early evidence of changes in experienced stigma, with positive examples of disability inclusive practice, such as greater participation of people with disabilities, including people with mental health conditions, in family and community activities. Overall, the findings show that a ‘toolbox’ of approaches has been useful in implementing stigma reduction, operating across layers of the eco-system. People with disabilities, including people with mental health conditions, most notably those in leadership, can be effective in directly engaging on stigma reduction, from identification and reporting to an educational role, through to reporting abuse.
- Community radio can be an important tool, especially in rural areas, for raising awareness.
- The programme has offered different mechanisms to engage with people of power and influence. The evidence indicates that these people, such as traditional leaders, are often likely to be respected and listened to, important for changing social norms, and additionally have relationships and resources that can be utilised and can open doors to other opportunities for stigma reduction. For example, appointing people with disability and mental health conditions onto decision-making boards.
- The use of enforcement to reduce stigma through the application of sanctions and laws was identified as another valuable approach.
- The SHG model appears to offer benefits of companionship and solidarity, which supports a sense of empowerment, most notably in addressing emotional needs and self-stigma.

Objective 5, gender and diversity: to explore how experiences differ across gender (especially for women) and disability types (including mental health) and other relevant intersectional experiences.

- Overall, the intersectional experiences of being a woman with a disability, living in poverty, and in a rural location, were all identified as impacting on experiences of stigma, for a variety of reasons.
- Women with disabilities and mental health conditions were seen as more vulnerable to abuse, sexual abuse and abandonment after having children. However, there were views expressed that increasingly fathers could be held to account for the care of children. This could be achieved, for example, through traditional leaders and champions/ambassadors engaging with families directly. At the same time, recognising that more needs to be done in this area.
- For the deaf population, the dearth of sign language interpreters, and the lack of progress in duty bearers in addressing this, was identified as the main obstacle to meaningful participation in some of the wider work to address stigma. This was given to explain their limited engagement in meetings with other disability groups, for example, at a Ghana Federation of Disability Organisations regional level. Deaf people struggle to communicate experiences of mental health, even within their own family, and isolation can exacerbate the impact of stigma.
- The participation of Mental Health Society of Ghana (MEHSOG) within Ghana Federation of Disability Organisations (GFD) was seen to be strengthened. However, at district level, there were still lower levels of engagement with those with mental health conditions amongst SHGs of people with various forms of disabilities. It was also more common for them to be represented by their carers. Stigma was closely linked with access to medication and control of symptoms for those with mental health conditions.
- Whilst children with disabilities were not a focus of this programme, in practice they were a priority for grantees and partners working at community level.
- The programme would have benefited from a gender analysis and application of a gender lens at the design stage. This would have further strengthened the understanding of how women and men experience stigma and engage in the stigma reduction processes.

Objective 6, monitoring: to explore how stigma can be understood and assessed to show changes in disability stigma through programme interventions.

- There was good alignment of the grantee indicators for stigma reduction with their results frameworks.
- Mixed methods approaches to monitoring and evaluating stigma reduction were used. Given that stigma is a social construct, use of the qualitative approaches were, for example, helpful for capturing the intersectional experiences of stigma.
- The survey questions were generally weighted towards understanding reported change to the stigma drivers, in alignment with the SBC strategy. There was mixed quality of grantee surveys to understand stigma reduction, and overall questions were poorly designed. A general weakness was that it was not always transparent how survey questions were developed, and/or if they had been piloted and tested. The exception was the Knowledge Attitude and Practices study that adopted some standardised tools.
- One of the main challenges identified was capacity issues in monitoring, evaluation and learning amongst grantees.

1. Introduction

1.1 Context

The World Health Organization (WHO) estimated that, in 2010, approximately 16 per cent of the global population lived with some form of disability. The prevalence of disability is higher among women, older people and those living in low- and middle-income countries (WHO, 2011), and about 80% of people with disabilities are estimated to live in low- and middle-income countries. In 2019, the WHO estimated that 1 in every 8 people (970 million) people around the world were living with mental disorders, and this figure was predicted to rise significantly because of the Covid-19 pandemic (WHO, 2022).

In Ghana, estimates for numbers of people with disabilities, including people with mental health conditions, vary. The 2021 Ghana Population and Housing Census reports that the prevalence of people with disabilities (excluding mental health conditions, which was not measured in the census) was 7.8% (Ghana Statistical Service, 2021). However, other reports, for example, the 2012 Human Rights Watch report, indicate that over 5 million people with disabilities live in Ghana (United States Department of States, 2017). Regarding people with mental health conditions, the WHO previously estimated that approximately 13% of Ghanaians have mental health conditions (WHO, 2021).

There is evidence that people with disabilities, including people with mental health conditions, consistently experience stigma. Stigma is a complex term and is used differently across settings. In academic literature, stigma is described as an “attribute that is deeply discrediting” (Goffman, 2009) and as a mark separating individuals from one another based on a socially conferred judgement that some persons or groups are tainted and “less than” (Pescosolido et al., 2008).

Globally, people with disabilities, including those with mental health conditions, experience stigmatising attitudes and discriminatory practices (Kuper and Heydt, 2019, WHO, 2021). Similarly, in Ghana, people with disabilities, including those with mental health conditions, continue to encounter barriers to participation and inclusion in socio-economic activities due to stigma and discriminatory practices that impact their lives (Baffoe, 2013; Mfoafo-M’Carthy, Grischow, Stocco, 2020; Naami, Mfoafo-M’Carthy, 2022), combined with inaccessible environment and institutional barriers (Naami, 2022).

Stigma faced by people with disabilities, including people with mental health conditions, is often deeply rooted in social and cultural norms and negative stereotyping, which perpetuate harmful behaviours and prevents the realisation of their rights such as access to healthcare services (Kuper and Heydt, 2019). Other contextual factors that can also shape stigma include the socio-economic environment and policy and legal frameworks (Ghana Somubi Dwumadie, 2021b).

The issue of mental health conditions and disability has come to the fore in most nations, including Ghana, and various efforts are being made globally to reduce disability-related stigma and to provide support to people with disabilities and those with mental health

conditions. A recent set of interventions in Ghana to address disability and mental health is the UK aid-funded programme, Ghana Somubi Dwumadie (Ghana Participation Programme).

1.2 Ghana Somubi Dwumadie

Ghana Somubi Dwumadie is a four-year disability programme with a specific focus on mental health. This programme is funded with UK aid from the UK government and run by a consortium led by Options UK, with partners including Basic Needs Ghana (BNGh), King's College London (KCL), Sightsavers and Tropical Health. The programme runs from 1 January 2020 to 31 March 2024, with consortium partners working across all regions with a variety of interventions. This programme focuses on four key output areas:





1. Promoting stronger **policies and systems** that respect the rights of people with disabilities, including people with mental health disabilities.
2. Scaling up high quality and accessible **mental health services**.
3. **Reducing stigma and discrimination** against people with disabilities, including mental health disabilities.
4. **Generating evidence** to inform policy and practice on the effectiveness of disability and mental health programmes and interventions.

Under output area three, the programme specifically seeks to reduce negative perceptions and discriminatory attitudes and behaviours against people with disabilities, including people with mental health conditions, primarily through its grants programme, which consisted of grants for SBC interventions and grants for advocacy interventions.

1.3 Ghana Somubi Dwumadie interventions to reduce stigma

There are four workstreams in Ghana Somubi Dwumadie, which have been identified with direct or indirect objectives relating to stigma reduction¹. Stigma reduction is integrated into each of them in a different way, which is depicted in Figure 1 and summarised below.

Figure 1. Collaborators and workstreams

Stigma reduction study (lead by Tropical Health)				
Programme studied	Ghana Somubi Dwumadie (lead by Options)			
Workstream leads / Study collaborators	Sightsavers	Options	Basic Needs Ghana	Kings College London
	Leading on 	Leading on 	Leading on 	Leading on 
Programme workstreams / Studied interventions	Social behaviour change	Policy, advocacy and communications	Self-help groups	District mental health care plans
Other programme stakeholders / Study population	Programme implementers: <ul style="list-style-type: none"> • Ghana Somubi Dwumadie staff • Grantees in receipt of SBC and advocacy grants 	Programme participants: Those targeted to benefit from SBC related interventions e.g. disability self help groups and other experiencing direct benefits	Wider programme SBC stakeholders and informants: <ul style="list-style-type: none"> • Ghanaian government authority partners • Media partners 	

¹ The programme is much broader with several components, but these areas were identified for this study (see **Ghana Somubi Dwumadie**)

The programme has adopted an inclusive SBC process to understand and influence disability stigma and discrimination (Ghana Somubi Dwumadie, 2021a). In 2020, a **formative behavioural research study** (2021b) on stigma in Ghana was conducted as part of the programme to provide a contextual understanding of the prevailing drivers and manifestations of stigma related to disability, including mental health conditions.

Findings described the widespread lived experience of stigma and discrimination, including neglect, abandonment, abuse, mockery and discrimination in marriage, relationships and daily life.

The major drivers of stigma and discrimination identified in this study included the use of negative language, limited understanding of mental health, religion, cultural factors, issues of family support, and poor implementation and enforcement of existing laws and policies on disability and mental health.

Based on the findings, the programme developed an **SBC strategy** to reduce such discrimination and stigma with three key objectives focusing on:

Creating a positive culture of support.

Increasing the use of positive disability and mental health language.

Ensuring duty bearers enforce and abide by Ghana's policies and laws.

This strategy is being delivered through a funding mechanism to local grantees throughout Ghana which focus primarily on SBC. Another set of grants focusing on advocacy for disability awareness and inclusion have been running in parallel. Although the advocacy grants do not focus explicitly on stigma reduction, in practice it is still core to their work. Table 1 (below) presents an overview of the nine grants awarded (five one-year grants, referred to as the 'small grants', and four grants of up to three and a half years, called the 'large grants').

Table 1. Summary table of grantees

Grant type	Grantee	Project name
SBC small grants	ABAK Foundation	Advocacy and Behavioural Change for Disability Rights and Inclusion
	Centre for Active Learning and Integrated Development (CALID)	Anti-Stigma and Discrimination Against Blind people
	Centre for People's Empowerment and Rights Initiatives (CPRI)	Challenging stigma and negative language; restoring the dignity of women, men and young people with mental health disabilities
SBC large grants	Hope for Future Generations (lead organisation) with The PsyKForum	The Social Behaviour Change Communication and Stigma Reduction for Mental Health and Disability Inclusion Project
	Voice of People with Disability, Ghana (VOICE)	#We-Matter Project
Advocacy small grants	Foundation for Community Empowerment Programme (FOCEP)	Promoting Disability Inclusive Development
	Global Action for Women Empowerment (GLOWA)	STOP Discriminating Against Persons with Disabilities and Mental Health Disabilities
Advocacy large grants	Ghana National Association of the Deaf (GNAD)	Empowered Deaf People for Improved Mental Health
	Songtaba	Promoting Women Mental Health Rights in Ghana

Policy advocacy and communication work is contributing to the reduction in stigma. This includes the development of policy briefs and the work of some grantees to influence policy and decision-makers at regional levels and at district assemblies. Some programme communications materials have directly targeted stigmatising stereotypes, prejudice and discrimination in their messages and materials at key moments events.

Support for **mental health SHGs**, which aim to support members to stay well and advocate to meet their members' needs in livelihoods, income, and health. Activities have directly and indirectly been impacting on stigma reduction through SHGs themselves, and through the training of SHG leaders (e.g. chairperson, secretary) on topics such as speaking and advocating for their needs, addressing local district governance and rights-based advocacy.

Finally, a fourth key element of the programme is **support for District Mental Health Care Plans (DMHCPs) to become more inclusive of mental health** at district level. The main objective of this work is the detection and treatment of mental health conditions in demonstration sites (Bongo, Asunafo-North and Anloga). Workplans for each district include stigma-related interventions and there is mental health gap training for health care workers who identify and treat mental health conditions.

2. Literature review

Stigma, which is described as a mark separating individuals from one another based on a socially conferred judgement that some persons or groups are tainted and “less than” (Pescosolido et al., 2008), has diverse effects at various systemic levels, including individuals, families, community, government and policy-making levels (Mfoafo-M’Carthy and Sottie, 2016).

Some studies indicate that stigma leaves those who experience it with a sense of hopelessness and helplessness and cause them to feel reluctant to seek help from various services available to them (Barke, Nyarko, and Klecha, 2011; Mfoafo-M’Carthy and Sottie, 2016). It also results in people with disabilities, including people with mental health conditions, to internalise stigma (Ghana Somubi Dwumadie, 2021b).

Meanwhile, people with disabilities and those with mental health conditions reported feeling stigmatised by their own family members as they are often left at home instead of being assisted to navigate support, including economic and educational opportunities (Opoku, Alupo, Gyamfi, Odame, Mprah, Torgbenu, and Eric, 2018; Tijm et al., 2011). These feelings of stigma contribute to the challenges faced by people with disabilities, including those with mental health conditions, in times of crisis.

Thus, ensuring that society’s perception of people with disabilities, including people with mental health conditions, and its practices that marginalise and discriminate against them (Baffoe, 2013), is transformed requires intensive interventions, such as the disability stigma reduction interventions that have been developed and implemented by Ghana Somubi Dwumadie.

However, which aspects of these disability stigma reduction intervention are working well, and which should be strengthened? How acceptable have these been, and what are the early effects? This study seeks to find answers to these and other questions.

3. Study design and methodology

This study was designed by Sightsavers and Tropical Health, in collaboration with Ghana Somubi Dwumadie consortium partners and stakeholders in Ghana. The study fills an identified research gap, both within Ghana and also the global disability sector, on what works and what is acceptable for people with disabilities and other stakeholders in the design, delivery and monitoring of interventions that aim to reduce disability and mental health stigma.

An appreciative enquiry lens was adopted (Howard ,2013). This means that more emphasis is placed on what is working well and why, with a focus on the positives and facilitating factors. The research began implementation in early April 2023 and fieldwork was conducted from 17 to 27 June 2023.

Stigma framework used within the study

Social stigma: prejudice and negative attitudes held by members of the public/society

Internalised stigma: the internalisation of prejudice (also felt or self-stigma)

Anticipated stigma: the expectation of bias from others

Perceived stigma: perceptions of how the stigmatised group is treated by others

Experienced stigma: experiences of being stigmatised by others

3.1 Theoretical frameworks

There are various models of stigma, and it is beyond the scope of this study to detail the various frameworks. For the purposes of this study, we adopted the stigma framework outlined in the formative behavioural research report (Ghana Somubi Dwumadie 2021) and described by Clay et al (2020). This framework (see below) builds on the work of Stangl et al (2019) and Corrigan and Bink (2005). This informed our design, choice of key informants, the development of the topic guides, and thematic analysis. We note that interviewees and reports generally refer to 'self-stigma' and therefore we adopt both internalised and self-stigma through the report.

In addition, we also drew upon the socio-ecological model of human development (Bronfenbrenner, 1994b) to inform our design and a framework for analysis. This reflects the understanding that a person with a disability is embedded in, and interacts with, different layers of a social system.

