BasicNeeds
BasicRights

community my community

BASICNEEDS REVIEW

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The BasicNeeds Review

D.M.NAIDU

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vision and mission

Children at a relief camp after Tsunami, Weligama, Sri Lanka DHARSHANA KARUNATHILAKE

Our vision is that the basic needs of all mentally ill people throughout the world are met, and their basic rights are respected.

Our mission is to initiate programmes in developing countries which actively involve mentally ill people and their carers and enable them to realise their basic needs and exercise their basic rights.

This edition of the BasicNeeds Review focuses on community. We work among communities where the very survival of most families is in doubt. They have hardly enough to eat and, in that situation, long term mental illness in the family makes life just that bit harder. If the community does not understand mental illness, it is quite likely that the mentally ill person and his family do not understand it either.

BasicNeeds addresses both people's mental illness and their poverty to enable the achievement of a sustainable recovery.

Our work is based on the philosophy of building inclusive communities where mentally ill people and those with neurological conditions such as epilepsy, through development realise their rights.

messages

Working with some of the most marginalised members of the community this past year, Basic Needs has seen continued growth and development. Familiarity of their own home, village and environs plays a significant role in the recuperation and rehabilitation of mentally ill people. Appropriate medication combined with pastoral support has proved to be life changing for the 17,173 mentally ill and an estimated 85,865 carers with whom we worked in 2004. We now work in Ghana, Uganda, Tanzania, India and Sri Lanka and we welcome a growing number of partners in each of these countries.

The introduction of urban projects was a new development during the year. The model for mental health and development is proving to be effective in both urban and rural settings, meeting the particular needs of both communities.

The shocking effect of the Tsunami of 26th December, 2004 saw our Sri Lankan colleagues move into rapid action. Chintha Munasinghe's superb leadership and the swift response of our staff, associates and volunteers gave unexpected new dimensions to our work. While many NGOs responded immediately to the material needs of those affected, we provided practical emotional support, an element we feel sometimes tends to be left out of traditional responses to international disasters.

I end this year with continued admiration for our staff and colleagues who do such important work on the ground. We have a model that works and which helps to fill a gap in many communities. We have achieved a great deal; but much more remains to be done. The year ahead will see us continuing to measure and monitor our work and reflect on good practice. It is only through this process that we can ensure that we are working to the highest standards in the most effective way with those who need us most.

Amelia Fitzalan Howard

A positive response from the community is at the core of our programme. It is the community's understanding of mental illness and their favourable response that contributes to the healing and well being of vulnerable groups.

When mentally ill people are included as members of self help groups that access government benefits and when associations of carers are formed to address issues of mental health at local level, we see the evidence of community response.

" Half of my village and most of my family members and relatives know now that my illness can be treated and that people like me can be cured" says Sachdev, from a remote village in Jharkhand, one of the poorer states in India. Such statements show us the efforts of our staff in the field who have spared no pains to create awareness of the human rights issues of mentally ill people.

Basic Needs has worked creatively, in the face of many odds, to create this environment in communities. New initiatives in urban slums and the sensitising of various groups at different levels in different parts of the country are some of the contributory factors.

We look back with a sense of gratitude and with tremendous appreciation for those who have enabled the support of over 5429 mentally ill persons and their carers in India. We are especially grateful to BasicNeeds programmes and partners worldwide, to all our staff and to all those who are associated with BasicNeeds India. We are constantly aware of our strength in being part of a global family.

Valli Seshan

From the Founder Director: Chris Underhill

Each of our reviews, published annually, tell the story of our organisation set against the backdrop of a particular theme. The first published in 2003 focused on the *Model for Mental Health and Development* which is the centre piece of much of our work in the field. In 2004 we took up the theme of the *Right to be treated to be treated right* since the rights of mentally ill people are predominant in our thinking.

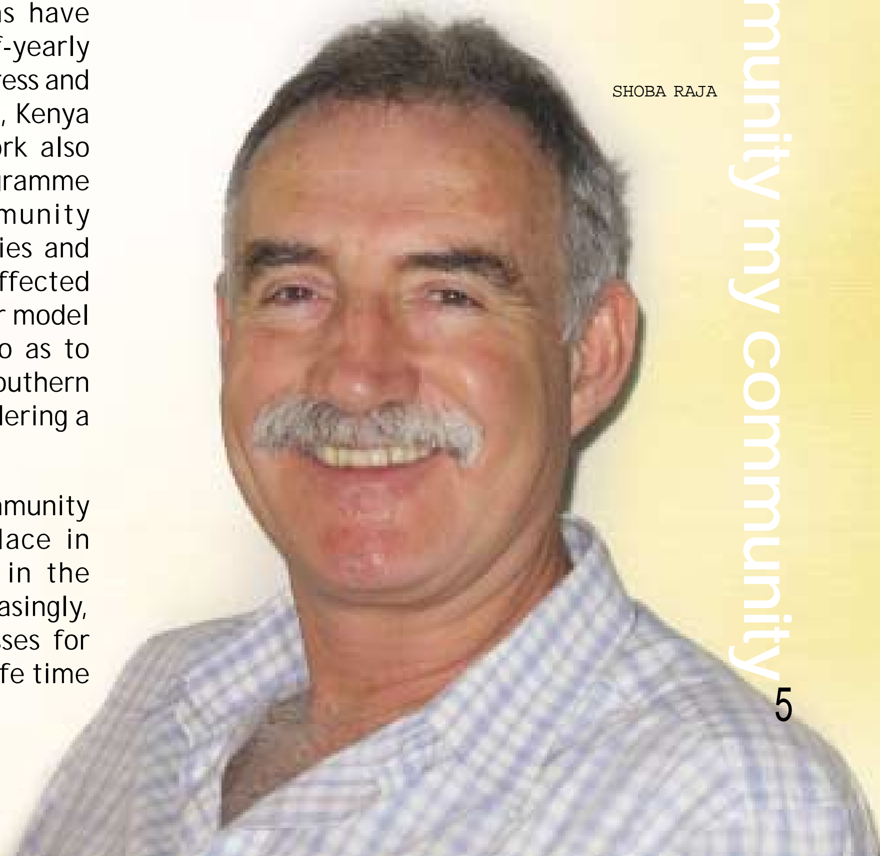
This current edition of the BasicNeeds Review is an examination of our work with mentally ill people set against the theme of community. We describe the work that we do and report on the inevitable ebb and flow that occurs within communities, as people with mental illness and those with a neurological condition such as epilepsy are ejected from their community and then, with heroic effort, struggle once again back to acceptance. I introduce the theme overleaf by talking about one man, Adam, using an example drawn from our work in Tanzania so as to give an insight into how this ejection / acceptance mechanism seems to work.

During 2004 the number of people we serve directly in the global programme has risen to 17,173 comprising of 63% mentally ill people and 37% persons with epilepsy. Urban community based work now runs along side delivery to rural communities in four out of the five countries we work in, these being India, Sri Lanka, Ghana, Tanzania and Uganda. Internal quality management systems have been laid out comprising monthly, half-yearly and annual procedures for tracking progress and new work is being developed in Lao PDR, Kenya and Northern Sri Lanka. Our new work also includes an international training programme which will initially focus on community practitioners wishing to support families and community volunteers in the Tsunami affected region. Meanwhile we have adapted our model for mental health and development so as to support internally displaced people in southern and northern Sri Lanka as well as considering a programme in Teso region, Uganda.