In our study, we sought to focus on changes experienced by the individual, and within the family and community environment to effect stigma reduction. Whilst there was recognition of the value of national level advocacy work and addressing more structural issues at that level, this was not a focus for this piece of research.

3.2 Study aims and objectives

The study aimed to explore how Ghana Somubi Dwumadie interventions have been designed, delivered, and monitored, and to identify what went well and what could have been improved in relation to disability and mental health stigma reduction. The study also provides recommendations about ‘what works’ in the Ghanaian context and what can be replicated. The study objectives are:

Objective 1a, participation design: to explore lessons learnt from adopting participatory approaches in the design of stigma reduction strategies and activities, with particular attention to the role of people with disabilities.

Objective 1b, participation delivery: to explore participatory approaches to the delivery of disability stigma reduction strategies and activities, with particular attention to the role of people with disabilities.

Objective 2, coherence: to investigate whether and how a diversity of intervention approaches can complement each other to improve implementation of stigma reduction interventions in Ghana.

Objective 3, acceptability: to understand the acceptability of different disability stigma reduction interventions in Ghana.

Objective 4, early effect: to contribute to understanding of the early effects of direct or indirect stigma reduction interventions on attitudes, perceptions and stigmatising behaviours in Ghana.

Objective 5, gender and diversity: to explore how experiences differ across gender (especially for women) and disability types (including mental health) and other relevant intersectional experiences.

Objective 6, monitoring: to explore how stigma can be understood and assessed to show changes in disability stigma through programme interventions.

Research questions were developed under each of these research objectives to guide the interview guides.

3.3 Study methodology

A mixed methods design was adopted, with an emphasis on the collection of qualitative data. This included secondary and primary data collection as detailed below.

3.3.1 Data collection methods

There were four approaches adopted, as outlined below.

1. **A document review** was conducted. This gathered descriptive information of each intervention studied and situated them in the study design objectives. This informed both the refinement of the research tools for primary data collection and provided qualitative and some very limited quantitative evidence, to complement the primary data collection. For Research Objective 6, the results frameworks, and data collection tools for assessing stigma, were reviewed.
2. **In-depth Interviews (IDIs)** were conducted with a variety of stakeholders at national and district level. Each IDI took up to 60 minutes and were tailored to each target group after the document review. Where possible, IDIs were conducted face to face. The list of topic guides is summarised in Table 2.
3. **Focus group discussions (FGDs)** were conducted, of 6-10 participants, and lasted between 60-90 minutes. They were conducted in the community, where SHG and community stakeholders normally convened for meetings, so that the setting was familiar and local to them, such as in the Community Disability Centre. We aimed to use some participatory tools in the FGDs, such as a mapping exercises, but in practice we found the community setting often not suitable, with no electricity and limited space. We therefore ran FGDs in a more traditional format. The three topic guides for the FGDs targeted different stakeholders, as listed in Table 2. At the start of the fieldwork, we also conducted a participatory meeting with Ghana Somubi Dwumadie staff to both inform staff of the proposed research process and map out key players and main relationships in the stigma reduction work. This meeting also helped the research team to finalise fieldwork plans and further tailor the topic guides.

Table 2. Topic guides

Topic Guide	Target group
IDI topic guide 1	Government partner staff and other collaborating partners, including media and Mental Health Alliance
IDI topic guide 2	Ghana Somubi Dwumadie core operational staff and consortium implementing staff
IDI topic guide 3	Grantee staff
FGD topic guide 1	SHG members, including group leaders, and caregivers

Topic Guide	Target group
FGD topic guide 2	Organisation of people with disabilities (OPD) staff and leaders including inclusion ambassadors (IAs), disability champions (DCs), and community volunteers (CVs).
FGD topic guide 3	Traditional authority and faith-based leaders, and IAs

4. **A participatory dissemination workshop** was organised to present and review emerging research results after the fieldwork. 23 participants attended this workshop from grantees to implementing and collaborating partners. This forum provided an opportunity to validate and probe further on some of the findings.

3.3.2 Study sample

There were two stages to sampling. A purposive sample (Green, 2009) of Ghana Somubi Dwumadie sites, and then purposive sampling within sites. The following criteria were used at both stages:

- Geographical spread
- Greater weight to ongoing work and so the focus was on the large grantees
- Greater weight to programme areas with a 'direct' stigma intervention. 'Direct' stigma was classified as programme intervention work where there were explicit stigma reduction outcomes, or at least one indicator which aimed to assess stigma/stigma reduction, and/or where stigma reduction activities were documented
- Balance of work with people with different types of disabilities including those with mental health conditions
- Logistical and safety constraints
- At least one geographical area where there is overlap with other studied programme workstreams to explore possible areas of cohesion
- Other information, including capacity of organisations to participate in the research
- A balance of male and female participants

Overall, when selecting SHG final groups to visit, there was an emphasis on selecting sites where the work was identified by operational staff as 'working well'. This lent itself to the adopted appreciative enquiry lens.

Study reach

- 16** Ghana Somubi Dwumadie Implementing staff and partners
- 37** Grantee staff
- 7** Government collaborating partners
- 12** OPD collaborating partners
- 10** Traditional and religious leaders
- 62** SHG members
- 18** IAs and DCs
- 4** CVs

In summary, we undertook data collection across five regions²: Northern, North East (NE), Volta and Savannah Region, and Greater Accra. We interviewed all four large grantees, although weight was given to the two SBC grantees, as this is where the most direct stigma work was focussed. Interviews were also conducted with relevant staff and participants from the other two workstreams – SHG support and the DMHCPs. Key collaborating partners, both governmental and non-governmental, and local traditional and religious leaders, were also included. In total, 26 IDIs and 14 FGDs were conducted.

3.3.3 An inclusive approach

The research was conducted with the involvement of key disability and mental health stakeholders at different stages of the process. Key to this approach was working in close collaboration with the Ghana Federation of Disability Organisations (GFD), the umbrella organisation of OPDs in Ghana. The GFD is a member of the steering committee for this study, and therefore played a key role throughout the research process. The GFD also assisted the research team in mobilising membership for FGDs and facilitating a participatory dissemination workshop.

The research team itself was inclusive of people with disabilities. All interviews were conducted in participants' preferred language to allow them to freely express themselves. Local language and sign language interpreters were employed to support the study, as needed. In addition, for any telephone interviews, a simple interview guide was sent in advance. The FGDs were held in physically accessible and comfortable spaces to accommodate individuals who use wheelchairs or with other mobility needs.

3.3.4 Data collection and management

In the data collection process, there were two teams that covered different regions. Key notes were taken in all interviews. In addition, recordings were made and used to check or clarify issues, if required. All data were stored on computers, which were password protected. Data was anonymised before analysis and when reporting the results of this study. No identifying information is reported in the findings.

3.3.5 Data analysis

A thematic analysis was conducted of the qualitative data (Pope et al., 2000). A pre-existing coding frame was developed, based on the scope of inquiry, and the two lead researchers based their review of the secondary data on this. In order to minimise bias, the two research teams discussed emerging themes at the end of each day, and also during a one-day de-briefing held in Accra. Preliminary findings were shared during a participatory workshop with a range of key stakeholders, and based on feedback, further nuances were

² Three study regions were originally selected: Northern, North East and Volta region. In addition, during fieldwork, disability champions from the Savannah Region were included, as they were attending a meeting in the Northern site of Tamale.

made to key themes and sub-themes. The lead researchers then independently conducted their own, more comprehensive analysis of the data from each of their visited sites and were in regular contact to compare findings across sites. A combination of Microsoft Word and NVivo software was used to manage the analysis of data.

3.3.6 Ethical considerations

This study received ethical clearance from the University of Ghana's Ethics Committee for Humanities Ethics (ECH 162 / 22-23) and adhered to all ethical standards governing research with human subjects to protect the dignity, rights and welfare of all the research participants. Participants were told that participation in the study was voluntary and that they could opt out at any time. If they agreed to participate, they were informed that they were free to stop the interview at any time, with no penalty or consequences. Informed consent to participate in and to record interviews was obtained from all participants.



Adaklu sopa SHG

4. Research findings

This was a large and complex programme of work, understudied as detailed previously; five consortium partners delivering four different workstreams (see **Figure 1 above**). The following sections look at the research findings under each of the research objectives. We first present the findings from the primary data collection and then triangulate with data from a review of the programme literature.

4.1 Participation in design and delivery

Objective 1a, participation design: to explore lessons learnt from adopting participatory approaches in the design of stigma reduction strategies and activities, with particular attention to the role of people with disabilities.

Objective 1b, participation delivery: to explore participatory approaches to the delivery of disability stigma reduction strategies and activities, with particular attention to the role of people with disabilities.

Participation: “Participatory approaches enable people to play an active and influential part in decisions which affect their lives. It is assumed within participatory approaches that individuals have capacity to exercise autonomy and set their own goals.” (User-led approaches, Ghana Somubi Dwumadie guidance, 2022).

This overlaps with ‘user-led approaches’, which is defined within the programme as: “An approach when it is guided by the needs and priorities of the people using that service. This includes meaningful consultation, engagement and improved systems for feedback and grievances in both civil society organisations and state-run services.”

“User-led approaches are achieved through involving different types of participation. This process takes time, and needs collaboration between service providers and service users, as both gain experience and confidence. It requires a balance between partnership, delegated power and some level of citizen control or ownership over the design and delivery of services.” (User-led approaches, Ghana Somubi Dwumadie guidance, 2022)

4.1.1 Overview of participatory approaches

In practice, during FGDs and IDIs, both aspects of design and delivery of the programme are often closely intertwined in the narratives and part of a continuous process. Where they can be more clearly delineated, we have done so. Before examining the role and experience of people with disabilities and mental health conditions, we briefly summarise the different approaches adopted by the programme for engaging with people with disabilities and mental health conditions, and with particular attention to their ‘leadership’. By leadership, we mean those who have key roles within SHGs and OPDs, such as a

chairperson, secretary, and treasurer, and/or members selected to specific project roles, such as IAs and champions.

Within the SBC grants mechanism, the participation of people with disabilities was core to that approach, embracing 'nothing about us without us'. Steps taken in the development of the SBC strategy and follow-up were participatory and cohesive and included:

1. A formative behavioural study was conducted, which was participatory in approach, listening to men and women with disabilities and mental health conditions, as well as engaging with community leaders, health workers, the media and people working in local government.
2. A co-creation participatory workshop to develop the SBC strategy with grantees, which included representation of mainly leadership of people with disabilities, including mental health conditions from OPDs and SHGs.
3. A second co-creation workshop was conducted to operationalise the strategy. This also allowed an exploration of how to make materials and approaches accessible and relevant to their context.

The large SBC grantees adopted slightly different models in their implementation of the SBC strategy, but engagement of people with disabilities, including people with mental health conditions, was a key conduit for delivery of stigma reduction work.

- HFFG trained 38 DCs. All DCs are people with disabilities and were selected in consultation with the regional GFD membership and state institutions, such as the Department for Social Welfare (DSW). These DCs are selected from OPDs and SHGs membership and continue to closely engagement with the groups they represent.
- VOICE promoted 44 IAs. These are a mix of 17 people with disabilities and mental health conditions, and 27 members of the community without disabilities or mental health conditions. Community chiefs made the selection, and the identified advantage of this process was that the chiefs continued to support and endorse their activities, which also enhanced community acceptance of the stigma reduction work. Community members were generally influential people in the community who could leverage their connections and power to support the SBC interventions, such as teachers assembly and committee members, religious and opinion leaders.

There are some parallels here with the approach adopted by BNGh, which uses community volunteers (CVs) as mental health advocates. These CVs are invited by the SHGs to work with them and/or are nominated by community leaders. They can be people with mental health conditions, caregivers, and other members of the community. They are generally people who are already in paid employment and take on this role in a voluntary capacity. From their data³, ten (13%) of the 75 CVs are people with mental health conditions. Their

³ Data provided on all 75 current CVs. From this 28 SHGs and CVs are supported through the programme.

role is to work closely with the leadership of the SHGs; that is the chairperson and secretary/deputy secretary and treasurer of the SHGs.

Within the advocacy workstream, engagement with OPD leadership is also important in the design processes. For example, GNAD targeted work through the leadership of their regional structures. Songtaba supported the establishment of a very loose leadership structure within the ‘alleged witches’ camps, although in practice the role of the leaders appeared minimal.

In the wider project literature on the small grantees, there was similarity in using champions and advocates for stigma reduction delivery; DCs (ABAK), or Community Watch Advocates (GLOWA). These were mainly people with disabilities.

4.1.2 Participation in design

The participation of the leadership of OPDs, including SHGs, was a core thread to the design of the stigma reduction work, most evident within the SBC workstream. People with disabilities, again mostly in leadership roles, took part in the trainings and brainstorming of the development of the posters, jingles, and the Positive Language Guides to ensure that their voices count in decisions that affect their lives. In the VOICE work, there was also engagement in the pre-testing stages of the SBC materials in six communities. Both DCs and IAs interviewed for this study reflected on their positive experience of engaging in the development of the language guide, and importantly how they made use of the guide. For example, in the Savannah Region, they were proud to show the final product and looked for their photos within the guide:

“I was so excited. I was so happy [to be involved in the development of the language guide] and I then walked into the radio station to talk about this work.” DC, Savannah Region.

A female champion explained how she then further adapted the guide to another local language specific to her district (‘Lobi’ in the Savannah Region) for the radio.

In the review of secondary data, the Positive Language Guides were also an example of strong participatory engagement of the leadership of people with disabilities and mental health conditions in the design and development process. A key lesson detailed from the VOICE language guide development workshop was of the importance of involving people with disabilities alongside other stakeholders. People with disabilities were then able to directly challenge local language ‘experts’ on what was acceptable (see [Acceptability](#) section).

“Some of the language experts we involved in the exercise strongly argued that existing derogatory/negative disability languages/terminologies should be maintained as they emerged from some historical facts, meanings, understanding and traditions of local people. But these assertions were debunked by persons with disabilities whom we involved in the various positive disability language guide workshops.” VOICE grantee, Ghana Somubi Dwumadie grant-making report.

In the other workstreams, whilst the leadership of people with disabilities was often part of the delivery, there was mixed evidence of their meaningful participation in the design stage of stigma work.

GNAD leadership reflected positively on their ability to contribute to planning for their research on mental health and opportunities to validate findings through a series of regional workshops, as well as engagement in advocacy planning. In the case of Songtaba, it was not clear from the FGD conducted with ‘alleged witches’ that they had been meaningfully engaged in any processes. Issues of poverty and their low levels of capacity to engage (such as lack of mobile phone), with low levels of education, were barriers to their participation. The document review indicated a roundtable discussion with senior stakeholders and ‘alleged witches’, although limited representation.

In terms of the development of the development of DMHCPs, KCL sought to improve participatory approaches for partner organisations. These were developed in collaboration with a sub-committee, including the Ghana Health Service, the District Mental Health Officers, Social Welfare, Commission on Human Rights and Administrative Justice (CHRAJ) and other relevant government agencies, as well as people with mental health conditions. Whilst there was representation of people with mental health conditions, in practice, it was considered minimal, partly due to the pre-determined nature of the sub-committee.