Enabling access to treatment in the community continues to occupy a prominent place in implementation and 92% of people in the programme now have treatment. Increasingly, strategies for sustaining these processes for access to treatment, well beyond the life time of particular programmes, are being built into operational design. To enable this sustainability a policy of always working with governments, though at times demanding, is proving to be very worthwhile. Wide treatment coverage has brought an appreciable measure of stability to 57% of affected people within the programme. Some 7,022 (41%) people are involved in livelihoods: 13.5% are now able to earn income and another 27.5% are making a significant contribution to their homes and communities.

Listening to mentally ill people is a central part of our value set, and during 2004 one hundred and two field consultations and focus group discussions with mentally ill people and their carers were carried out. In addition, 421 training workshops for partner staff, health service providers, government officials, medical practitioners, community leaders, and elected leaders of local governments were also undertaken, meaning that overall approximately 20,206 key stakeholders from the community were capacitated through the worldwide programme.

This review *Community, my community* brings to life the struggle of mentally ill people and the commitment of our donors to them. It evokes the passion of our numerous partners and the hard work of our staff, associates and volunteers. To all these stakeholders I offer my sincere thanks.



SHOBA RAJA

community, my community

Chris Underhill

ADAM YAHAYA DOKURUGU

Mentally ill people and their carers queing to see a psychiatrist in an outreach clinic at Bolga, Ghana

To be cast out of your own home and the community you belong to for being mentally ill is a sentence to destitution, and often a sentence to death. Adam of Mtwara Province in Tanzania started to live rough about twenty years ago. He left his family and began to drift a little. He was deprived of his family and they were deprived of him. The parting involved incomprehension, an inability to care for his family and their inability to care for Adam. It was not a physical distance that lay between him and his family; rather a social one since all the protagonists still lived quite close to one another. And so, alone and very ill with schizophrenia, Adam survived in the bush and his family lived in the village.

It is not possible to imagine how he coped, foraging for food and putting up with the casual cruelty he was subjected to. Perhaps

Mental health day celebrated by community members at Newala district, Tanzania

PROSPER MSUYA

Cllr Ngugu, a retired military man, was not as frightened of Adam as others were. Cllr Ngugu had already started to leave a little bag of cooked rice by the roadside for Adam to find and eat. However, it was not until Ngugu heard Magawa Abdallah, our Programme Manager, and his colleagues talk about mental illness at a local leadership information session that the "penny dropped". To his eternal credit Ngugu cycled promptly to inform Adam of what he had learnt. Even if one is destitute and ill, one gets used to a place and a kind of life. So Ngugu's words must have come as a shock when Adam realised that he was being asked to leave his place in the bush and to come and live with the Councillor and his family.

Adam's illness was diagnosed as schizophrenia and his recovery, though not without problems, has been remarkable. Quiet and very stable, he now lives happily at Ngugu's home and meets regularly with his own family, who increasingly recognise him as one of their own. He has held his grandchildren. The little ones have held their grandfather. When Adam lived in the bush neither party knew of the other.

I sat with Adam and Ngugu in the evening sun as they told me the whole story. I saw the incomprehension of the villagers. I could feel the closing of the gates as his family, his community, cast him out. I could see his own family unable to cope, feeling hurt at the effect of the illness, not sure what to do. Miraculously, I could also see the community responding in equal measure to

Adam Mohammed with his grand-children, Tanzania

Ngugu's leadership and the changing fortunes of Adam's health. Finally, the change in his own family and the meeting with his grandchildren.

Information, leadership and treatment seem to be the key factors which bring about change in the two states of relationship within the community. There is also the important factor of commitment. The effect of mental illness in Adam's case was withdrawing his interest from family, community - his whole world. Against the backdrop of the community's poverty, his family and his world also withdrew their commitment. This lasted for twenty years. It is one thing to increase the ability of the community and its leaders to understand, but it is another thing to provide the opportunity to receive the all important treatment. In the end, however, it is not the treatment that finally makes the difference; what really seems to make the change is when the mentally ill person puts something back into the community. Then they accept you.

If you are two grown men riding one push bike you would have thought it hard to maintain your dignity! But in this case you would be wrong. Luckily Ngugu's bike is very strong and sturdy and it easily took Adam in front with his feet on the pedals and Ngugu behind. The shadows lengthening, they gave a casual wave and majestically wheeled out on to the dusty path and weaved their way between the little houses of the village.

Adam and Ngugu have lessons for us all. Watching them go, I realised that these two friends had taught me a great deal about the community, my community.

Mental Health and Development model of BasicNeeds

Capacity-building:

Supporting mentally ill people and their carers to actively participate in consultation workshops and self-help groups; institutional strengthening of community-based partner organizations on a range of aspects required for the sustainability of the programme.

Community Mental Health:

Mechanisms developed for easy access to mental health services by mentally ill people.

Sustainable livelihoods:

Once feeling more stable, many mentally ill people return to the work that they were doing before they fell ill. After a while some of the participants in the programme join formal savings and credit schemes along with other members of the community.

Research and Policy:

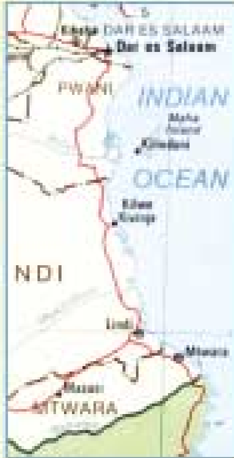
Understanding the context within which the programme operates, with the involvement of all the stakeholders, so as to build an information base to represent people who are mentally ill.

In order to place the voices of mentally ill people at the centre of the narrative, a series of life stories as related by them has been developed. These narratives will contribute to our collective body of knowledge and will be published with consent at appropriate times.

Management and Administration:

Administering the programme with the active participation of partner organizations in planning, implementation and monitoring.

tanzania



- **6408** mentally ill people served
- **80** mentally ill people are engaged in productive work, of whom about **78%** have started earning income
- **07** delivery partners
- **03** resource partners

MAKENE MALEMBO

Working in the community, a clinical nurse taking history of a patient in the community at Masasi, Tanzania

Listening to mentally ill persons and acting together with the community to create positive changes is the mainstay of the BasicNeeds programme in Tanzania.

One may find it surprising - the extent to which the mentally ill voice the grievances and issues they have been going through in their daily lives. Equally significant is their readiness to act collectively to bring about a change in their lives, underlining the need for communities to work together with mentally ill people.

A fundamental weakness in institutional based mental health services is that it undermines community involvement in caring for mentally ill people while at the same time reinforcing stigma and isolation.

"Understanding the social context and managing psychiatric illnesses within context is a key to recovery of mentally ill persons" says Dr. Johnnson Hauli, retired senior psychiatrist.

Now he works with BasicNeeds treating mentally ill people in communities, joining a panel of freshly trained general health workers to diagnose and prescribe drugs to mentally ill people in outreach clinics. Over 700 have been treated by him. He has also given the chance to health workers to undergo training, at times working continuously for over ten hours, both at Nanyamba and Lubangala clinics in Mtwara Region where the majority of our work is.

The importance of treating mentally ill people in the community was revealed forcibly when on March 17, 2004 a multitude of mentally ill persons and their carers were consulted by BasicNeeds, Tanzania:

JOHN KILAWE

Chris, Dr. Mbatia and BasicNeeds Tanzania team in meeting with mentally ill people, carer and village leaders at Masasi district, Tanzania

" Never has anybody asked for our opinion before. It is only today that we have a chance to talk to you..." said Esha Ismail, a forty five year old woman who has suffered from schizophrenia for the past fifteen years.