4.1.3 Participation in delivery

In terms of delivery of the stigma reduction work, the participation of people with disabilities was generally substantial, with some variation across workstreams. The role of the champion or ambassador was critical for this work, and they spoke positively about their roles:

- DCs and IAs are embedded in their community, and they can more easily see when and where stigma occurs. DCs talked about being able to ‘see what is happening’ and being a ‘focal point’ in the community for any disability issues, including stigma. SHG members also confirmed this view and saw them as a ‘mouthpiece’ for them. This was particularly noted when the champion or advocate was a person with a disability and a member of their SHG or OPD. In contrast, in the VOICE mid-term evaluation, a recommendation was that their ambassadors could do more to work more closely with the SHGs.

- They play various roles to address stigma; an educational role, challenging on issues of language in the community, awareness-raising in various venues, and influencing attitudes, for example, by directly visiting families. They gave examples of working in a variety of settings: marketplace, with health staff, churches, mosques, and on the radio. This also included a role in enforcement, that is reporting on issues of abuse, which is further explored in section **Error! Bookmark not defined.**
- One of the most common stigma reduction activities discussed in both sites visited was engagement in interactive radio discussions using the Positive Language Guide to share their lived experiences. For example, one of the grantees had a radio programme called Dignity Hour with people with disabilities as resource persons. This also contributed to the reduction of stigma.
- They all engaged in interface meetings with different stakeholders at community and district levels. This ranged from 'formal' meetings through to more informal networking. For example, meeting with traditional leaders as they are powerful. A key change was that, as a result of the project, organisations were now approaching them to talk to them, so their network of contacts was increasing, and they felt more visible.



Adaklu Sopa SHG leader

Referring back to the main differences between the VOICE and HFFG model, for the former, a substantial proportion of the delivery was through IAs and other collaborating partners rather than people with disabilities themselves. The fact that the IAs were selected by the traditional authorities meant they were given greater support in the community in their role, and this was seen to make a difference in terms of their ability to implement their stigma reduction activities.

For the model of DCs, there was a more mixed experience when working with people with disabilities and mental health. For example, in the Savannah region, one DC had employment as a teacher, had been the secretary of GFD for 14 years, was on the District Assembly Common Fund Committee, and had access to his own motorbike. He was active in his role, with a wide range of contacts that he leveraged for additional support. In contrast, at the second site, a female DC was struggling to live off her DC stipend (200 cedis per month) and was begging, whilst supporting her two children. She had no access to transport, which she explained also made mobilisation problematic. That said, she was clearly committed to her role, but this example illustrated that some DCs needed additional support to be effective in delivery. They also consistently requested more training in topics such as rights and livelihoods.

The model of BNGh similarly invested in SHG leadership and CVs in delivery of their stigma work 'they mainly carry the voice of the members'. The SHG leadership and CVs were invited to trainings and had interface meetings with governmental organisations.

One CV explained that his role was visiting the members in their homes to check on their condition, to provide education on medicines, and support and follow up on referrals. The SHG members similarly identified leaders as the focal point person in the community on mental health issues and key to changes in stigma: "It is through the leaders that the change [to stigma] is happening."

This was also confirmed with the District Social Welfare Officer who met SHG leaders regularly each month. Their role was broader than stigma, and key to linking the SHGs to other opportunities, most notably livelihoods. Whilst there was no explicit formal link with the traditional leaders, it was clear in the site visit that there were strong relationships with traditional leaders. The strength of the stigma work was attributed by staff to 'good leadership', 'being well organised' and 'well connected' in the community, including with GFD. The linkages with the latter were strengthened after capacity-building with BNGh supported through the programme.

Interestingly, a senior GNAD member also identified the need for 'community catalysts' to engage on stigma and advocacy work. These were described as people who have power and are also willing to engage on the issues. Songtaba staff reflected on their experience that the 'alleged witches' were not always listened to by the authorities, and then support had to be given by their staff to engage with key stakeholders.

One of the main challenges identified for engaging with leadership of people with disabilities and mental health conditions was issues of self-stigma. This was highlighted by Ghana Somubi Dwumadie staff and grantees:

“Self-stigma was high throughout the implementation of the project; we had to constantly talk to the DCs to give them confidence in themselves. [What do you mean by self-stigma?]. That you yourself are looking at your condition – I have self -pity, I don’t belong, I make myself less of a person with my thoughts – whereas if you respect yourself, you have a voice.” IDI, grantee, NE region.

The secondary data also highlighted self-stigma as a challenge. For example, it was considered the main reason for limited SHG member engagement by the grantee ABAK Foundation. The small grants final evaluation questionnaire indicated that 59% of people with disabilities and mental health who responded ‘felt ashamed’ by their condition.



Bohira nye Bangda self help group

4.1.4 Role of GFD and other OPD networks

Another area where the leadership of people with disabilities contributed to both design and delivery was through the role of GFD. This was direct engagement in design planning workshops, and also in their support to other OPDs and OPD networks, such as Mental Health Society of Ghana (MEHSOG) and GNAD.

In the Volta Region, GFD members interviewed reflected on the positive empowering experience and benefits of being involved in both the design and delivery. These quotes illustrate the particular popularity of the language guides:

“We ourselves coming together to deliberate on derogatory names and developing a Positive Language Guide has given us some awareness about how these names were really affecting us negatively, affecting our dignity and the need to advocate for our rights.” Partner organisation FGD, Volta Region

“We went round on different radio stations and having discussions on derogatory names and acceptable alternatives provided by the project [in the Positive Language Guide] on radio. Whenever we went on the radio discussions and there were phone ins, anyone that used a derogatory name was corrected. We shared our experiences about how those names affect us.” Partner organisation FGD, Volta Region.

Where the local GFD structure was strong and well organised at regional level, the work of the DCs was better supported, in comparison to another site, for example, where the GFD structure was still relatively new and/or organisational capacity issues were identified. This was because GFD had a role in selecting the DCs and ongoing support.

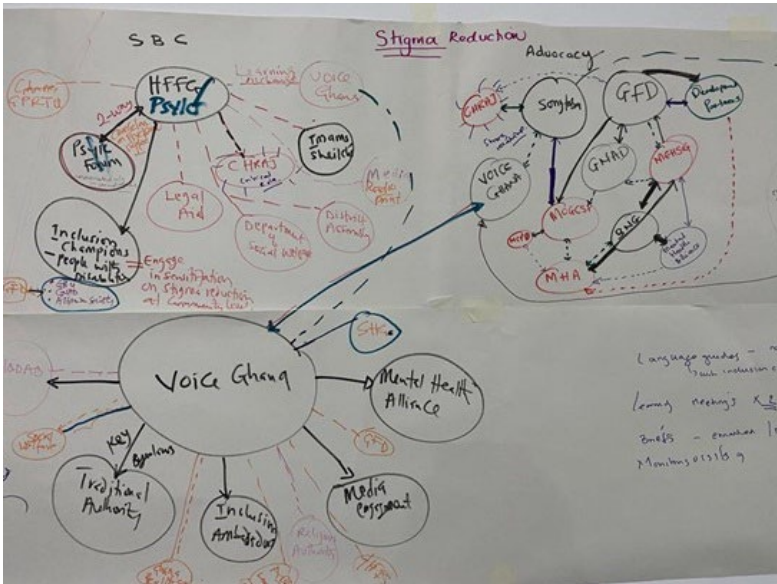
MEHSOG was also involved in both the design and implementation of the SBC interventions and played an important role in building the capacity of people with mental health conditions through training workshops for the SHGs. There was some awareness of, and use of the SBC anti-stigma posters, although limited evidence of this during the field visit.

“Issues of stigma are critical to us, as it is so pervasive in the human life of persons with mental disorders. Service users were brought in, I think 2–3-day consultation meetings where we engaged with Ghana Somubi Dwumadie. We contributed in making sure that our understanding of what stigma is was comprehensive enough that it resonated with how Ghana Somubi Dwumadie also understood stigma to be. We were engaged from the very beginning.” National IDI, partner organisation MEHSOG.

4.1.5 Participation of other partners and stakeholders

Adopting participatory approaches with other partners and community stakeholders was also common in the design and delivery of stigma reduction activities and was seen as key to success. It was evident that the programme provided a platform for the leadership of people with disabilities and mental health conditions to engage with key players.

These were individuals or organisations who typically had power at various levels; traditional leaders, religious leaders, the media and various local government organisations and platforms; most notably the DSW, CHRAJ, the National Commission on Civic Education (NCCE), and the Mental Health Authority (MHA). These relationships were mapped out in the workshop with staff, as illustrated below.



Mapping of the different key organisations engaged.

One commonly used approach was ‘interface meetings’ between the leaders and government organisations. It appears that, as the project progressed, relationships were strengthened, and the leaders felt able to reach out to these organisations, and that this was reciprocated. They have ‘got to know them’ and ‘through this togetherness’, and ‘more senior people’ attending meetings, they have been able to access additional support. The importance of building relationships with people and organisations of power was a consistent theme:

‘What we gave the [disability] champions was a structure to engage with the key players.’ IDI, HFFG grantee staff.

There was recognition of the value of collective working, especially given that some of the issues of stigma experienced can be substantial. For example, one DC talked about his role to address the appalling conditions of prayer camps, where people with mental health conditions can still be sent in some regions of Ghana. He explained that in one camp in the Sawla Tuna Kalba District, they still chain the people up outside and beat them.

“It is constant education needed. We sat with the pastor, and we met with the [District] assembly man – you have to bring a lot of people on board. It is to do with being human beings. You want to say something which is correct, but there are blockades. You have to fall on an opinion leader, and on people of authority, to have a chance to have an effect. One person as a [disability] champion is not enough.” IDI, DCs, Savannah Region.

A consistent theme was that leaders are respected in the community, so people will listen to them if you have them on your side.

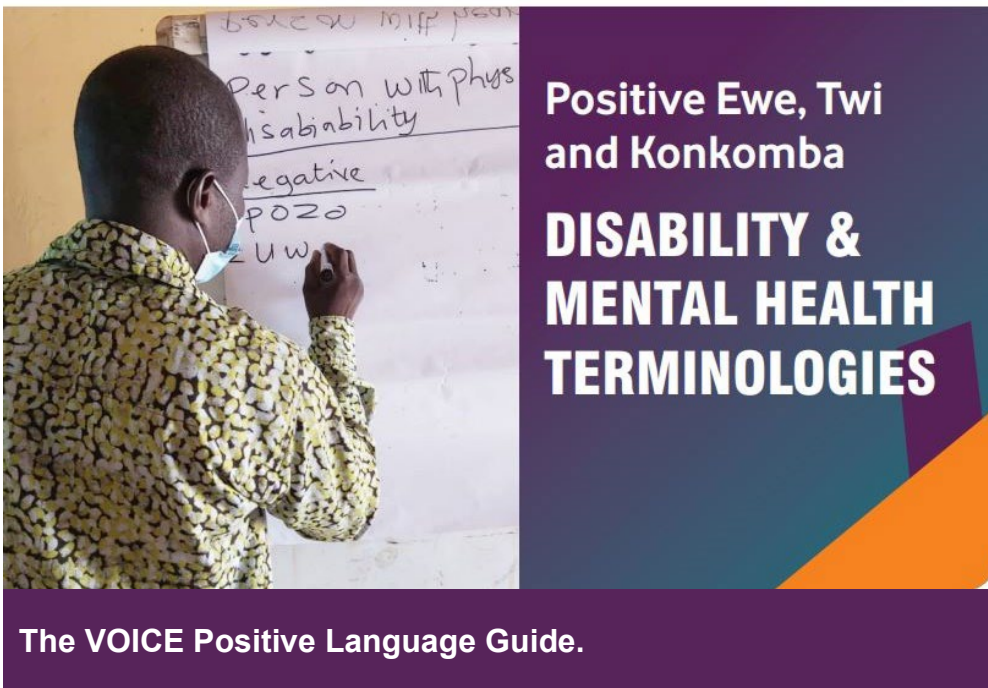
“I will go around on my bicycle from place to place – markets, church, youth groups. I will meet traditional leaders as they are powerful.” IDI, DC, Savannah Region.

The engagement and participation of a wide range of stakeholders was particularly strong in the Volta Region, in the design and delivery. These included IAs, traditional leaders, religious leaders, caregivers, non-governmental organisations, and government implementing agencies, such as the DSW and the NCCE.

For example, there was robust engagement in training, brainstorming, and the development and pre-testing of SBC materials (posters, jingles, Positive Language Guide). It is noted that some of the stakeholders’ voices were used for the radio jingles. The government agencies saw this contribution as complementary to their own work to promote the wellbeing of people with disabilities and used the stigma materials to implement stigma reduction work. This was a particularly strong feature in the urban settings. For example, the DSW explained the value of their engagement and use of the materials:

“We as a department has worked with them [VOICE] for a very long time. And we know they play a major role in the disability sector, supporting and complementing what the government does and they have been in the disability sector over the years. And with the introduction of the SBC, when they started, they also called us to inform us about what they were doing and if we had any input to make.

“As for stigma, it has been a very long age challenge that we, who work at the DSW, know the level of stigma persons with disabilities encounter. So, we appreciated it when they wanted to work in that direction. I used it [referring to the Positive Language Guide] to sensitise other officers and they are also using it. So, my officers are doing well unless they are new recruits. So, when we recently had an orientation for recruited and newly posted officers, we made sure we included some of it [referring to the Positive Language Guide] in the training as well as an introduction to their orientation to the department.” IDI, partner organisation DSW, Volta Region.



Positive Ewe, Twi and Konkomba
DISABILITY & MENTAL HEALTH TERMINOLOGIES

The VOICE Positive Language Guide.

Similarly, the 14-member Volta Mental Health Alliance, both individually and collectively, engaged the public on stigma in diverse ways, highlighted here by one member organisation:

“After the partnership with Mental Health Alliance, I now devote time to educate the public about persons with disabilities whenever there is an opportunity, using the Positive Language Guide at public forums and the jingles at the Community Information Centres.” DSW representative, NCCE.

In the Volta rural areas, there was greater emphasis on delivery of SBC interventions by the IAs and the traditional authorities; the traditional authorities were seen to have a particularly prominent role which was key to success. This role was persuasion via the enforcement of anti-discriminatory measures such as censures and leveraging support for the work of the IAs (that they had selected). In the Savannah/NE sites, there was greater emphasis given to participation with CHRAJ. In fact, a full day of research was hosted by CHRAJ at the Nalerigu site. This relationship with CHRAJ was seen as critical for reporting abuses, as further detailed in early effects.

“I now feel closer to the powers. Previously, I saw CHRAJ as a place not to get closer to, but it has brought us to those who are powerful”. IDI, DC, Savannah Region.

In contrast to the above positive relationships, and despite the important role of the Social Welfare Office was also seen to play, one consistent theme across different workstreams in the North/NE was of poor relationships with the OPD community. This was because of a history of mistrust, which largely related to their role in the disbursement of the Disability Common Fund. Interviews with people with disabilities similarly talked about being turned away from the Social Welfare Office and being seen as a ‘nuisance’.

In the review of the documentation, a consistent theme was similarly that partnership working was key to the success of the stigma work. The identified benefits included:

- Traditional leaders ensure the ‘buy in’ and **acceptability** of the programmes (see **Acceptability** section), leveraging new opportunities for stigma work with a multi-faceted approach:

“Members, traditional and religious leaders especially, Queen Mothers on the project were very helpful in mobilising the targeted beneficiaries due to their level of influence in the communities”. Advocacy grantee report.

“I am very happy with the project. In fact, we, the traditional leaders in Anlo Afiadenyigba, are willing to support the project by educating our community members at our various meetings. Based on this, I will invite the inclusion ambassadors to attend the tradition council meeting so that we can see how best to put some sanction mechanism in place to address abuse cases for people with disabilities, including people with mental health conditions. From here, I will inform all the chiefs so that we can arrange a day for the meeting and inform the inclusion ambassadors and the leadership of the self-help groups accordingly.” SBC grantee report.

- Provided a **platform** for people with disabilities and mental health conditions to engage with duty bearers:

“Before the project’s implementation, it was quite difficult to meet with stakeholders or even invite them for programmes. Now with the relationship established with key stakeholders, things are beginning to change for the best as they respond to our calls and also give GNAD the audience.” Advocacy grantee mid-term evaluation.

- **Facilitated entry** into communities, for example, ABAK Foundation's partnership with the Local Council of Churches in the five Municipal and Metropolitan District Assemblies (MMDAs) enabled DCs to engage with the church congregations.
- Offered a more **sustainable** approach:

“Songtaba have engaged with the Mental Health Unit and DSW under the District Assembly as strategic partners in the mental health project. Involving them in the project implementation is not only strategic but a step to a strong sustainability of the project.” Songtaba quarterly report.

- Increased **collaboration** between different actors is considered more impactful because it promotes a more coherent approach (see also **Coherence** section).

“Due to the participation of multiple stakeholders in the project, activities such as community durbars, forums and interface meetings in discussing the challenges of people with mental health conditions, there is an increased collaboration among the state agencies in the district in supporting people with mental health conditions.” Small grants evaluation.



Inclusion Ambassador from Adaklu

At the same time, Ghana Somubi Dwumadie also sought to improve the user-led approach for partner organisations. Whilst this was not exclusively about work on stigma, it indirectly impacts on stigma. This included the development of a briefing paper: Improving user-led approaches in mental health and disability services (2022). Another learning product – What works in grant-making mechanisms for mental health and disability inclusion programmes in Ghana (April 2022) – similarly promotes the: “Value and power in approaches which uphold the principle that people with lived experience are best placed to bring about changes in attitudes around disability and mental health.” It was beyond the scope of this research to understand how this may have influenced partners’ approaches.

Strong engagement with partners and stakeholders was attributed to shared organisational values, which include honesty, transparency and respect. Additionally, a history of participatory engagement in the region on disability and mental health, with existing relationships that could be built upon, were factors attributed to success:

“We actually don’t look at anything we do as though we have the money, and for that matter, we are champions. No! We try every possible means to work well, respect, to give that room to people who can effect change. Because if we don’t have a better way to relate to them, the changes won’t come.

We are open to them [other stakeholders]; we make them understand whatever projects we are working on. And they are able to buy into it. So, it’s easy to maintain that relationship. The openness also relates to our transparency. When we receive grants, we tell them this is how much we are awarded, and for every activity, this is what we will be using, it makes it very easy for them to understand.” FGD, grantee, Volta Region.

In contrast, where a grantee was relatively new to working in that region on disability, there were some challenges initially in building relationships and managing expectations around the project.

4.1.6 Gender and diversity

Overall, there was lower participation of women with disabilities in design and delivery, with the exception of VOICE, which stated that women were more likely to engage in activities than men. Evidence showed that IAs, DCs and VCs positions were dominated by males (86%); indeed only 4/13 IAs with disabilities were females, 9/37 DCs, and 7/75 CVs.

GNAD similarly reflected on the low levels of women in leadership positions within their organisations, although this is an area they are targeting to address. The male-dominated leadership also extended to the OPDs that were engaged with. Whilst we did not explore gender representation within partners, MEHSOG reflected on the low representation of females, which they attributed to a lack of self-esteem:

“For leadership, we rather unfortunately have more males than females. Unfortunately, we have more males than females because when it comes to elections, more women will not want to put themselves up for them to be elected. So, on that score, we have more males.” National IDI, partner organisation MEHSOG.

Some identified barriers were perceived lower levels of confidence and capacity of women to engage in some of the activities. In contrast, in one FGD with women with disabilities, they attributed their low participation to issues relating to gender roles, such as doing household chores and nurturing, combined with their work, as illustrated by the following quotes:

“We are hairdressers and seamstresses, and we don’t get work often. So, sometimes, when you are in the middle of working, it is difficult to leave work. We also have children to take care of at home. We also get pregnant and nurture our children, taking care of the home and working.” SHG, person with a mobility impairment, Volta Region

“I have grandchildren that I take care of. Besides, I have difficulty in walking, I don’t walk fast.” SHG, person with a mobility impairment, Volta Region.

Some lessons learnt from the wider programme documentation on promoting women’s participation included:

- The importance of setting targets for women to attend events in all communication with communities and partners.
- Targeting women in leadership roles within the activities. For example, increased female participation in the campaigns against stigma by training them as champions in mental health. Female SHG leaders were given priority to represent the project and share their experiences about stigma, for example, on the radio.
- Female traditional leaders were targeted in communities, for example, Queen Mothers, so that they could vocalise on the issues that affected women.
- Forming partnerships with women-led organisations. For example, VOICE partnered with Women with Disability, Development and Advocacy Organization (WODAO) to engage in the design and delivery of various stigma related activities.

In terms of diversity of disability, the evidence was minimal, as this was not tracked within the interventions. In summary; 1/38 DCs with a hearing impairment, 4/38 with a mental health condition, 7/38 with visual impairment. For IAs, 1/13 with a visual impairment and 12/13 with a physical impairment. Whilst it would not be expected that there was equal representation of disabilities, as there is variation in prevalence of disability, there do appear to be challenges here.

It is noteworthy that organisations such as WODAO, which works with VOICE Ghana, our main grantee in the Volta Region is targeting women with disabilities. In the Volta Region, WODAO played a key role in mobilisation of women with disabilities and building their capacity to self-advocate and to participate in community activities as well as decision-making. Hopefully, the impact would be evident in the near future.

Key lessons learnt – participation

The value of a participatory and user-led approach is core to the programme and permeates through the design and delivery phases and programme guidance notes. There are a variety of roles that people with disabilities, including people with mental health conditions, play at community level in addressing stigma in their role as DC, IAs, CVs, and/or leaders of SHGs.

As a result of their engagement, people with disabilities were empowered in various ways, which facilitated their engagement on stigma reduction activities. That said, internalised/felt stigma was identified as an issue that needed to be better addressed in supporting the work with people with disabilities.

Where DCs/IAs/CVs were well supported and drew on strong networks and relationships (social capital), they were able to utilise and mobilise these connections for their work on stigma. In contrast, when people with disabilities are selected, and there are issues related to their capacity, combined with limited support, they have struggled more to implement stigma reduction activities. The model of intervention approaches, which includes both people with disabilities and community members, appears to work well. The latter are able to utilise their positions of power, and access to resources, to implement activities. And where traditional leaders are involved in the selection, this can provide valuable additional support for implementation.

As a result of their engagement, people with disabilities were empowered in various ways, which facilitated their engagement on stigma reduction activities. That said, internalised/felt stigma was identified as an issue that needed to be better addressed in supporting the work with people with disabilities.

It was clear that adopting a participatory collaborative approach with a wider range of partners and community stakeholders was also key to success. This was more evident in some study sites than others, and also attributed to a range of factors, including a history of engagement in area of disability with an existing strong relationship, and shared values. This offered greater synergy in stigma reduction activities.

The importance of being able to engage with ‘people of power’ to effect change in stigma was a consistent theme.

4.2 Coherence

Objective 2, coherence: to investigate whether and how a diversity of intervention approaches can complement each other to improve implementation of stigma reduction interventions in Ghana.

Coherence: as mentioned earlier, this is a large and complex programme of five consortium partners delivering different workstreams, with the stigma focussed elements being delivered by nine grantee projects. The focus of this research question was on internal coherence, building on the OECD/DAC definition of internal coherence, that is ‘the synergies and interlinkages between the intervention and other interventions carried out by the same institution’⁴.

4.2.1 Coherence within and across grantees

For the two SBC large grantees interviewed, their interventions were clearly informed by the SBC strategy and co-creation activities, which also guided their operationalisation. As one grantee explained, the SBC strategy “was core to guiding our work” and was one of the main project documents used.

Ghana Somubi Dwumadie staff similarly said they found the SBC strategy⁵ useful as it helped align the work of SBC grantees and brought coherence across the various grants’ projects. These findings were also reflected in the review of programme documentation, where there was account of a clear and systematic approach to the development of the SBC workstream (see below).

Steps that have supported a coherent approach of the SBC grants

- Formative research conducted on stigma, with a clear theoretical framework underpinning to the study.
- SBC participatory strategy workshop to develop the SBC strategy. This provided:
 - A clear set of objectives to guide work of grantees
 - A theory of change (ToC) to guide the work on stigma reduction
 - A set of intervention categories: education and training, incentivisation, persuasion, restriction, modelling, enablement and coercion
 - Identified areas of policy categories as part of advocacy and communication strategies
- A second co-creation meeting to operationalise the strategy and help grantees to work together to identify their own priorities but also areas for collaboration and

⁴ OECD Evaluation Criteria –at [Evaluation Criteria - OECD](#). Retrieved 30/01/23

⁵ An advocacy strategy was also developed in Year 3 but not rolled out due to budgetary cuts.

cohesion. One product was a results framework for each grantee, with shared and/or aligned outcomes across grantees.

- Ongoing capacity-building and technical support to grantees was provided.
- A quality assurance process for stigma materials developed.

To further support peer learning, and opportunities for a more coherent approach, there were two learning meetings (September 2021 and June 2022) conducted for grantees. Additionally, a learning exchange (September 2022) was another participatory approach adopted between two SBC grantees, VOICE and HFFG, which included engagement with a wider range of stakeholders. The purpose again was to share good practices, working strategies and lessons learnt. Across the primary and secondary data sources, there was generally positive feedback on these events, and they were seen to be useful. What was less clear was how they translated into changes in practice and uptake of lessons learnt, including greater shared use of some of the high-quality stigma resources developed or other forms of improved coherence.

Between the advocacy and SBC grantees, there were mixed experiences of synergy and sharing but, overall, it was generally limited. Whilst their focus was advocacy, in practice, working on stigma was still core to all their work. Yet at a strategic level, the advocacy grantees had not engaged with the SBC strategy, nor articulated their own approach to stigma reduction. In the North and NE study sites, there were no clear examples of collaborative work and/or sharing of resources on stigma-related resources across the three Tamale-based grantees. A GNAD staff member reflected on attending one 'valuable' learning meeting with the SBC grantees, but in general, advocacy grantees tended to see their work as quite separate. On reflection, it was felt that that it was an artificial divide between 'advocacy' and 'SBC' work and that perhaps one strategy that combined different programme elements, including the stigma reduction work, would be a useful future way forward.

4.2.2 Coherence within and across the other workstreams

In terms of coherence across the other two workstreams, the work with SHGs and with DMHCPs, there was some mixed experience in terms of synergy and collaboration. BNGh identifies mental health stigma reduction as core to the SHG work, but there was no explicit engagement with the SBC strategy, nor a clearly articulated approach to stigma reduction. It was clear, however, that BNGh was generally perceived as the 'go-to' organisation on mental health issues. There were areas of collaboration with Songtaba in the North, for example, BNGh advising on a rights-based approach to their mental health work, and some joint training. This was facilitated by quarterly meetings⁶ and indeed Songtaba became members of the regional Mental Health Alliance platform as a result of this work. Similarly, the grantee GNAD valued and benefitted from technical input from BNGh in their research design.

⁶ These quarterly meetings have now stopped with the budget cuts

There was a view expressed that the other workstreams could have benefitted from more learning and sharing events on stigma, rather than the narrower focus on grantees, and particularly learning between SBC grantees. This may have fostered more coherence in the stigma work across the programme.

Within the DMHCP body of work, there was a systematic coherent approach used for the development of the DMHCPs, and alignment and learning across the three DMHCP sites, supported by an overarching theory of change (ToC) that helped to guide the design and detailed implementation of this workstream. Based on this, all District Health teams produced their own ToC map to facilitate the implementation of their plans.

The DMHCPs address four critical domains (raising awareness, improving detection, treatment and recovery, enabling functions) and employ a coherent approach across all DMHCP three sites. Yet, whilst stigma was identified in all district plans, and all have included indicators to reduce stigma, there are no explicit linkages or synergy between the DMHCP work and other workstreams.

One of the demonstration sites overlaps geographically with the grantees in the Volta Region (although different districts), but interviews with the Community Mental Health coordinators in the Ahafo and Bongo districts indicate that they had no awareness of, or access to, the range of stigma resources available through the programme. This finding was also reflected in the documentation review.

4.2.3 Coherence with collaborating partners

Given our focus on internal coherence in the programme, we did not explore in detail the coherence of stigma work with the wider range of collaborating partners. That said, coherence with partners was particularly evidenced in the Volta site, where there were many examples of working in synergy, which include widespread use of the grantee stigma reduction materials. For example, the NCCE, a government institution responsible for the education of Ghanaians on civic matters, works with VOICE and uses their SBC materials for disability sensitisation:

“NCCE distributes VOICE materials as well as uses them for public education. VOICE also engages our staff in some of their programmes to handle the translation in the local language.” IDI, partner organisation NCCE, Volta Region.

The DSW uses the VOICE materials to complement their work, and the language guide was shared with all their district officers:

“I use it [referring to the Positive Language Guide] a lot in my sensitisation activities and in any forum I find myself. I use it at all times, everywhere. I use it to correct people. For example, the Church of Pentecost invited me to speak to the congregation about disability issues and I spoke well about the need to use positive terms in referring to persons with disabilities.” IDI, partner organisation DSW, Volta Region.

The Volta branch of the Mental Health Alliance (a coalition of civic society organisations, civil servants, and other organisations working with people with disabilities) has used the VOICE SBC materials to create awareness about mental health in various settings including churches, schools, marketplaces, radio, and a weekly TV programme on TOSH TV called Time with mental health.

These examples of collaboration across partners’ work are a likely indication of consistency in messaging on stigma, which in turn is more likely to have impact than a fragmented approach. The willingness to use stigma materials is also a strong indicator of the acceptability of these materials in the Ghana context (see [Acceptability](#) section).

Outside of the Volta site, despite considerable effort invested in sharing resources, it was not always clear that these resources were fully utilised. This also includes the guidelines and briefs. Possible reasons given for this included ‘insufficient ownership’, and the need to improve how we ‘critically engage’ with partners on the materials.