" See the chain and shackles in my hands and legs. I want to see the shackles and chains out of my hands. How can I do any work when my arms and legs are tied? I need treatment. Not chains!" Juma Ali Livinda, a mentally ill young man who was brought to the consultation by his brother.

"I feel so bad that I don't achieve what I have always wanted. This is because when every time my examination approaches, the illness starts disturbing me continuously... which has made it difficult for me to achieve my expectations. I am determined to pursue my studies if I am given one more chance." Pill Akili, a 23 year old girl.

The mood among mentally ill people was clear. They wanted the community's care and concern, for the community to work together to address age old stigma towards mental illness.

The change in the nine months since the first consultation is hard to believe. When we met some mentally ill people to document their life stories, they voiced the changes in their lives. We travelled far into the interior to see the quality of changes which the programme has brought to the lives of poor mentally ill people.

We meet Ali Livinda, an energetic, gentle man, living in a small mud house. This is the same man we met nine months ago at our consultation. It took me a while to recognize him as the man with shackled arms and legs.

Oh, yes, he is the same. But now he wears a big smile as he shook hands with us. Only the

JOHN KILAWE

Women carers in a discussion during a consultation meeting at Nanyamba ward, Mtwaral rural district, Tanzania

scars on his legs and arms remain now, no chains.

"I am out of chains now. It is because of the drugs I am getting at Nanyamba health centre. I can't believe what has happened in my life!" says Ali.

He is now independent, and works daily in his cashew farm.

Thirty six year old Somoe Abdullah has been mentally ill for the past 8 years. Her father travelled 150 kilometres to Mtwara regional hospital to collect her anti psychotic drugs for her. "It used to take four days at times to find there was no medication. Now I can get the drugs in the nearby heath centre, just 5 kilometres from our house... Somoe is stabilized now and is rearing a goat."

BEN MISSAN

Mr Emanuel Achiula , the district mental health coordinator for Masasi taking patient history in the community at Mwenge village, Tanzania

Magawa facilitating Training of Trainers programme on mental health case management and development on April 2004 at Mtwara, Tanzania

MAKENE MALEMBO

There is Abdallah Maulid, forty five years old and mentally ill for 8 years. His sister was his carer but now she is released from caring for him as she has accessed treatment and he can care for himself and even rear his goats. He has since married and is now a happy man.

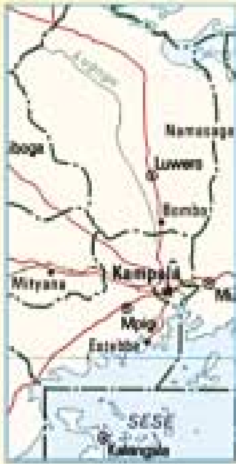
Observation:

Staff are encouraged to document their work as can be seen in this contribution from the team in Tanzania. The change in the lives of individuals such as Juma Ali Livinda is very powerful. As is the contribution of individuals to the greater good whether it is Somoe's father or Dr . Johnnson Hauli. The Tanzania Programme is managed by Magawa Abdallah.

NEW DEVELOPMENTS (LAO PDR AND KENYA)

We are looking forward to working in the informal settlement of Kangemi, Nairobi, Kenya and with a number of municipal districts within the capital of Vientiane, Lao PDR and will be reporting on their progress in the next Review.

uganda



- **110** mentally ill people served
- **68** mentally ill people are engaged in productive work of whom about **93%** have started earning income
- **03** delivery partners
- **02** resource partners

TINA NTULO

Leaders consultation in Kaseta Hoima District, Uganda

In starting our programme at local level in Uganda, local council chairpersons, the secretary for health and community health workers and other community resource persons were asked three questions:

- what is your understanding of mental illness and mental health?
- how is mental illness treated in your community?
- what else can be done to assist persons with mental illness?

The objective of this process was to ensure community acceptance of this programme through its leaders - vital in implementing a community based programme and ensuring its sustainability.

One participant speaks up and says of mentally ill people : "We take them to the witch doctor or the traditional healer, we take them for prayers in the church, we try to talk to them and comfort them. If this does not work, we tie them up with ropes for their own safety..."

To take an example from out work in Kaseta-Hoima district we begin the process of choosing a Village Health Team or VHT whose role will be:

- to identify mentally ill people
- to follow up treatment of mentally ill people in their homes
- to educate the community that mental illness can be treated and that such people can be useful to society once they are treated.

We add to the team people like the local council Chairperson to ensure that the community plays an integral part.

Tina talks about mental illness to Leaders of Amuria camp Katakwi Dsitrict, Uganda

JULIUS KAYIIRA

In Sembabule the VHT confesses that, even during their training, they did not believe that mentally ill people can really be stabilised. After identifying and bringing mentally ill persons to the clinic they are amazed at the speed of recovery.

"A kid that I introduced to the programme has now gone back to school." says one VHT member.

If the heart of the process is the consultation of mentally ill people and their family and carers, then one of the most important regular activities are the monthly mental health clinics held in the village clinic. Members of the community and local health staff are deeply involved. Community members watch treatment being given to those with epilepsy and others with mental illnesses.

Hanifa now manages her schizophrenia. She once used to walk around naked shouting at people but now she tends her garden:

"When I would fall sick my husband's other wives used to raid my garden and when I would recover I had nothing to eat. My husband used to beat me up and even send me away to relatives. Now I am better...if I decide to go away I carry my medicine with me".

News comes to the community that the clinic provides free drugs from the district. This makes a huge difference which we see played out in the life of Hanifa. With each passing month the village health teams and the development staff learn to "care more about more". But of course they face problems :

"My patient does not have parents; the drugs weaken him. I am afraid he may be relapsing

TINA NTULO

Leaders consultation in Kaseta Hoima District, Uganda

because he has started shouting – I do not have transport to keep supervising his progress" says a VHT member in Semabule who badly needs a bike to transport him to the village patients.

"I will not continue to take the tablets because I am fine" said a patient to a VHT member who was rightly afraid that the patient might suffer a relapse. And from Sarah Kutta, staff member KCCC, our main partner organisation working in Kamwokya which is a big urban slum:

"We spent the whole day looking for this mentally ill person's house. In the end we discovered she could not remember her family and had to refer her to Butabika Hospital" (Uganda's main mental hospital).

There is positive change of attitude amongst development staff at grass roots level towards mentally ill people:

"When you spoke to our staff about the mental health and development model and said that we will have a consultation workshop within mentally ill people and their carers, we said to ourselves this woman must be crazy!"

"But on the day of the consultation we saw with our own eyes that truly mentally ill people are capable of discussing things that concern them."

BasicNeeds works to the Model for Mental Health and Development and this always starts off in a particular community with a consultation with the mentally ill people and their family members. This idea of talking to mentally ill people straight about their issues and ideas is unusual. Understandably the VHT partners and volunteers are not sure if mentally ill people and their carers will attend the meeting. We stress the need to listen to the mentally ill and their carers. After some time the people are relaxed,

TINA NTULO

A group of women discuss mental health at Okubu camp Soroti, Uganda

laughing and mentally ill people begin to open up and for example, Mulasa, a man from Kamwokya slum, speaks about the insults he has to endure from his neighbours.