It was less clear why there was not always more take-up of shared resources internally in the consortium, especially given some of the excellent materials developed, but that ‘tension between agencies and institutions’ and ‘protecting their turf’ were identified as possible contributory factors. Certainly, the challenge of the Covid-19 pandemic in the first year of the programme meant that relationships were not as strongly established in the first year. There were repeated requests to have additional hard copies of materials available outside of Ghana Somubi Dwumadie offices, for example, posters and language guides.

Key lessons learnt – coherence

Within the SBC component, there was strong coherence in the approach. This was facilitated by having one SBC strategy, including alignment of indicators and outcomes. In a similar vein, whilst not specific to stigma, there was coherence within the work on the DMHCP specifically in the development processes for the plans, supported by an overarching ToC.

There was no one single conceptual and articulated approach to understanding stigma, or of stigma reduction interventions, across the various elements of the programme. Overall, cohesion could have been improved between grantees and different Ghana Somubi Dwumadie workstreams. Greater engagement with the SBC strategy and learning from the formative research conducted on stigma could have benefited other programme elements.

There was scope for greater shared learning and opportunities for synergy across different components of the stigma work. At an operational level, some of the excellent resources and training materials produced, for example, could have been more widely adopted and adapted as necessary.

Learning meetings and exchanges were valued by participants but, in practice, it was less clear how this translated into take-up of stigma approaches and resources. The guidelines and learning briefs were seen as valuable, but the evidence also indicated they were not used to their maximum. Their use could be enhanced with a stronger, more cohesive approach to dissemination of resources and enhanced opportunities for learning.

4.3 Acceptability

Objective 3, acceptability: to understand the acceptability of different disability stigma reduction interventions in Ghana.

Acceptability: we draw on the definition used for designing feasibility studies (Bowen et al., 2009), that is ‘How the intended individual recipients – both targeted individuals and those involved in implementing programmes – react to the intervention’. This includes issues such as satisfaction, intent to use, perceived appropriateness, fit within organisational culture, and perceived positive or negative effects.

4.3.1 Approaches to strengthen acceptability

Core to promoting the acceptability of the stigma reduction interventions was the principle adopted of a user-led approach. This was about promoting people with disabilities and mental health conditions as central to both design and delivery of the stigma reduction materials, as elaborated upon in the above section on **participation**. A powerful example of where user-led involvement made a clear difference to acceptability was illustrated in the development of the Positive Language Guides. The role of people with disabilities directly engaging with other key stakeholders meant that cultural and traditional views could be challenged, and more inclusive and acceptable language then adopted.

Another approach that encouraged acceptability of the materials and approaches was the participation of various partner organisations and other community stakeholders. In sites where their engagement was particularly strong, there was evidence that they adopted and utilised the materials and contributed to acceptability. This is illustrated with the example of working closely with a traditional leader to check on, and contribute to, cultural acceptability:

“Although VOICE had introduced us to the chief, we went to see him before playing the jingles at the information centre. During one of these engagements, the chief added some negative derogatory terms that were not captured in the [language] book. He told us that persons with albinism are also called ‘gbelemo’” which means “cassava dough”, thus having the characteristic of being soft like dough, implying that people with disabilities are weak or fragile. FGD, IAs, Volta Region.

A process which seemed to work particularly well for one SBC grantee was the use of the pre-testing processes for production of language guides, jingles and posters. A combination of people with disabilities and mental health conditions and partners were engaged in a 3-step process of pre-testing, adapting materials, and then returning to check that it was acceptable. They used this to improve the acceptability of posters, as the original images used were seen as “foreign”.

SHG members were happy for their images to be used, and also wanted their voices used for the jingles, which again is an indicator of acceptability of the approach. The translation into local languages for the posters and jingles was also important. These processes appeared to foster ownership of the materials, and many of them continued to be replicated and used without funding support from Ghana Somubi Dwumadie at the time of this research.

“The posters made an impact on the community as the community sees their members with disabilities telling them in their own language to stop name-calling which sends a signal. So, more materials should be translated into the local language.” IDI, partner organisation NCCE, Volta Region.



The ‘standard’ image used (in English: Deaf persons or persons with hearing impediment) and an example of one adapted from Volta Region (in English: we can teach, we can farm and do many kinds of job. Everyone has the right to equal opportunities).

However, with another grantee, whilst translation had been made to some local languages, it was not translated into all local languages and the ‘standard’ images were not modified to reflect local people. With an estimated 80 local languages in Ghana, the issue of translation is not without its challenges. It was also unclear why materials from another grantee were

not utilised. One of the tensions identified was the balance between needing to ensure quality, but sometimes lengthy quality assurance processes. As a result, there were some delays, and regional staff for one grantee explained that they therefore chose not to follow up with additional translations and adaptations. The need to streamline this process was similarly highlighted in the document review.

4.3.2 Adoption and use of materials

The adoption of materials is also a good indicator of acceptability. There were many examples of adoption of the materials by a wide range of organisations, and notably by traditional leaders, also reflected in the **Coherence** section. Again, this was particularly strong in the Volta Region and is powerfully illustrated by the example of a Queen Mother⁷ who mounted one of the posters in her palace; she used it to sensitise visiting community members. The palace was strategic because many events take place there, including durbars, adjudication of cases and community fora.

Importantly, there was also evidence of adoption of the SBC materials by religious leaders in the Volta Region. The Christian and Islamic religious leaders said that they accepted and used the material with congregants. It was noted that they further adapted the materials for their audience by integrating sections from their religious texts, as illustrated by the following quote:

“Anyone can get a disability at any time, and when it happens, do not discriminate against the person. So, if it happens to you now, do you want to be called that name that you used to call others?” IDI, Imam, Volta Region.

⁷ Female traditional leader



Poster used on the wall of a Queen Mother's house in the Volta Region.

4.3.3 Adaptations for different types of disability

In terms of making adaptations of materials and approaches for those with different types of disabilities, there were several examples to learn from, but they were not widespread. GNAD adapted the language guides into video material for disseminating materials, for example, sharing videos about mental health terminology and findings of their research for members with hearing impairments. This was also because members often had low-literacy levels. One of the SBC grantees modified their monitoring, evaluation and learning (MEL) data processes to make them more accessible for DCs with low levels of literacy; they adjusted their monitoring approach to include the use of pictures shared on WhatsApp combined with regular calls.

Programme documentation additionally detailed a range of other adaptations made to improve acceptability:

- A partnership with the Ghana Blind Union facilitated an audio version of the Language Guide. There were plans to put it into braille, although not implemented due to time and budget limitations in a 1-year small grantee project.
- Adequate budgeting for expenses of aides and caregivers and sign language interpreters in all grantees and other programme activities.
- Planning for sufficient time to enable participants to travel to and from meetings or training.
- Use of sign language – but this has some challenges because of some concerns about the quality of interpretation. Some participants are familiar with Ghana sign language and others are not. A recommendation from GNAD has been to suggest that participants select their own sign language interpreters to allow for regional variability.
- Ensuring the content and format of training, and all information material, is appropriate to different needs of participants. Learner-centred techniques such as role play, use of local languages in training, and applying basic accessibility principles can help.
- Checking that the environment is physically accessible for attendees, ensuring adequate lighting in venues for people with low vision and albinism.
- Importance of user-friendly infographics, large fonts for materials, and other accessibility features such as the use of alt text for describing images, and appropriate colours.

○

Key lessons learnt – acceptability

Several approaches were seen to strengthen the acceptability and adoption of materials. This included a user-led approach, combined with wider participation of other key stakeholders. This also clearly fostered ownership and widespread use of the materials.

The pre-testing quality assurance processes worked well with one grantee and resulted in various adaptations to suit the cultural context. However, there was an identified need to streamline this process to avoid delays.

There were documented examples of adaptations for people with different types of disability, but this is an area where more work was needed. For example, more materials in braille or easy read versions.

4.4 Early effects

Objective 4, early effect: to contribute to understanding of the early effects of direct or indirect stigma reduction interventions on attitudes, perceptions and stigmatising behaviours in Ghana.

Early effects: in exploring early effects, and views on how change came about, there is overlap with other research objectives in this report. In particular, on the role of the leadership of people with disabilities and participation of partners and other stakeholders as explored in the **participation in design and delivery** sections. The early effects of Ghana Somubi Dwumadie, combined with a reflection on the processes, is further explored in this section.

In understanding the different stigma dimensions, it is difficult at times to disentangle what type of stigma is in the narrative. We use the terms that they use, where possible, for example, staff talk about ‘self-stigma’ to refer to internalised stigma.

4.4.1 Knowledge and attitudinal change

The general perspective of people with disabilities interviewed (SHG members and leadership) was that there has been an overall improvement in knowledge and awareness, combined with more acceptance of people with disabilities and mental health conditions in families and communities. This was in terms of improved knowledge on the importance of using non-stigmatising language, about mental health and disability rights, some improvement in understanding of services available, understanding legal processes to seek redress, and awareness of mental health issues within disability organisations.

“Awareness has increased in the community. The community has seen the need to reach out to persons with disabilities rather than sympathising.” IDI, partner organisation WODAO, Volta Region.

“The community now gives them the opportunity to participate in community activities. Some persons with disabilities are now members of Easter planning committees, school management committees, community water project committees and some are ushers in their churches.” FGD, grantee, Volta Region.

There was, not surprisingly, the commonly held view that more needs to be done. The initial comments in interviews would always be that, yes, things are changing, and then later in the interview shared examples of persisting challenges. The recognition was that these things take time, as one traditional leader reflected:

“The process is ongoing. Acceptance in society is increasing every day, day by day.” Traditional leaders, BNGh site, Northern Region.

“We are seeing a change in positive language and more respect, but we still need more.” FGD, ICs, NE Region.

An important early effect was increased knowledge and awareness, and acceptance about mental health conditions within the disability community. This was reflected by MEHSOG, and also evidenced by the fact that MEHSOG has become a full member of GFD, and their relationship was strengthened through the programme:

“Awareness in general has increased and the understanding of mental health conditions has also increased. The attitude of the public towards mental health was so bad in recent times. But recent times there has been significant attention given to mental health, very much significant attention given to mental health, even in the Ghana Federation of Disability Organization, even though there hasn’t been any baseline. And, for that matter, we cannot measure, or we have the measure. I have a feeling that, from what I’ve been hearing, people do, people ask, people say, yes, there has been significant awareness about mental health.” National level IDI, MEHSOG.

Similarly, GNAD leaders emphasised the groundbreaking change in both their understanding and attitudes about mental health within their own deaf community. Their view was that this understanding has to start within the deaf community, so that they can be ‘empowered’ to challenge stigma on mental health. At the same time, they felt there was still considerable work to be done to disseminate the research findings within their community.

“This is the first project on mental health for persons with hearing impairment in Ghana. It is the first step, and it has opened our eyes to so many things.” IDI, senior staff, GNAD.

“If you want to reduce stigma amongst the deaf community, the first people that have to understand is the deaf people themselves. We marry within ourselves. If we are able to reduce stigma amongst ourselves, we can then be empowered to make change outside.” IDI, GNAD leaders, Northern Region.

“Previous to the research conducted at national and district levels, we never knew that so many of our members have mental health issues. We, the leaders, when we have meetings, some of them [with mental health] will come up, and we have learnt we should not reject them.” IDI, GNAD leaders, Northern Region.

Increased knowledge and awareness, and attitudinal change, were also well documented in the project reports.

“Our engagement with ABAK and the project has improved our knowledge on the people with disabilities rights and inclusion.” Chairperson, GFD, ABAK evaluation.

“If you have the opportunity to attend this kind of seminars, you will be enlightened. As a theologian, I can say we have been unfair to people with disabilities including people with mental health conditions for a long time.” Church desk coordinator, VOICE quarterly report.

The document review similarly highlighted gaps in the understanding of key agencies, including duty bearers, on the rights of people with disabilities and mental health conditions, including law enforcement required to reduce discrimination. The programme effected change here:

“During the interaction with law enforcement agencies, it was both challenging and surprising to realise that these agencies lacked information on some of the laws protecting people with disabilities, including people with mental health conditions. Through information sharing, they become more informed about the needs of people with disabilities, including people with mental health conditions, as far as law enforcement is concerned.” VOICE, learning exchange report.

“I commend VOICE for the partnership opportunity. I must admit that many of us are not aware of the content of the disability laws and policies. I suggest we marry that with the awareness-raising where a public forum should be organised for citizens, and at least soft copies of the law are made available to all officials. There are a lot of opportunities like tax exemptions for people with disabilities, accessible building regulations etc., but everyone is silent on them. For me, I admit that, when it comes to sensitisation on issues of people with disabilities, I am not doing well. As part of my commitments, my department shall also collaborate with the Mental Health Unit to do better.” DSW, senior manager, VOICE quarterly report.



John Mahama of Savanna Echoes.

4.4.2 Change in language

A change in use of derogatory language also reflects an improved knowledge and changing attitudes, and this was a key component of the project, with considerable investment in developing language guides and training. The lack of suitable non-discriminatory language was identified as one of the key drivers of stigma in the baseline stigma research. Positive language terms used for people with disabilities, and a reduction in name-calling, was the most commonly identified change in the SBC work in the Vola Region, and similarly reflected in the document review. This also appears to be an important stepping stone to greater disability inclusion, as illustrated in these quotes:

“Before persons with disabilities couldn’t go to church because they were mocked in the church and on their way to church, but because the name-calling has changed, they can go to church now.” FGD, SHG-Adaklu Waya District, Volta Region.

“Persons with disabilities are happy that name-calling has ceased, and they can freely go out without being asked why they are where they are.” FGD, SHG-Anfoeta District, Volta Region.

“People have been calling me names like ‘a person having difficulty in walking’. It is what I have been teaching them to say during community engagement meetings, not to use negative names. So now when they see me in town, they call me by a positive name, and we all laugh together.” FGD, IA, Volta Region.

The value of the language guides was consistently identified as a useful tool to effect this change, and again particularly highlighted in the work of VOICE where it was used widely by ICs and other partners. Whilst the guides were also used in other sites, delays in receiving copies and limited numbers of copies might go some way to explain why they were less utilised, and thus less commented on.

Similarly, consistently across the secondary data, there was high reported levels of awareness about discriminatory language, and reported commitment to changing practice, both at the level of community and family.

“The education on the use of positive terminologies in our language (Waala) when referring to people with mental health conditions has been very impactful. We previously used the denigrating words comfortably without even thinking about the impact on the person with a mental health condition or even their families. But since my involvement in the project, I have been very careful when I am speaking about disability so that I do not mistakenly use a word that can be offensive.” A chief CPRI end of project evaluation, Wa Municipal.

In the small grants evaluation, 74% of project participants said that they experienced an improvement in the use of positive disability language. In one powerful quote, a woman with a disability explained that the change in positive language made her feel more ‘human’, with impact on her feelings of self-worth.

“Before this project started in Ashiabre, everywhere I go, people call me ‘the woman with hunchback’, both children and adults. They say I am not meant to be among human beings. That is the insult I receive from the community members every day. But when this project started in our community, the name-calling has stopped because my community members are now enlightened that my condition does not mean I am an outcast. Now, everything has changed. They do not call me that derogatory name. This project has brought great change and relief to me, as my community members are now relating with me well and have realised that I am also a human being and not a woman with hunchback.” Ashiabre disability self-help group, VOICE quarterly report.

4.4.3 Disability inclusive practice

From the perspective of people with disabilities interviewed, all were able to give examples of positive changes in disability inclusive practice, evidencing a reduction in stigma. This included examples given of general participation in everyday activities, being able to eat together in the family, and being invited to attend community social programmes.

“[Stigma] has changed, my granddaughter is now able to fetch water, and even the family members have changed. My granddaughter is now also able to access education.” FGD, SHG Gushegu, Northern Region.

“People with disabilities and their families now eat together from the same bowl. Their foods are not kept on the floor as before.” FGD, partner organisation Volta Mental Health Alliance, Volta Region.

A common example given was of families changing their views and sending their child with a disability to school. This was often seen as a consequence of a home visit and direct engagement with an IC/DC/CV/SHG leader/traditional leader visiting the home.

One early effect, commonly highlighted in the Volta Region, was evidenced by several examples given of people with disabilities being invited onto various leadership positions and/or community roles. The key here appears to be the close working relationship with the traditional leaders, from early in the programme, which has brought them into greater contact with people with disabilities. A traditional leader reflected on this:

“I recognised the capabilities of persons with disabilities, so I involved them. An example is the selection of one of the ladies onto the Easter Planning Committee. That woman is hardworking.” IDI, traditional leader, Volta Region.

In contrast, in one of the NE sites, where the programme had not engaged closely with traditional and religious leaders, it was apparent that the local leaders were not familiar with the local DC’s work; they questioned whether they were literate and would have capacity for such leadership roles.

Whilst experiences of stigma in the community still clearly existed, there did seem to be a shift in the understanding of processes to report these issues, and willingness to do so. This is further explored in the [Application section of sanctions and local by-laws](#). A common example given of positive change in social norms and practices was that people with disabilities and mental health conditions could get married. At the same time, there were many examples of abandonment of the women with their children, which is explored in the section on [Gender and diversity](#).

Similarly, in the secondary data, there were consistent reports of expressed willingness of community leaders to meet and engage with people with disabilities and mental health conditions as a result of their engagement on the project. The data was thinner on actual changes in disability inclusive practice. That said, the Small Grant Evaluation showed 35% of project participants had experienced improvement in general support. 44% said they had experienced an improvement in decision-making, at both family and community level. There were a small number of examples of people with disabilities appointed to decision-making boards.

4.4.4 Empowerment of people with disabilities

Another early effect on people with disabilities and mental health is revealed through examples of empowerment found in the primary data collection. This is reflected in the knowledge change already highlighted.

Whilst the stigma interventions were largely about engaging with leadership of OPDs/SHGs, it was also apparent from interviewing members of the SHG membership that

they benefited from their support groups. This seemed to be particularly in addressing feelings of self-stigma and of the value of ‘togetherness’. Members gained confidence and emotional support from each other, illustrated here by quotes from SHG members in the NE Region:

“Sometimes I feel like weeping, but with courage from my group, I am helped.”

“It makes you feel that you have another family, especially if you are rejected in your family.”

“Even belonging to the group is something to be proud of, [you] feel that you are at home here.”

“If you are with your colleagues, you have motivation and you feel more capable and it can give your ideas.” SHG members, HFFG, NE Region.

Some members talked about being able to give advice to each other, and one reflected on the collective power to ‘team up and support each other’ when there were problems in the family. Although, commonly, they would refer onto their leadership to address issues. SHG members and leadership also commonly requested more access to training, most commonly asking for training in livelihoods, and also on human rights, advocacy, and how to address inclusion in schools. Caregivers were also SHG members, and one staff member reflected that they could be ‘agents of change’ within their own families. Exploring the role of caregivers in any depth was outside of the scope of the research and SBC plan, but is worth addressing in future.

The early effect on empowerment of people with disabilities was also highlighted in the project reporting and evaluations. Reporting showed an increase in self-confidence, self-worth, and the development of new skills for people with disabilities and mental health, all of which were felt to be important for addressing issues of self-stigma. For example, in the learning event report (September 2022), one small grantee commented on the self-stigma existing amongst people with disabilities, which often results in their limited engagement, and the need to address this. Importantly, the evidence of early effect shows change in feelings of self-stigma, and growing confidence from the acquisition of knowledge and new skills, and the way they feel treated with respect. Consequently, people with disabilities felt able to increase their participation and challenge stigmatising attitudes.

“The increased positive attitude and use of positive disability language by stakeholders has also contributed to restoring the self-esteem and confidence of people with mental health conditions to participate in social and economic activities.” CPRI end of project report.

“I am now more confident than before. I don’t have to allow people to underate or humiliate me.” HFFG mid-term evaluation.

“I was unaware about my rights at first, but through the Somubi project, I’m now empowered and will not accept any form of abuse at the marketplace or the community.” Woman with a disability, GLOWA small grants evaluation.

The confidence building meant that some people with disabilities have felt able to take up leadership positions, which also puts them in a stronger position of power to address stigma within decision-making platforms.

“I have been appointed as a member of the Assembly’s Disability Funds Management Committee and representing people with disabilities and mental health conditions at the Assembly. The project has empowered me to speak for myself and defend myself wherever I go. I always tell people that disability is not inability and I encourage parents with disability kids to treat them well and speak well of them.” GFD staff member, ABAK final change stories, Gomoa West Municipal.

The ability to take up leadership positions also has depended on the project fostering a supportive environment from local community leaders who have encouraged these appointments in some areas.

4.4.5 Application of sanctions and local by-laws

In this section, we explore the role of strengthening sanction mechanisms through traditional leaders, as well as the review and application of traditional by-laws at district level. These were identified across all sites as an important strand in stigma reduction, with some variation in approach.

In Volta Region, the role of the traditional leaders in using censorship was emphasised as an important tool for effecting change at community level. VOICE have recorded, at the time of writing, that the traditional authorities in 16 out of the 21 communities where they operate have instituted censures to end abuses against people with disabilities. This most commonly consists of the use of fines, as illustrated by one chief:

“And I told the people with disabilities are also human like you. They eat, drink and do other things like you, so if anyone call them names like ‘Pozo’ the person would be charged GHC500.00 (45 dollars).” IDI, traditional leader, Volta Region.

‘Pozo’ was a nickname given to a Ghana musician who had a disability. Thus, some Ghanaians call persons with disabilities by that name, which simply signifies that one has a disability.

Another example given by a man with a visual impairment illustrated this:

“A man bought a goat from me, but he refused to pay all the amount involved. I reported the case to the chief and the chief intervened and ordered the person to pay the rest of the money owed.” FGD, member of SHG-Anfoeta, Volta Region.

There was not one single course of action described as most effective, and it might depend on the reported issue and level of complexity and seriousness. In the Northern and Savannah sites, in the HFFG work, there was also close engagement with CHRAJ, and this was seen as complementary to the work of the traditional leaders. Both the DCs and the traditional leaders might reach out to CHRAJ, as needed, often on more serious issues. For example, one DC explained how: “There was a case in Sola District of a man who married a physically challenged women and then abandoned her and her 8-month-old child.” The CHRAJ director and DC engaged with the husband and the family to get support for the mother.

At another site, a woman with visual impairment and a DC explained that she was now more willing to report cases of stigma:

“Someone’s child came and defecated in front of my door. When we complained to the parents, they threatened to beat me. So, I told my husband that next time they misbehave this way, I will report them at the CHRAJ office.” FGD SHG members, NE Region.

There was evidence of changing social norms in terms of acceptability and importance of reporting issues of stigma. As one grantee staff member explained, having this strategy to address stigma was important because: “In the past, the issue would have been swept under the carpet, but now they [DCs] are more engaged with reporting abuses.”

Some SHG members commented that people would be ‘afraid’ of the law, and therefore this was an important deterrent for stigma reduction. However, it was also clear from the narratives that this ‘enforcement’ approach was not without its challenges. With some

probing, examples were given where families, and traditional leaders, still had a preference to resolve issues within the family.

In the Savannah Region, there appears to have been particular progress made engaging with the district authorities on incorporating by-laws on disability. One of the DCs shared his personal action to engage with the social service sub-committee to ensure local by-laws were reviewed and made inclusive of people with disabilities. He was aware that the process took time, and in his example, he was still waiting for the review process to be undertaken, but he felt this was an important approach:

“The assembly belongs to everyone so they shouldn’t make by-laws that don’t include people with disabilities. We have a Disability Act (at national level), but it needs to be translated down to local level.” DC, Savannah Region.

In the same region, there were examples given of further progress being made where the laws were ‘gazetted’. That is, they had incorporated and endorsed disability into the district by-laws, and it was now being sent back to central government for registration. In Walewale District, the Social Welfare Officer had reviewed all by-laws relevant to disability rights, and then held a meeting to bring all the social welfare officers together to be aware of these laws. This was seen an important first step, although there was still recognition that ‘enforcement is a problem’.

4.4.6 Role of community radio

In terms of the role of the media, the use of community radio was consistently identified across all sites and all type of organisations as having an important role, and particularly in the rural context where it can increase the reach of work on stigma. The language guides were used on the radio, most commonly by champions and ambassadors where they also gave testimonies and felt that the ‘call-ins’ were valuable to interact directly with community members.

There were also examples of other collaborating partner organisations using the radio, most notably in the Volta site. What was less commented on was the role of the radio presenters themselves, although in one interview GFD reflected that radio hosts have been observed to play a role in correcting derogatory language:

“Language used on media has changed, the host of programmes corrects callers who call persons with disabilities derogatory names. Some of these radio stations include HO FM, VOLTA STAR and KEKELI.” (FGD, partner organisation GFD, Volta Region).

Limited project resources to pay for airtime was the reason given for limited use of radio by the DCs in the NE and Savannah sites. That said, interestingly, one DC commented on being able to use his own personal networks to facilitate free use of the radio for additional airtime.

One of the main identified challenges identified by MEL staff and in the document review was the difficulty in monitoring reach and impact.

4.4.7 Challenges in early effect

The various challenges in addressing stigma have been interwoven into this report. In this section, we report on some overarching challenges that were identified, which impacted on the implementation of activities. These included:

- Difficulties of access and transport in the rural communities with insufficient funding through the project for facilitating this. Combined with this, a lack of inclusive transport.
- A limited number of psychiatric nurses, particularly in rural areas and the North, combined with medication stock-outs, which affect access to treatment in this region and also in rural areas. Similarly, a dearth of sign language interpreters.
- Overall funding issues for organisations as well as substantial cuts (30-75%) during the review period to Ghana Somubi Dwumadie have impacted on the delivery of some activities, on relationships, and on the scope and scale of what grantees can do.
- Covid was a key challenge in the first year, even though the project pivoted its activities. All public activities stopped and there were no peer support groups. This had implications for the entire first year of the programme, as it was felt to negatively impact on relationship building between the various organisations engaged.

Key lessons learnt – early effect

There was evidence of an early effect on knowledge and attitudinal change for individuals, families and communities. A common change identified was more positive use of language, with examples of how this was an important stepping stone towards greater disability inclusion.

GNAD identified their research on mental health for people who are deaf as ‘groundbreaking’, although more was needed to disseminate findings.

There was some early evidence of changes in experienced stigma, with positive examples of disability inclusive practice, such as greater participation of people with disabilities, including people with mental health conditions, in family and community activities.

Overall, the findings show that a ‘toolbox’ of approaches has been useful in implementing stigma reduction, operating at different levels, operating across layers of the eco-system. People with disabilities, including people with mental health conditions, most notably the leadership, can be effective in directly engaging on stigma reduction, from identification and reporting to an educational role, through to reporting abuse.

Community radio can be an important tool, especially in rural areas, although this has been difficult to evaluate.

The programme has offered different mechanisms to engage with people of power and influence. The evidence indicates that these people, such as traditional leaders, are often likely to be respected and listened to, important for changing social norms, and additionally have relationships and resources which can be utilised and can open doors to other opportunities for stigma reduction. For example, appointing people with disability and mental health conditions onto decision-making boards.

The use of enforcement to reduce stigma through the application of sanctions and laws was identified as another a valuable approach.

The SHG model appears to offer benefits of companionship and solidarity which supports a sense of empowerment, most notably in addressing emotional needs and self-stigma.

4.5 Gender and diversity

Objective 5, gender and diversity: to explore how experiences differ across gender (especially for women) and disability types (including mental health) and other relevant intersectional experiences.

Gender and diversity: in this section, we explore the intersectional experiences of stigma, gender, disability, and other individual characteristics. Gender and diversity are cross-cutting issues across the research objectives, and where relevant, issues have already been highlighted in the relevant sections.

Intersectionality: describes how different elements of a person's identity can be discriminated against, with negative outcomes (Crenshaw K., 1989).

4.5.1 Gender and stigma

Overall, the primary research findings reflect the view summarised by one staff member that the programme was 'gender neutral' in the initial design. Whilst the programme sought to address this from year two, for example, with gender mainstreaming training and additional support to grantees, this remained an area to further strengthen.

In general, a consistent view held was that women with disabilities experienced more stigma than men with disabilities. One religious leader described it as a 'double agony' of being disabled and a woman. One of the alleged witches explained why women are considered witches in their communities, and not men:

"Men are strong and women have no voice." FGD, 'alleged witches', Northern Region.

The issue of the abuse of women with disabilities was a consistent theme amongst all categories of participants in the Northern/NE/Savannah sites, the most commonly described example was the 'impregnation' of women with disabilities, and then their abandonment:

"The impregnation of women with disabilities is still an issue. The man runs away. After the baby is born, he abandons her." IC, East Mamprusi, NE Region.

Those interviewed generally reflected there was some progress and change in attitudes, in that women and men were now able to marry and have children. At the same time, women were commonly abandoned by their husbands or rejected by the husband's family. This

was illustrated by the case of one female IC, a woman with albinism, who shared her own experience of being abandoned by her husband after having two children. Her only income is 200 cedis from her work on the project, combined with begging from local families. She now lives with her sister who is a person with deaf-blindness and has also been abandoned with three children.

On a more positive note, there was a commonly expressed view that there is a shift in community understanding of women's rights, and the husband could be punished, with his family liable to provide financial support for any children. This 'punishment' of the husband or 'making them marry by law' was seen as an important step. It was the role of the traditional leader and/or CHRAJ in resolving such issues.

On a separate but important note, in one interview with the GNAD leadership, they commented that when a woman gives birth to a child with a disability then it can lead to divorce. These mothers can feel 'ashamed' and 'depressed'. This stigma by association was not explored further as it was beyond the scope of the research.

In the review of secondary data from the programme, there was limited documentation about the specific stigma experiences of women with disabilities and mental health. The exception was the focussed research conducted by Songtaba (Songtaba, 2022) which showed that 94% of 'alleged witches' were women and 67% were widows. Poverty also contributed to the accusations of witchcraft and the impact of this. The women abandoned by their families in camps were 'often stigmatised and suffer discrimination with serious psychosocial consequences' (P.1 report, Songtaba, 2022). The consequences documented included having low or extremely low quality of life (97%), with very high levels of depression reported (49%). The GNAD mid-term review also highlighted that women with a hearing impairment can be more vulnerable to sexual and physical abuse and were less likely to access services and treatment compared with their male counterparts.