Consolata shares her need to have her children, who care for her, trained so that they can understand when she is ill and when she is not:

" I feel bad when people out there laugh at me and call me names mulalu (mad person)...but when my children insult me and call me mulalu or ignore what I am saying...I feel worse...having a family member insult you is very painful..."

At the end of the meeting we share a meal together and mentally ill people and their carers go home, glad that someone has listened to them. Community members who were hanging around approach us and ask, almost ashamed of their actions, " you mean mentally ill people can remember when they are abused?" Food for thought.

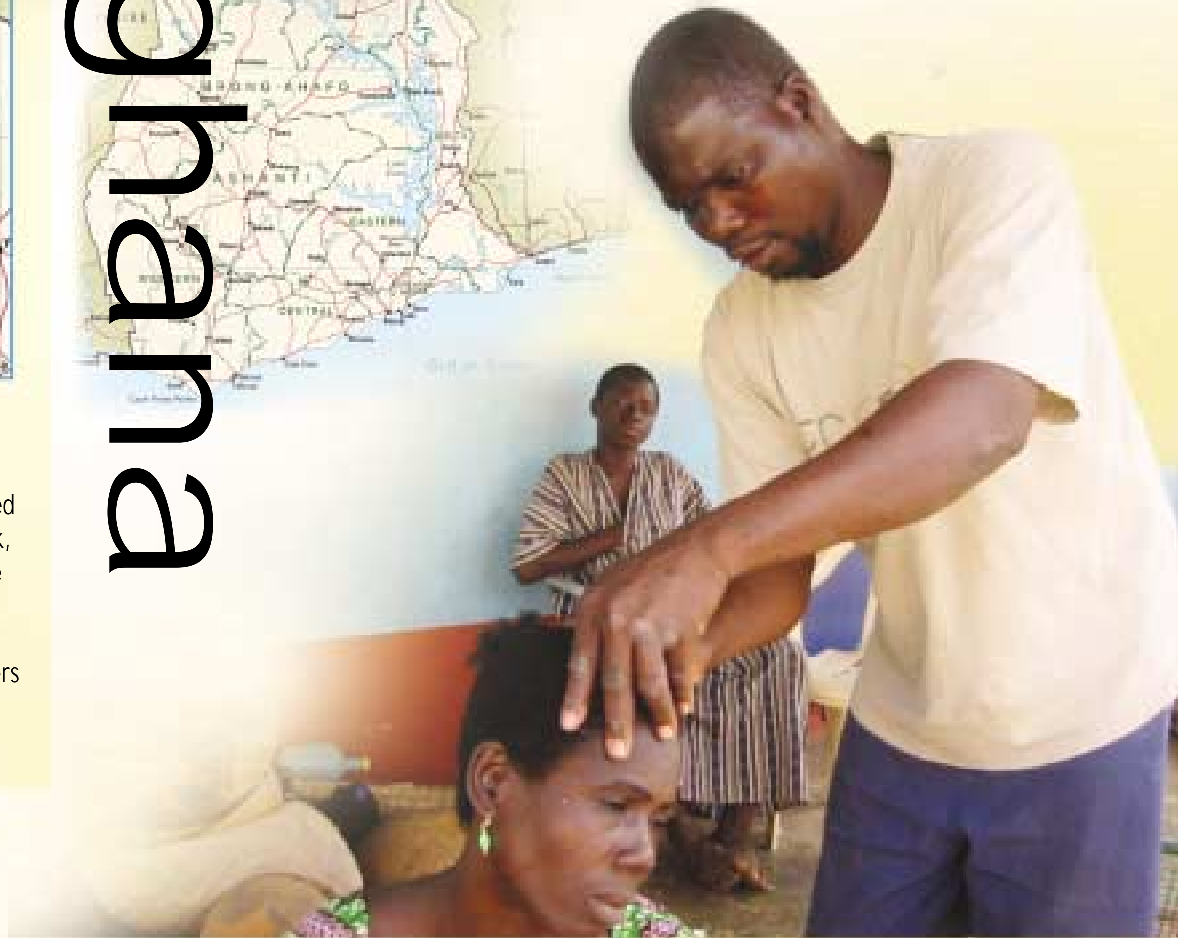
The community is beginning to accept mentally ill people in all the districts where the programme is being implemented. Mentally ill peopel in Sembabule have even started attending local council governance meetings. They are beginning to see that there is hope.

Observation

At first, people from the community, like the village health teams, do not automatically believe that mentally ill people can be consulted or that they will give cogent views about their future treatment. Involvement in the daily lives of mentally ill people is a good way to understanding them better, and hearing them describe their suffering at the hands of the community is very thought provoking for all. The Uganda Programme is managed by Christina Ntulo.

northern ghana

- **3932** mentally ill people served
- **3705** mentally ill people are engaged in productive work, of whom **20%** have started earning income
- **02** delivery partners
- **02** resource partners



SAYIBU MONTIA

A traditional healer performing a purification ceremony to discharge a mentally ill person after treatment in Ghana

During 2004 Ghana has progressed considerably in integrating community mental health into primary health care. Mentally ill people have been consulted and regular home visits have encouraged people to support mentally ill people and their carers to talk about their condition, their problems, hopes and aspirations. They have begun to realize that within the community they can achieve their objectives

Health workers of the Ghana Health Service, ministries, departments and agencies as well as local partner NGOs and traditional healers have all combined to take our work forward, to do that just little bit more for the poor with the double burden of poverty and mental illness. Attitudes towards mental illness are changing and here are several examples drawn from our recent programme experience:-

Working with Traditional Healers

Most mentally ill people in BasicNeeds' programmes have generally met a traditional healer of one kind or another before entering the programme. Mma Mayiya is a woman traditional healer renowned for her prowess in healing mental illness. She has a no nonsense stance towards aggressive or violently mentally ill persons. The burly young man assisting her will hold the patient while she caned, shackled and locked away the patient to calm him.

She was one of the first traditional healers to participate in the maiden consultation with traditional healers organised by BasicNeeds. The consultation and follow up interactive programmes helped to reorient Mma Mayiya on the human rights implications of such treatment. BasicNeeds also facilitated

CMH Officer, Adam Yahaya Dokurugu writing the discussions of mentally ill people at a community consultation session in Bolga, Ghana

AHMED ABUBAKAR (CLIFF)

training of traditional healers on more effective and humane ways of handling violent patients through the Community Psychiatric Nurses of the Ghana Health Services.

"This was an eye opener for me. I started inviting Madam Amina (a very senior psychiatric nursing officer) or one of her staff to inject patients so as to calm them down for treatment. They also give them tablets to take daily and this makes them sober. After going through my herbal treatment for some time, they get well and return to their homes..." says Mma Mayiya.

She is not the only one. Many traditional healers have improved their ways of handling mentally ill people and have gone even further so as to integrate their practice with the practices of the Community Mental Health Care of Ghana Health Services.

Community Involvement

After a community consultation in Bolgatanga, one participant said that the community must sit up and support Abagna, a mentally ill woman in his community.

"We must not wait for outsiders to treat her" he said.

There were many who agreed with him after the consultation. When we visited Abagna we found that this one man's words had echoed through the community's resolve to do something about mentally ill peopel in his village.

Abagna herself commented "My cousins came that night where I was sleeping in a dilapidated building and asked me to follow them home. I ignored them because I felt that they were only going to tease me. But no. This time it was a compassionate appeal unlike previously. I

ADAM YAHAYA DOKURUGU

Peter Yaro, Programme Manager, Northern Ghana interacting with staff at the Community Psychiatric Unit in Tamale, Ghana

followed them home and was invited to eat in the compound with them and after dinner I was invited to sleep in the room…"

Abagna continued "For the first time after my illness my uncle spoke to me…I was asked to bathe and given clean clothes…my nephew took me to the specialist psychiatric outreach clinic…the doctor spoke to me kindly and I told him how the people harass me…he said I was all right and gave me some drugs to take."

In another consultation Alhassan Yasif told his story, "During my illness most of my friends left me, even those I had helped when I was well would not even come near me. I was so alone. My uncles sold my property and claimed that they used the money to treat me. In fact someone else now owns that land. What a world!"

"Now I am part of the community and I earn and support my family. For long I was sidelined in decision making. Now after the way BasicNeeds staff visit me and treat me, I am part of the community and I am fully involved."

"I feel I am part of my community now, maybe because I earn and can support my family… I am involved and participate in decision making. The way BasicNeeds staff treat mentally ill people has made the community want to get close to me and some people even confide their problems in me – at every opportunity I tell them that BasicNeeds have made me what am today…" Mohammed Alhassan, now a bicycle repairer.

Professional Matters

Dr Samuel Allotey, Chief Psychiatrist, at his maiden outreach clinic in Bolgatanga says:

"I see 311 cases a day which tells me how badly psychiatric services are needed in this

Community Drama at Savelugu Nanton district sensitizing the community on the need to treat people with mental illness with respect and love organised by our Advocacy Partner - Gubkatimali Society, Ghana

AWULATU INUSAH

part of Ghana. I face the challenge of wanting to do something for these patients, particularly those suffering from alcohol related mental illness and epilepsy which is very high here."

Awolu Ziblim is stabilized and back to his work as a Tractor operator at Gushiegu, Ghana

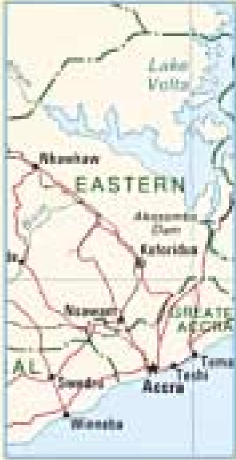
ADAM YAHAYA DOKURUGU

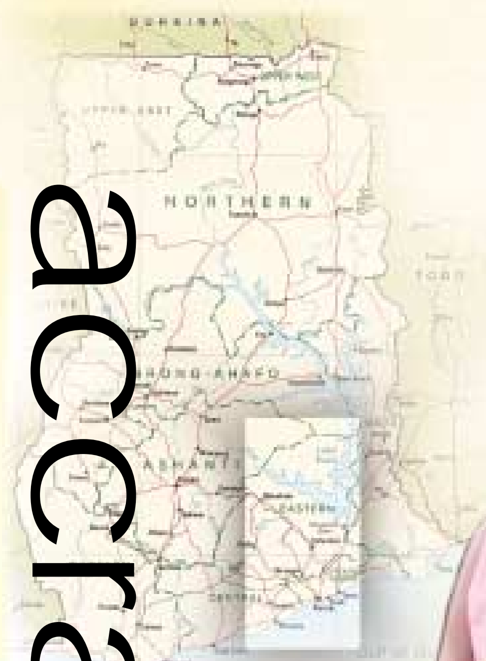
Alhaji Issah Salifa from a partner organisation to BasicNeeds, Northern Ghana, observed "One of our donors was very impressed with our success in the micro credit scheme with mentally ill people. They were full of praise and commended us for going into such a new but necessary area of development..."

Observation

The Northern Ghana programme is now reaching out from northern region to the other two regions of what constitutes the "North". This is a huge geographical area and we very much value our partners' support in making access to mentally ill people possible in such a demanding terrain. The programme manager for Northern Ghana is Peter Yaro.

accra





HUMPHREY KOFIE

A mentally ill lady proud of her appearance

Lance Montia, Representative, and Beauty E. Agbavor, our Associate for Communications, report on the realities of consulting mentally ill people in the big city of Accra. Beauty writes:

What a challenge it was, we stared at one another then Lance said, "We can not get a circle in here, how do we see one another during the consultation?" There was silence for a period then frantic activities began. Dusting and moving of the pews.

Our first urban consultation in the Ashiedu Keteke sub metro area was held in Bukom, a slum of the capital city. The densely populated area has a high level of illiteracy with fishing as its predominant occupation. We had to make do with the only available venue, a dilapidated chapel in the heart of the community.

Our early arrival, following the feedback we received from our contact person about the venue, enabled us to get our therapeutic circle. Oh No! Not this time, rather than a circle it was a square. We heaved a sigh of relief, hoping the worst was over. Little did we know that quite a number of surprises were in store for us!

The first to come was the fact that the windows on the eastern side of the chapel opened into our neighbour's courtyard and forced us into participating in their daily household chores and quarrels. Whilst the western end opened into a busy pathway attracting a number of intruding passers-by, who were eager to either satisfy their curiosity or while away the time with unwelcome commentaries distracting our attention.

JERRY BROWN

Mentally ill man saying sorry for coming late

About an hour into the programme, we heard a blast of music so loud that it was difficult for us to hear each other! Thus, we went out and discovered that the noise came from a record seller who could only attract his customers by playing the music loudly. After dialoguing with him, we had to pay him to keep the music low until the end of the programme.

In addition, we had most of the mentally ill people and their carers arriving late. Coming from various locations within the sub metro, most of them had to wait in long queues to take "trotro" (the local name for commercial mini buses) since walking to the venue could be risky or stressful for them. This made the consultation start some 40 minutes late. They kept trickling in even after the programme was well under way forcing us to pause and introduce them to the group from time to time.

The participants, though embattled with poverty just like their rural counterparts, were decently dressed. We later discovered that some of them had some support from a few charitable organisations such as Catholic Action for Street Children. We also had to manage the ethnic mix of the participants thus making it necessary for translations from English to Ga, Hausa and Twi. Lance, the animator, doubled as an interpreter.

What was really encouraging however, was that the consultation brought together a number of health professionals, together with mentally ill people and their carers. It even made it possible for several policy makers to attend. Present at this meeting were two important personalities from the health

JERRY BROWN

Darleen thanking Lance for the consultation Meeting

JERRY BROWN

Asiia Kalidu can only understand Hausa

Observation

This major programme working in the whole of the Accra metropolitan area represents a substantial investment in urban community mental health services. BasicNeeds now works in the cities of Kampala, Dar es Salaam and Accra in Africa. Next year we will also report on a new programme in Nairobi. By the end of 2006, more than half the world's population will be living in urban areas, it is important for us to be able to report what this means for mentally ill people. By the end of 2006, BasicNeeds will also have important programmes in Bangalore, Dhaka and Vientienne. Lance Montia is our Representative in Ghana.

sector: the Deputy Director of Ussher Polyclinic and the Deputy Director of Nursing Services, Community Psychiatric services.

Working in an urban environment is going to bring BasicNeeds many issues. Members of the community are well informed compared to many people in rural areas. Community leaders have strong opinions such as opinion leader Mr. Issah Kalamulah, who forcefully expressed his misgivings about our credibility following their local experiences with other NGO's. According to him: "People always come here and give us all the promises of helping us. They take photos, write our stories and unfortunately we never hear from them again. What makes you so different from the rest? Who do we hold responsible when we don't hear from you?" When we assured him of our integrity and said we would deliver on our promise he remained unconvinced and said, "I will wait patiently and see what happens."