4.5.2 Type of disability and stigma

In addition to gender, we explored the intersectionality of stigma and type of disability. One of the main challenges here was that those grantees working across more than one type of disability did not capture data on type of disability, severity of disability, or age. One grantee explained that this was due to the difficulties in recording disability, and concerns were raised by Ghana Sumubi Dwumadie staff about the capacity of grantees to adhere to good quality data protection procedures. This is an issue to be addressed, as the disaggregation of data would have further enriched understanding about the differences in level of participation, and in stigma experiences.

People with hearing impairments

Overall, a key theme, and also in the participation data available, people with hearing impairments were one group least likely to be well represented when working with disability organisations that target all disabilities. This is with the exception of GNAD, which exclusively focuses on this target group. This was also detailed in the **participation in design and delivery** section.

The commonly held view across all sites was that limited participation was not due to stigma but attributed to the dearth of sign language interpreters. This was also confirmed by the leadership of GNAD. This deficit of sign language interpreters is part of a wider national problem, and felt acutely in the NE Region, where there were currently no resident interpreters. This lack of importance given to it by the DSW was described by the GNAD leadership as a form of ‘major discrimination’ which prevents the meaningful engagement of people with hearing impairments with service providers and support organisations. For example, it was highlighted as an impediment to accessing the Disability Common Fund as they cannot engage with government structures, and support NGOs who facilitate that access as the following quote highlights:

“We work less with persons with hearing impairments due to a lack of resources, such as lack of a sign language interpreter, but we intend to extend the scope when we get funding to hire interpreters who would assist women with hearing impairments.” IDI, partner organisation WODAO, Volta Region.

In terms of the intersection of hearing impairments and mental health, research conducted by the GNAD team on knowledge and access to mental health services among deaf people in Ghana (GNAD, May 2022) was seen by interviewees as groundbreaking, in terms of raising awareness of the issues, both within GNAD membership and at a national level. This research highlighted the particular vulnerability of people with hearing impairments, often compounded by their isolation. The lack of sign language interpreters intensified these issues, as it was difficult to ‘expresses their feelings’ and ‘talk about the kind of depression they have and communicate about it’ to other people. Additionally, GNAD interviewees reflected on the stigma towards mental health which still exists within their own community. The leadership felt their own understanding had improved as previously explored in knowledge change in the early effects section.

These findings echoed those of the GNAD mid-term review and the GNAD research conducted (GNAD, May 2022). Whilst the research was not explicitly on stigma, it was a key thread running through both reports; they highlighted intersectional stigma experienced for those who were deaf and living with a mental health condition.

“A concern was that some deaf people with mental health conditions felt a deepened stigma by their own peers without the condition and, as a result, decided to stay away from the very spaces that the project created for them.” GNAD mid-term review.

The research on mental health for those who are deaf identified other areas of stigma. These included: stigma still seen as a main barrier to accessing mental health services; mixed experiences of stigma within the family; poor communication exacerbating the experience of stigma; stigma contributing to a poorer quality of life, including depression,

suicide, and isolation; and stigma linked to a cycle of poverty due to low patronage of services and a lack of employment opportunities.

People with mental health conditions

Overall, the primary research illustrated some areas of positive change in terms of improved understanding related to mental health and stigma. At a structural level, MEHSOG is now a full member of GFD, which is an important achievement.

One theme raised was that appearance impacted on perceived stigma; people with mental health conditions could be seen to look ‘dirty’ and ‘dishevelled’, especially if unsupported, and that this poor appearance could further contribute to stigma experienced. One BNGh staff member explained how they sought to address this: “We say to caregivers that it is important that they [the person with a mental health condition] look presentative [sic] when they attend meetings.”

Another theme was fear, of the possible behaviour of people with a mental health condition. For example, one woman with a visual impairment explained her concern about engagement with people with a mental health condition:

“You don’t know what he [person with mental health condition] is going to do, and it will be difficult to see. He could hit you.” FGD, ICs, HFFG.

One of the main differences highlighted between mental health-related stigma and other types of disability stigma was that the level of stigma experienced was seen to be closely linked with treatment. Participants in all interviews with SHG members and staff emphasised the importance of access to medication. Their narratives illustrated that, if symptoms were treated, they were more accepted and experienced improved participation in everyday life and work, as one man explained: ‘Because of the use of the drugs, I am now living with my wife with four kids.’

This appeared to suggest that level of stigma was closely linked to their observed behaviour and less associated with their diagnosis and label. However, BNGh staff explained that stigma could be more ‘subtle’ for people with mental health conditions, and it was not always immediately apparent how stigma was manifest. It also required a local organisation to ‘be embedded in the community to identify and explore issues around stigma’.

4.5.3 Urban and rural contexts

A common intersectional issue was about living in a rural or urban context, identified by different types of grantees and implementing partners.

In rural communities, for example, there might only be one to two people who are deaf, and this isolation could exacerbate any mental health issues: “There might only be one person in a rural setting, and she has no one to talk to. This is a major challenge, and it is [also] difficult to reach those communities.”

In contrast, in towns such as Tamale (Northern Region) members of the deaf community said they met as a group on a regular basis, and shared information amongst themselves to support each other. This lack of information sharing avenue, combined with limited or no availability and/or access to disability-related services, was highlighted as a factor across all grantees in the Northern and NE Region. One programme officer said: “Some of the people with disabilities [in the rural areas] don’t even know that social welfare exists – we need a stronger approach to working in these areas.”

Whilst this was not stigma specific, it was again highlighting that stronger links to information and services can contribute to reducing the impact of the stigma experienced.

Access to medication for those with mental health conditions was also seen as poorer or more ‘erratic’ in the rural context. A BNGh staff member explained that this was more likely to result in relapses, and in turn, more stigma experienced.

This finding was also echoed in the secondary data. GNAD research (GNAD, May 2022) similarly showed that rural-urban settings combined with poverty played a role in the experience of deaf people with mental health conditions. In urban and southern communities, people were more likely to access Accra psychiatric facilities, which have sign language interpreters. However, in the northern and rural communities, there was both fewer services and limited awareness of what was available. The challenges of the programme’s ability to reach into the rural context has been previously mentioned.

4.5.4 Poverty, stigma and disability

Another area of intersectionality identified was that of living in poverty, disability, and stigma. This was a theme commented on by most grantees, partners and SHG members and leaders, and across all the types of disability. This was illustrated by DCs in the Savannah Region. They explained that many young people with disabilities they worked with were not educated, had dropped out of school, and needed economic empowerment ‘so they are not begging’.

They talked about the ‘double stigma’ experienced when young people have a disability and cannot work and contribute to the family. They identified economic empowerment as ‘a priority’ for addressing stigma in their setting. Of course, the programme aims to make those linkages, for example, through the Disability Common Fund, and the various partnerships to facilitate access to government programmes such as the LEAP programme⁸.

Additionally, the original programme plans intended to do more regarding livelihoods, but post-Covid adaptations and budget cuts meant that this wasn’t possible. However, the consistent request across the SHGs was for more to be done in this area, which in turn will impact on stigma.

⁸ The Livelihood Empowerment against Poverty programme in Ghana

Access to medication and treatment was also seen as more readily available to richer families, commented on when discussing those with a mental health condition. It was also about wealthier families having relationships and networks that they can reach out to, and not having the stigma associated with being poor.

“A poor family has no one helping them, they don’t have anyone assisting them, no one to pay their health insurance. Life is more difficult, they often go alone to the hospital, people look down upon them.” Grantee staff, national level.

Other areas of intersectionality included the level of education, mentioned by one grantee, although not expanded upon in any detail. They mentioned that this would mean better understanding of how to get support in the case of discrimination.

These findings on intersectional experiences were also mirrored in the secondary data review. Notably the GNAD research highlighted poverty and urban-rural difference in the experience of stigma, again linked to access to treatment and support. A Songtaba report raised the issue of working with poor/uneducated women, and how it can be more difficult to help them to have voices to be heard to challenge stigma. The report stated that: “Appropriate means of translation were instituted so that women who are largely illiterate were not just physically present but able to put their voices across the table.” Although it is not clear what that meant in practice.

4.5.5 Children with disabilities

The issue of children with disabilities and stigma emerged as an important area to address. Whilst children were not a target group for the programme⁹, the need to address stigma at community level for children as well as adults was consistently raised in all settings, and many grantees and collaborating partners were already working on this outside of the programme. Caregivers of children were also members of the SHGs. Across all grantees and implementing partners, except for Songtaba, they talked about the importance of engaging with families so that children with disabilities were not hidden.

⁹ At the programme planning stage, it was agreed that UNICEF would be responsible for any work with children.

Key lessons learnt – gender and diversity

Overall, the intersectional experiences of being a woman with a disability, living in poverty, and in a rural location, were all identified as impacting on experiences of stigma, for a variety of reasons.

Women with disabilities and mental health conditions were seen as more vulnerable to abuse; sexual abuse and abandonment after having children. However, there were views expressed that increasingly fathers could be held to account for the care of children, for example, through traditional leaders and DCs/IAs engaging with families directly. At the same time, recognising that more needs to be done in this area.

For the deaf population, the dearth of sign language interpreters, and the lack of progress in duty bearers in addressing this, was identified as the main obstacle to meaningful participation in some of the wider work to address stigma. This was given to explain their limited engagement in meetings with other disability groups, for example at a GFD regional level. People who are deaf struggle to communicate experiences of mental health, even within their own family, and isolation can exacerbate the impact of stigma.

The participation of MEHSOG within GFD was seen to be strengthened. However, at district level, there were still lower levels of engagement with those with mental health conditions amongst SHGs of people with various forms of disabilities. It was also more common for them to be represented by their carers. Stigma was closely linked with access to medication and control of symptoms for those with mental health conditions.

Whilst children with disabilities were not a focus of this programme, in practice they were a priority for grantees and partners working at community level.

The programme would have benefited from a gender analysis and application of a gender lens at the design stage; this would have further strengthened the understanding of how women and men experience stigma and engage in the stigma reduction processes.

4.6 Monitoring and evaluation

Objective 6, monitoring: to explore how stigma can be understood and assessed to show changes in disability stigma through programme interventions.

Objective 6, monitoring and evaluation: to explore how stigma can be understood and assessed to show changes in disability stigma through programme interventions.

Monitoring and evaluation (MEL): the main approach adopted for this research objective was a review of MEL-specific documentation. This focussed on the large grantee reports and small and large grant evaluations. MEL staff were also interviewed.

One of the limiting factors in the review of the tools was the poor quality of some of the grantee evaluation reports, where there were limited details about tools used and/or how adapted to the local context. The lack of information does not necessarily mean there was no piloting done or adaptations made, but we have insufficient information to make that assessment.

In terms of the grantee work, the types of stigma-related approaches and tools were informed by the grantee results frameworks. Overall, there was a strong emphasis on process indicators within the frameworks, with more limited outcome indicators. This posed some significant challenges for capturing changes in stigma and was similarly highlighted as a limitation in the Small Grants Evaluation.

4.6.1 Tools and approaches

In this section, we provide a summary overview of the various tools adopted.

In summary, a mixed methods approach has been the preferred programme MEL approach to understanding stigma and assessing change. This is reflected in the following main approaches which have been employed by/with grantees.

- Monitoring tools/templates: quarterly reporting templates which include feedback sections, quantitative templates to record numbers reached (disaggregated latterly by gender and with/without disability and with/without mental health conditions), success stories template, training pre-post evaluation/tests, interview and focus group discussion guides.
- Surveys questionnaires
- Change Stories
- FGDs
- IDIs
- Quality assurance checklist
- Learning exchange/workshops

- Learning documentary videos¹⁰

4.6.2 Monitoring tools and templates

There are comprehensive quarterly reporting templates for grantees. In addition to output reporting, the format valuably offers grantees space to self-reflect and report on different dimensions of impact, including: ‘unintended outcomes’, ‘successes and challenges’, and ‘participant feedback’. ‘Change Stories’ were also more recently embedded to the end of project template.

From reviewing the reports, and interviews with MEL staff, a mechanism for recording rights abuses was considered as a helpful approach to understand changes in the levels of enacted stigma (discrimination). However, care needs to be taken in how an increase or decrease in reported abuses is interpreted. For example, an increase in reported rights abuses may also indicate that the programme is successful with the level of awareness-raising about rights.

The monitoring of media reach and how media have changed in their reporting of disability was identified as a challenging area for the programme to assess, again reflected in the reports and by staff interviewed. This is an area which requires further attention, as noted in the early effects section on media, as the community radio is identified as an important approach to stigma reduction.

The use of Change Stories, modelled on Most Significant Change Stories, offer an insight into what contributes to the change in stigma and contributing factors. But, in practice, these were quite ‘thin’ and commonly offered as quotes rather than material for deeper analysis of factors which have contributed to change.

In response to a recognition by Ghana Somubi Dwumadie that some of the data on stigma reduction was not being adequately captured, and/or difficulty in presenting it in the data, the programme worked with grantees to develop short videos of ‘documentaries of change’.

In the ‘unintended outcomes’ section of the quarterly reports, there was substantial reporting of appointment of people with disabilities, from both the community and OPD leadership to decision-making platforms. This appears to be a useful indicator of progress for improved disability inclusion and a proxy indicator for reduced stigma.

¹⁰ The videos for the small grantees were made available as this piece of research was completed and they were not reviewed.

4.6.3 Small grantees evaluation approaches

At outcome level, the main data collection method for small grantees was a final independent evaluation. Additionally, there was a final self-evaluation conducted by grantees themselves.

The independent evaluation of the small grants adopted a mixed methods approach for assessing changes in stigma: a document review of project reports, and a questionnaire to a sample of 159 people with disabilities, including mental health conditions.

The stigma-related survey questions focussed on understanding how the drivers of stigma were addressed: change in culture of support, including participation and engagement in work and community life, and change in use of language. It also included several questions that usefully explored internalised stigma.

A strength of the independent evaluation was that a question set was used to explore different aspects of support and language; this offered a more nuanced picture of where change is happening, from the perspective of people with disabilities, including those with mental health conditions. It was also useful to have questions on access to social protection mechanisms as a proxy indicator of improved support. The approach could have been further strengthened by additional open-ended questions to explore perspectives on how those changes may have come about. A full copy of the survey was not available, and the sampling process was also unclear, and it would have been helpful to be clearer in the reporting whether/how people with disabilities were involved in the development and/or piloting of the questions.

Each grantee was also supported to conduct their own self-evaluation. Despite the similarity in data they wanted to collect, there was wide variation in approach and quality, but all grantees adopted a mixed methods approach. One strength of the grantees' approaches was that they included 'Change Stories' from individuals and/or FGDs with people with disabilities. Whilst the qualitative information presented was limited, and these stories could have been more developed, the quotes offer some valuable insight into how individuals have experienced stigma and/or the processes in challenging stigma.

Overall, the internal grantee surveys, as part of the self-evaluations, were generally of poor quality in terms of the survey questions to capture stigma reduction and how key drivers were addressed. There was also a lack of detail about sampling, so care would need to be taken in interpreting results. The small grantee projects only ran for one year, and the difficulty of capturing changes in social norms in such a limited time period was highlighted across the evaluations. A lack of comprehensive baseline research on stigma limited assessment of the change in stigma.