Driving back from the meeting, we were convinced that poverty and poor services in urban areas are truly understated. Just like our rural programme in Northern Ghana, access to treatment for mentally ill people in their own community, poor sanitation, lack of practical sustainable livelihoods, and the effects of stigma all seem to be very apparent.

Darleen Ankrah a divorcee had this to say, "People still think I am sick because of the epilepsy. They call me a mad woman. I used to sell post cards and stationary but now I cannot, due to the stigma. I know how to sew things, so if I can get a sewing machine, I can work from home."

policy and research

The Policy and Research Manager working with staff on the BasicNeeds Strategy for Africa due out in 2005

AHMED ABUBAKAR (CLIFF)

Shoba Raja, Programme Manager for Policy and Research, writes about the BasicNeeds approach to community based research:

Close your eyes and travel far away to a tiny village in the south of Sri Lanka. There a group of men and women dressed in colourful clothes, some of who are mentally ill, gather at the local Buddhist temple in animated discussion. One of the group members is clearly helping the others to stay on course. Another is writing rapidly…

Now travel further again to Nakasenyl, a village in rural Uganda. Here another group of men and women, some very tall, dressed in attractive clothes, are in a small simple church. Again, some of this group are mentally ill. They are all seated on low benches, working on big sheets of paper with brightly coloured thick pens. An attractive smartly dressed young woman walks around gently guiding the group to keep focus.

All these people are, believe it or not, researchers! At the centre of their own enquiry they are the protagonists of a research endeavour spread across South Asia and Africa. In these groups there are mentally ill people, their carers, family members, volunteers, leaders, traditional healers and field workers. They live in poor communities where BasicNeeds has initiated mental health and development programmes.

As we catch them at work they are analyzing their own problems and needs and they are also assessing the practical solutions the programme brings including the mental health services they now get.

Life Stories : chronicling change

DHARSHANA KARUNATHILAKE

Life stories are a vital part of BasicNeeds Policy and Research Programme. They are untold stories of people with mental illness from the poverty stricken areas of Africa, India and Sri Lanka. Collectively they give the views, perceptions and experiences of mentally ill people and others important in their lives - a rich mine of insights.

BasicNeeds staff disperse into the community areas initiating processes for recording the pulse of the people's lives, their hopes and despair, their struggles with mental illness. A majority ultimately do triumph over it with treatment. This brings about remarkable transformations - mental well being, a revived capacity for work, the respect an income commands, the weakening hold of stigma. Life stories chronicle this human experience tracking change in an unexplored world.

" I believe there is hope for the future, I am simply happy to be well," says fifty five year old Fati Abukan from Tamale, Ghana, now committed to treatment and acknowledging its significant role in her restoration and positive energy which has made it possible for her to be back at work, trading in ground nuts and shea butter.

Observation:

Life stories have been one of the most powerful ways of influencing many people as to the importance of the situation of mentally ill people. Our life story project is managed by Lakshmi Mohan

They have been recording their own data collected in individual files, their life stories, process documents and they now bring these different elements to life by analysing, by understanding, what this says about their illness. The phrase *their illness* of course is simply a short hand for so many different elements: their treatment, improvement, hopes for recovery, getting back to work, earning money, gaining their dignity and, most importantly, earning back people's respect.

Of course interesting as this is, it is not merely the end result but also the process that is capacitating and empowering. People with mental illness and their families are keen and enthusiastic and mostly, they think it is worth the time and effort.

How does this research help mentally ill people?

- Being part of the research process and the production of its findings and recommendations equip them to inform and spread knowledge about mental health and mental illness.
- The information they gather brings up hard facts and more importantly, it brings insights that tell the truth about the realities of their lives.
- Realities that tell how services, policies, practices, resources actually work for them or don't.

In short this process redefines how to research and who should research to inform governments and other important

IRENE AMONG

Mentally ill people, carers and members of the village health team, during a participatory data analysis session in Nakasenyi Sembabule District, Uganda

people who make policies on mental health.

Part of a BasicNeeds Manager's job is to produce convincing data about the progress of their programme and that of the mentally ill people whom they serve. The Policy and Research Programme works to support country programmes to develop ways of making inclusive research possible. Training in research at different levels within country programmes leads to testing or piloting practice in the field areas.

The BasicNeeds team is small and is spread across five countries in two continents. In implementing such research on the ground, we continuously review through discussion, debate and collective reflection - a process in which each one of us question every idea and action. Team members can be assailed by doubts, questions and anxieties especially when confronted with difficult implementing issues and situations. In such situations a visit to our convictions and concepts of inclusive practice often serves as a good test to see if we are on track.

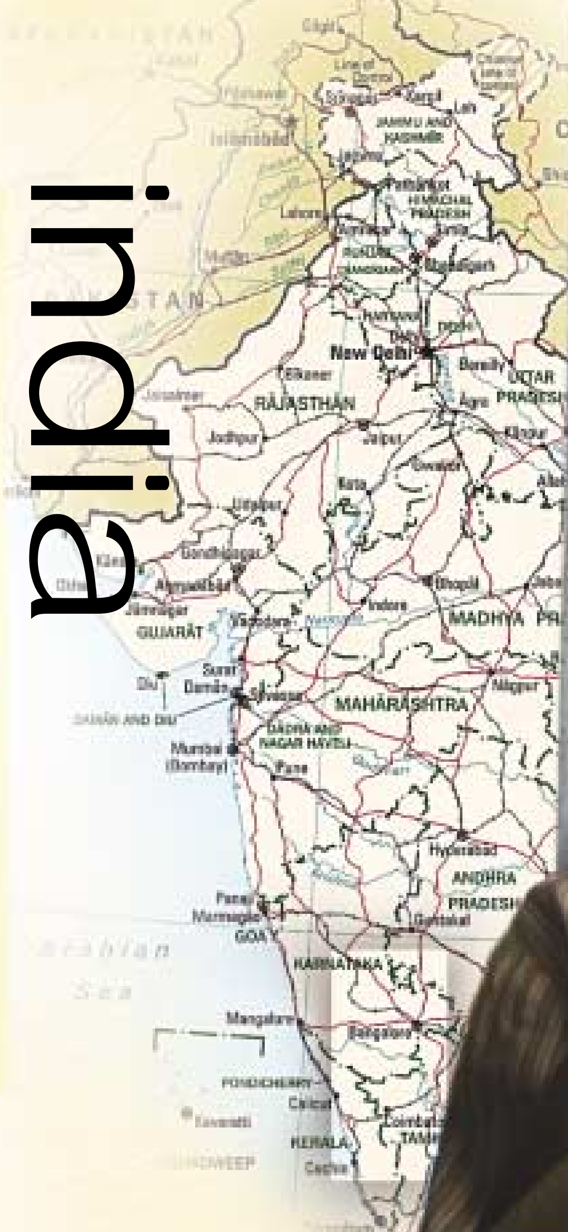
Observation:

The enquiry work described is an integral part of the model for mental health and development and is thus both developmental and therapeutic in its realisation. The Programme Manager for Policy and Research is Shoba Raja.

View our e-journal at
www.mentalhealthanddevelopment.org

india

- **5429** mentally ill people served
- **2017** mentally ill people are engaged in productive work of whom, about **55%** have started earning income
- **10** delivery partners
- **10** resource partners



SUBRAT

Caregiver at a consultation meeting organised by NBJK at Jarkhand, Northern India

Founder Director Chris Underhill writes: "DM Naidu started testing the model for mental health and development in September 2000 with several of our long time partner organisations including SACRED, Narendra Foundation and GASS. The basics of how mentally ill people are genuinely consulted were forged in these important early days. Many of the other ideas incorporated in our model also took root first with these early trials. Thus, the use of life stories as a means of communicating both the essential saga of a person's experience with mental illness and the progress being made by programme and individual.

The model for mental health and development (pp.9) is at the heart of each our programmes giving us both coherence and the volume of people served. At the same time each programme is a continuation of the experiment that allows us to test the model in so many different contexts. Naidu, one of the most accomplished animators of mentally ill people and their families, reflects below on the model, its results and uses.

A different - and better - world for mentally ill people can be created through the community's understanding of mental health and a resultant positive response to the issues concerned. In this scenario the families of the mentally ill are vitally involved in such understanding. Through these an environment of mutual understanding can be built. There will then be mutual resource enhancement as well.

Perhaps what I am about to describe looks too much of an ideal situation? For example, a policeman acting as a community resource, yet it is certainly not impossible as the Indian experience demonstrates. In fact it is more than three years back that the mental health

JANARDHAN

Sensitization workshop for NGOs, at Hospet in colloboration with Samuha, India

and development programme (MHDP) was initiated among mentally ill people with the model for mental health and development at its centre. This whole concept emerged from a series of consultations with mentally ill people, their families and the Non Governmental Organisations (NGOs) involved in community development.

To take an example of how the whole model fits together, Balu, about thirty years old, was wandering in Hasanur in Tamil Nadu. Our field staff took the initiative to address Balu's needs. A local psychiatrist Dr.Anbudurai diagnosed Balu's illness as schizophrenia and prescribed medicine. At this point the local police came forward and offered him a place in their police station as Balu was homeless and destitute. Balu started responding to the medicine as well as to the care and compassion he received from the police. They gave him small jobs to do, making him feel needed and compensated him for the work he provided.

Gradually his benefactors were able to get from him the details of where he came from and where he belonged. It happened that he was from Tirupur, about ten hours' journey from Hasanur. They met his mother and sisters and made sure that Balu was part of their family. He is now happily reunited with his family and his medicines are regularly posted to him.

Several partners work together building an alliance among the mentally ill and their various supporters, to strengthen the community so as to be strong enough to address mental health issues currently prevalent and those that may occur in the future. The alliance building process really took off in a big way in 2004 where all the partners and teams got together to form an

D.M.NAIDU

Caregivers meeting organised by ADD-India at SCORD, Thiruvarur District, India

alliance to run the Mental Health and Development Programme (MHDP). To give meaning to the reach of the alliance and to our understanding of what community might mean in relation to mentally ill people, the Chair of BasicNeeds India Trust, Valli Seshan, had the bright idea of getting the group to prepare a web chart explaining the community's many and varied associations with mental health. The chart, a little like a spider's web, was to be based on the voices of people involved in mental health work. A web chart is never complete in the sense that other relevant groups could be added as the process goes on expanding.

Gradually large structures are making an effort to support mentally ill people. The Society for Elimination of Rural Poverty, an autonomous body of the Government of Andhra Pradesh, has come forward to meet the needs of people with mental illness in nine *mandals.* A *mandal* is a group of *panchayats*, these being the smallest area of local government administration. Nine

Street theatre performed by SAMUHA at Koppal, India

JANARDHAN

mandals represents a huge number of people being supported by the authorities.

Yet somehow it boils down to our inability to listen to mentally ill people - to our need to listen actively and attentively. In some corner of my heart echoes Ben Okri's eminently quotable words from his aptly named Mental Fight:

We have been dilettantes and amateurs
With some of our greatest notions
For human betterment.
We have been like spoilt children:
We have been like tyrannical children;
Demanding proof when listening is required
Let us keep listening for human betterment.

Observation:

Why should not the police be of service to mentally ill people? The story of Balu and his happy reunion with his family greatly facilitated by friendly police personnel reminds us of the story of Adam (pp.6) and his return to family and community after the intervention of both the BasicNeeds team and a local Councillor. The link is that people understand the "odd" behaviour and react with compassion on behalf of the community. Dr.Anbudurai goes beyond what is called for – he is an enthusiastic psychiatrist who supports many of the BasicNeeds partner organisations. The Programme Manager and Secretary of BasicNeeds India is DM Naidu.

sri lanka

- **1283** mentally ill people served
- **1238** mentally ill people are engaged in productive work of whom about 39% have started earning income
- **04** delivery partners
- **08** resource partners

W.A.CHANDRASIRI

Model farm owned by Debokkawa self-help group, Angunukolapelessa, Sri Lanka

The Sri Lanka programme is built on the principle that all members of the community should be included and that no-one, particularly mentally ill people, should be excluded.

It was this principle that resulted in BasicNeeds Sri Lanka developing the BasicNeeds Mental Health and Development Model to work out collaborative interventions on a pilot basis to demonstrate that mentally ill people can participate actively in the process of development.

The pilot project started in February 2003 with thirty four mentally ill people. We now have 1,283 registered mentally ill people in just a small part of the Southern Province.

As a result, the mechanism called "Mental Health Care through Community Partnership" was developed, which complements the local government service delivery structure. Crucially perhaps, the most outstanding feature of the partnership are the community volunteers in which community volunteers run a number of very important community based activities including:-

- Monthly mental health camps run in collaboration with a specialist mental health hospital, Angoda and the teaching hospital at Ratnapura.
- Outreach clinics by medical officers providing local service in collaboration with general hospitals at places such as Hambantota and Kahawatte.
- Out patient clinics for drug administration in collaboration with primary level hospitals such as the District Hospital of Katuwana.

BBC radio team recording the stories of mentally ill people, Suriyawewa, Sri Lanka DHARSHANA KARUNATHILAKE

Piyasena was treated as a mentally ill person when BasicNeeds first came into his village. However, now he has joined the volunteer committee which plays an active role in organising communities in the programme. Equipped with a three wheeler and a loudspeaker, Piyasena is responsible for announcing in the neighbouring villages when we have events such as mental health camps. About 30% of the membership of our volunteer committees are mentally ill people. The balance comprises carers and community members free from mental illness.

The programme has started to get everyone thinking. For example, when BasicNeeds and the Southern Provincial Directorate of Health Services invited five mentally ill persons to share their experiences about mental illness. This was to help the Southern Province Mental Health Forum propose recommendations to the government for the effective replication for the "Mental Health Care through Community Partnership" pilot for other parts of Southern Province. Recommendations were also made to the government so that its medical scheme includes A-typical drugs into the essential drug list from January 2005.

Chintha Munasinghe, our Programme Manager, also sees herself as a user of mental health services. She is sitting with a group of mentally ill people and notes:

"I am sitting with my friends here to talk about our personal experiences in mental illness. We feel that this is our duty so as to motivate other mentally ill persons to come forward, talk, discuss and get rid of their pain. We see ourselves as "live" case studies who want to share their experiences so as

DHARSHANA KARUNATHILAKE

Community volunteers registering participants at mental health camp, Suriyawewa, Sri Lanka

to educate primary heath care officers. This is all part of the training that our Consultant, Dr. Neil Fernando, would like to see happen."