4.6.4 Large grantee evaluation approaches and tools

The large grantees results frameworks detail their stigma-related outcomes and approaches to collecting stigma data. There is a common set of shared outcomes for the SBC grantees, similarly focussed on understanding change in drivers of stigma at community level, in line with the SBC strategy.

The main approach adopted to assessing outcomes is through a mid-term and final evaluation. At the time of conducting this research, the mid-term evaluation had recently been completed. Mixed methods were adopted with a heavy use of surveys and questionnaires generally combined with a small number of FGDs. In a similar vein to the small grantees, there was a wide variation in survey tools used; grantees appeared to have developed their own design and tools, with Ghana Somubi Dwumadie technical support.

The surveys mainly aimed to assess knowledge, attitudes and stigmatising behaviours of different segments of society, from the perspective of those community members. The limitation of any questionnaire which explores sensitive issues such as stigma were illustrated in one grantee's survey results. It showed 100% of community and family members stating improved attitudes towards people with disabilities, including the use of non-discriminatory language. However, the FGDs with people with disabilities portrayed a contrasting picture of still living with stigma and exclusion. The overall quality of some of the questions used was poor and/or oversimplified sometimes complex issues into only one single question. However, this example highlights the value of a mixed methods approach in disentangling the different layers of stigma, and importance of mitigating for social desirability bias.

All SBC grantees were also provided with guidance and coaching on survey tools to support the alignment of their data collection methods, but in practice this remained an area of challenge. It was noted from reviewing the reports that grantees would benefit from additional and more structured support for both analysing and presenting data.

4.6.5 KAP study

One of the other MEL approaches adopted was a Knowledge, Attitude and Practices (KAP) study conducted in October 2021. A mixed methods approach was employed to reach a representative and comprehensive sample of key stakeholders at community level. A mix of tools were used to explore including standardised tools on mental health (MAKS, CAMI and RIBS). These were adapted for people with disabilities, although adaptation process (including testing) was not clear. There were also tailored, project-specific questions which aligned with the SBC strategy on support and language.

A strength of the KAP is that it employed a mixed methods approach and employed some standardised tools that had been tried and tested previously, particularly for mental health. The questions related to disability were not as strong, and it would have been helpful to understand how they had been adapted and/or piloted. The KAP was good at providing baseline data about the low levels of knowledge on mental health and disability. But there were also high levels of reported positive behaviour towards people with disabilities, which may make it more difficult for the project to demonstrate significant change in behaviour at endline.

The issue of social desirability is always a factor in KAP surveys, and particularly for more sensitive issues, and this was also discussed as a limitation by the study author. A substantial amount of qualitative data must have been collected through six FGDs and 48 KI interviews, but relatively limited information is provided in the report, and characteristics details of that sample were unclear. Where that data was provided on the perspective of

people with disabilities, it did offer some rich insight into the pervasiveness of experienced stigma in their lives, and how that stigma is internalised.

Overall, there seemed to be some misalignment between the design of the KAP study and the SBC strategy. The section in the KAP report which talked specifically to stigmatisation was quite narrow in its interpretation of a stigma reduction process, and there was an emphasis and arguably an oversimplification on the role of changing knowledge for stigma reduction. This did not reflect the broader complexity of the SBC work. That said, the KAP was a deliverable for the programme within the original MEL design, and it was important for the project to deliver on it in a timely manner.

4.6.6 Gender and diversity

In terms of reporting on outputs, such as participation/attendance data, this has been disaggregated by gender. However, there was no disaggregation by type of disability for grantees that worked with mixed groups of people with disabilities and mental health conditions. In terms of outcome data, the employment of a gender lens was limited. Overall, while gender data were sometimes collected, there was very little or no interpretation of the data.

Qualitative data, whether captured through Change Stories or FGDs, were better suited to explain some of the more complex and intersectional experiences of stigma, which were harder to capture in tools such as questionnaires.

4.6.7 Overall grantee MEL capacity

A common issue identified across reviewing documentation and interviews was the weak capacity of grantees to develop and use tools effectively. This also included limited capacity to then analyse and present data which captures change. Whilst Ghana Somubi Dwumadie offered considerable technical support and MEL training to grantees throughout the programme, MEL was still identified as a significant capacity gap. Identification of this weakness in organisation capacity as part of initial planning, and how best to address it, would be useful in working with grantees in future.

5. Strengths and limitations of the research study

A strength of this research project was the research team, which included researchers that had strong knowledge of the local context, as well as lived experience of disability in the Ghanaian context. We worked as two teams and constantly compared and contrasted findings and perspectives across sites, during and after fieldwork, to maximise the opportunity for reflexivity and minimise bias (Darawsheh, W. and Stanley, M., 2014). In addition, we promoted an inclusive approach, for example, closely working with GFD to ensure tools and approaches utilised were accessible.

The methodology used a purposeful sample and therefore findings are not generalisable across the programme. However, we drew on experiences from across four regions,

triangulated findings between FGDs, IDIs, and the secondary data. In addition, we conducted a workshop with key stakeholders to validate emerging key findings.

When reflecting on changes in stigma, it is sometimes difficult to disentangle what has been contributed by Ghana Somubi Dwumadie specifically. For some of the SHGs, for example, these were well-established groups, which in some instances have been operating for over ten years and have been engaged in a variety of programmes. That said, the study offers key lessons to learn about stigma reduction more broadly.

There was no disaggregated data collected by the programme on type or severity of disability and so it was more difficult to draw out lessons learnt from the secondary data on the stigma experiences of people with different types of disability. We sought to address this with a balance of interviewees in the primary data collection, although people with hearing impairments were largely absent from our FGDs, even though sign language interpreters were available.

6. Discussion

A common recurring thread across the different research objectives in this study was the importance of addressing issues of power in stigma reduction. This included importance of participation and empowerment of people with disabilities and mental health conditions, combined with engagement with people and institutions of power to endorse and implement stigma reduction activities.

We showed that people with disabilities and mental health conditions actively participated in both the design and delivery of stigma reduction approaches, although this was more notable in the SBC component. Their direct engagement also contributed to increased acceptability of the stigma materials, as illustrated in the development of the language guides, where workshops enabled direct dialogue about what was acceptable between those with disabilities and mental health conditions and other stakeholders. The importance of social contact with people with disabilities and mental health conditions has similarly been shown to be an effective approach to reduce stigma in other studies (Clay et al. 2020, Smythe et al., 2020).

The study illuminated how people with disabilities and mental health conditions were also empowered through these processes to engage more on stigma reduction work. For example, people with disabilities also gained knowledge and confidence through these processes. This was not limited to the leadership roles, but also was identified as a benefit of the SHG model. The model of SHGs appeared to offer important opportunities for solidarity and psychosocial support, which also helped to address any feelings of internalised stigma. These benefits of SHGs have been shown in another study in Ghana which used this model with caregivers (Zuurmond et al., 2022). The participation of people with disabilities in decisions that affect their lives has been shown in other studies to be important since they have direct and expert knowledge of their issues and can help identify and address their unique needs (Naami and Mfoafo-Mcarthy, 2020; Vila et al., 2007).

The early evidence in the study indicates that this empowerment of people with disabilities to address stigma is not sufficient on its own. It was also about creating platforms to enable better direct access to power holders, including duty bearers, and then leveraging these people and organisations with influence to support stigma-reduction activities. The study showed that this engagement could also add to the acceptability of the material for the local context, such as additional input and endorsement from a traditional leader on locally discriminatory language before messages are then shared in the local information centre. It also could result in people and institutions of power directly engaged in implementing stigma reduction work. And where institutions adopted the stigma reduction materials in some settings, it offered a multiplier effect, and is thus more likely to be sustainable. The stronger engagement appeared possible when IAs, DCs or CVs could utilise their positions and social capital, that is existing networks and relationships of trust, to better facilitate the engagement.

The study also illuminated the acceptability and perceived importance of using enforcement of local laws to address stigma reduction. This could be traditional sanctions and/or district-level by-laws as an important tool in the stigma reduction toolbox. The traditional authorities, particularly in the rural context, are custodians of the land, with the power to apply these sanctions. That said, we also illustrated that it was not without complexities in the implementation of such laws.

In understanding the early effect of the interventions studied on stigma reduction, one key identified early effect was that of changing discriminatory language. This had been identified as a core driver of stigma in the formative research (Ghana Somubi Dwumadie (2021b)). Whilst this change in language may not necessarily translate into changed levels of social and experienced stigma, our findings indicated that there is power in a name. This was well illustrated by the woman who talked about her 'relief' and feeling more 'human' as a result of being called by her own name, rather than a 'woman with a hunchback'. This indicated the important impact on feelings of self-worth, and internalised stigma, and that addressing this can be an important stepping stone for stigma reduction. These negative effects of name-calling have also been indicated in other studies on disability in Ghana culture, including terms such as 'snake babies' (Avoke, 2002; Slikker, 2009).

The study findings also illustrated the intersectional nature of stigma, and again these illustrated layers of power which contribute to the experience of stigma. In terms of gender and disability, this was illustrated by the 'alleged witches' who are predominantly women, and their reasoning for this was in their community 'men are strong and women have no voice.' The study showed some important shifting social norms, such as women with disabilities and mental health being able to marry, but issues of abuse were also common. This reflects findings from other studies on the systemic marginalisation of women and girls with disabilities and their greater vulnerability to violence (The Lancet, 2012). The lower overall engagement of women in the stigma reduction work, and the fact that males still dominate leadership positions of the SHG and the OPDs, is also consistent with the literature in the Ghana context (Naami, 2014).

In terms of understanding differences in stigma across those with different types of disability, we showed that for those with a mental health condition, a key difference compared to other types of disability, was linked to access to medication and being able to

control their symptoms. There was also generally low representation of people with hearing impairments/deaf in stigma reduction activities, but this was attributed to a dearth of sign language interpreters which limited participation, as opposed to higher levels of experienced stigma. However, the lack of attention and importance given to address this issue by duty bearers is arguably a form of structural stigma.

Other key characteristics which the study showed contributed to the intersectional nature of stigma was living poverty, and in a rural/urban setting. In the latter, people with disabilities are more isolated, generally more limited access to services and to information. In turn, this isolation can impact on their own mental health and internalised stigma. In terms of poverty, there is an extensive body of literature on the inter-relationship between poverty and disability (Banks and Polack 2014, Mitra et al 2011, Naami 2015, Hanass-Hancock et al., 2017) and specifically on the stigma of poverty further compounding disability-related stigma (Zuurmond et al 2020).

Finally, core to effects of stigma reduction approaches, is the use of effective tools to assess stigma. The very limited outcome indicators for assessing stigma reduction have posed a challenge for understanding change in this programme, compounded by the need to strengthen the capacity of MEL, specifically for grantees. A literature review of measures of health-related stigma (Van Brakel, W. H. 2006) showed that there are a range of tools and methods which exist, but they are often condition-specific, and that instruments need further validation and adaptation for generic use. This is an area which requires further attention, in order to have tools that can assess different dimensions and the intersectional experience of stigma.

7. Recommendations

Below are recommendations for consideration in any future replication and/or scaling up of stigma reduction interventions. This builds on the lessons learnt in the research, and briefly explored at the participatory workshop.

Whilst the weight of this research was focussed on direct stigma reduction interventions, it was apparent that wider structural issues, to be addressed at a national level, are also critical to effect stigma reduction.

7.1 Future programme-level investments

- The IA approach appears to work particularly well, that is, where there is a combination of people with disabilities combined with other key community members in key roles for stigma reduction. This appears to maximise opportunities to engage with people of power at different levels. It is important to strengthen the role of people with disabilities as champions or advocates and provide the necessary capacity-building.

- Invest in SHGs as one approach to address stigma, in particular internalised stigma. Explore a cascade model that builds capacity of leaders down to SHG members. Address the issue of internalised (self-stigma) explicitly as part of any training package.
- Strengthen approaches to adapting stigma resources for people with different types of disabilities. For example, materials available in braille and easy read available for people with intellectual disabilities, as well as those with low literacy.
- Any future programme to address disability inclusion should include stigma as both a vertical and horizontal issue to address, and would benefit from one overarching stigma reduction strategy, built on a ToC. This would help align different approaches, provide clear signposting for synergy, and elevate the understanding of stigma as a key issue to be addressed.
- Further strengthen the approach to intersectionality in stigma reduction approaches. The first step is data collection, which can be disaggregated by type of disability and gender, as well as other characteristics. A gender lens used in stigma reduction programme design should include targeted approaches to increase the capacity and participation of women with disabilities, and women-led OPDs. Also explore avenues to strengthen the participation of people with mental health conditions and people who are deaf in stigma-reduction programmes.

7.2 Monitoring, evaluation and learning

- Outcome level indicators on stigma reduction could be further strengthened in any future programmes. Given the complexity of the stigma concept, and associated challenges with measurement, it might be useful to consider other proxy measures, such as improved levels of participation, or improved quality of life.
- Strengthen opportunities for learning on stigma, including the use of evidence to inform interventions.
- Strengthen overall capacity for OPDs on MEL. This should ideally include the disaggregation of data, for example, through the introduction of the WG questions and/or some measure of disability type, and assessment of level of severity of disability, in addition to gender, age and other measures.

7.3 National level

Continue to promote the research findings on the mental health needs, and the associated stigma, of deaf people. This should include strengthening approaches that improve access to improved communication, including use of sign language. Consider the use of deaf peer interpreters and explore IT-based solutions which could go some way to support individuals and families, where stigma can be exacerbated by isolation, particularly in rural areas.

7.3 Research

- Build in longitudinal research to better understand stigma reduction over time, and factors that contribute to or impede change.
- Conduct further research on the intersectional experience of stigma and disability. This should include understanding on abuse and abandonment experienced by women with disabilities.
- Deepen the understanding of the linkages between stigma and access to medication and treatment for people with mental health conditions.
- There is a need to better understand stigma by association, for example, the stigma experienced by female caregivers, and by health staff, and the potential for expanding their role in addressing stigma.

8. Conclusion

In conclusion, this piece of implementation research examines five key areas of implementation of the stigma-related work of Ghana Somubi Dwumadie, focussing on lessons learnt on participation, coherence, acceptability, monitoring and evaluation, and gender and diversity. It also then examined early effects. Summary findings are presented in the Executive Summary and there are also a set of recommendations presented at national, programmatic, MEL and research levels.

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10. List of appendices

A separate appendices document can be requested from Ghana Somubi Dwumadie, Sightsavers or Tropical Health, which includes:

Appendix 1 – Awarded grants factsheet

Appendix 2 – List of documents reviewed

Appendix 3 – Sample

Appendix 4 – Research matrix

Appendix 5 – IDI topic guides

Appendix 6 – FGD topic guides

Appendix 7 – Preliminary findings workshop

Appendix 8 – Ethics approval letter

Appendix 9 – ECH protocol consent form

Appendix 10 – Grantees MEL tools summary

Appendix 11 – Characteristics of IAS, DCs and CVs