Chintha reflects:
"We still have much to do but I am pleased with "Ape Viththi" – Our News. I was once a journalist and take particular pleasure with this newsletter, which offers an opening to consult mentally ill people and their families for a wider sharing of the model. Stabilised mentally ill people are our main contributors and we also have news from community leaders. Contributions from practitioners are particularly welcome!" chuckles Chintha.

Here are some of the milestones that Chintha and her team have achieved:-

- Community mental health model of BasicNeeds Sri Lanka recognised nationally and internationally as an effective way of providing service
- Sri Lanka's largest enterprise development organisation, Sarvodaya's Economic Enterprise Development Services (SEEDS) Guarantee Ltd. is involved in developing an enterprise oriented sustainable livelihoods package for mentally ill people and their families.
- A training programme with project participants to record and analyse family expenditure which is now being used in many households, was developed.
- A participatory home management training programme with 10 families of the mentally ill people experiencing family conflicts, was developed.
- Home gardening systems and horticulture therapy programmes to suit the needs and interests of mentally ill people continues with high participation from mentally ill people. As a result nine

DHARSHANA KARUNATHILAKE

Spiritual ceremony organised by stabilised mentally ill people with community, Angunukolapelessa, Sri Lanka

discharged mentally ill people labelled as destitute, have reunited with their families and five have been employed as gardeners.

- Seventy six members of volunteer committees have taken the responsibility of working with victims of the tsunami disaster in immediately providing emotional support and designing development interventions.

Piyasena, who alerts the community about the mental health camp from his three wheeler comments:

"Even during my schooldays I was scared even to sing a song at a social gathering. It is true that the programme has covered all our medical needs, but more than that, it has helped us to come forward and develop our talents. I was really surprised to find how well I could do the announcing part at the mental health camp. Now I can address even a huge gathering."

Chintha smiles appreciatively and observes:

"The BasicNeeds family is proud of mentally ill people in Sri Lanka for taking the lead in sharpening the mental health services in our country - slowly but surely!"

Observation

By involving mentally ill people in the delivery of community mental health services, the programme achieves very high levels of mainstreaming. The community become used to seeing marginalised people helping themselves – a tremendous way of reducing stigma. The programme manager of the Sri Lanka programme is Chintha Munasinghe

emotional support to internally displaced people

a new vocation for BasicNeeds

TINA NTULO

An elderly carer of a mentally ill person talks to camp leaders and the BasicNeeds Uganda team in Amurai IDP camp Katakwi District, Uganda

Living in a refugee camp is not like living in your own home. Having lost all your belongings and, at times, close family members, and then ending up in a world of strangers is a great trial. This is a brief insight into actions taken and foreseen for the future.

In Sri Lanka more than 1,000,000 people are presently taking refuge of temporary shelters with a hope that they will be moving to their own place soon. But this is still open to question.

In another part of the island another 500,000 people have been stranded as internally displaced people in camps for more than 20 years as a result of the civil war between North and South.

Debriefing meeting after consulting Tsunami survivors, Weligama, Sri Lanka

DHARSHANA KARUNATHILAKE

In Uganda's Teso Region the total number of registered internally displaced people in the 3 districts of Soroti, Katawaki and Kabaramaido number 449,000. Many have lived there as camp dwellers for twenty years.

Sri Lanka

From 30th December 2004 onwards, BasicNeeds along with the Southern Provincial Health Administrators and staff, our existing partners - *Navajeevana* and *GIDES* and seventy-six members of community mental health and development committees started consulting about 5,000 families affected by the Tsunami with a view to rebuilding their lost hope through emotional support and care. As one volunteer from the Tsunami affected community said:

"We are confused when reasoning out the true cause of Tsunami disaster. However strong the shock that we still experience, I feel Tsunami disaster has forcibly made us see the true picture of life. Even today, if someone says that another tide is coming up we get panic; we feel our body trembles... it is not easy to recover, even though we know that it is not true. It takes several days or weeks for us to become normal. However, at a time of mental pressure like that, this programme is like a painkiller for a person suffering from a terrible headache. The soothing feeling we get by being with you, is like pouring cold water on our body in a hot day of summer. We are grateful to all who served us with many offerings... but, for us who were helpless being attacked by Tsunami tide, the biggest gift came from BasicNeeds."

For our work in emotional support to Tsunami survivors in Sri Lanka and the affected region

DHARSHANA KARUNATHILAKE

Consultations with affected communities, Tangalle, Sri Lanka

we are very grateful indeed to the DFID Conflict and Humanitarian Affairs Department, the Northern Rock Foundation, the One Foundation, Dublin, and the Ryan family, the Health Foundation, our DEC twinning partner Christian Aid not to mention the many people and organisations who contributed to our own Tsunami appeal which at time of writing had raised £76,225 (pp.41).

One of the studies prepared for BasicNeeds were written by psychiatrist Prof. Daya Somasundaran when the organisation was first considering working in Sri Lanka. With the help of the Diana, Princess of Wales Memorial Fund we have initiated our Northern Programme to work out emotional support interventions with communities who are now taking refuge in temporary shelters far away from their home.

We will concentrate on internally displaced people who have returned to their homes in the North as well as those who are still living in the refugee camps, having no place to go. The model for Mental Health and Development will be at the heart of what we have to offer to suit the needs of the communities that we are planning to work with. With the support of three partners we are launching work in April.

Uganda

Christina Ntulo, our Programme Manager for Uganda, made a visit to Teso Region to various camps for internally displaced people in different districts. We are preparing to work in the region and Christina has made a number of initial visits before the final planning work with local and government partners. Voices from her notes:

"We were forced to come and anyone who refused to come was considered the enemy.

Children playing at a relief camp, Dickwella, Sri Lanka

DHARSHANA KARUNATHILAKE

Now we have lost everything and they want us to go home. Where is home? Where our children were burnt or forcefully taken from us? Where our wives were raped before our eyes? Is that a place we can call home?"

"I feel as if there is constant water in my head, something keeps moving in my head..."

People are very emotionally disturbed and mental illness is not adequately attended to. From Tina's notes (with acknowledgement to the report on Teso Region of the joint interagency assessment mission 8-13 November 2004):

1. Total number of registered IDPs in the 3 districts is 449,000. 53% are from Katawaki district

2. For over 20 years this region has suffered insecurity from cattle raids by the neighbouring Karamajong.

3. Lords Resistance Army (LRA) entered into Teso region in June 2003 doubling the number of IDPs as a result of killings, burning of houses and abducting of children.

4. No fresh attacks recorded since November 2004.

5.Mental illness seems to be common in all 3 districts. There are no drugs and mental health care is lacking in all 3 districts.

6. Staffing levels are inadequate.

7. There is increase in reported cases of child sexual abuse in the camps. Alcohol is blamed for this.

8. Over 50 cases per camp of girl children forced into early marriage.

Christina visited three camps. Emotional and mental health support to internally displaced people: a new vocation for BasicNeeds.

support for basicneeds

Clare and Chris Mathias, together with their young family have been supporters of BasicNeeds for some time. In due course they travelled to India to look at our work there. Clare Mathias writes:

"A chance meeting with Chris Underhill and Naidu in India in 2003 began the Mathias family's support to BasicNeeds from those early days. Our focus for support was to help the poorest and most marginalised people in the world, especially in India. It is sad indeed that the mentally ill are often unable to access the facilities they need and this is exacerbated when these people are part of the poorest of the poor in society. They are people who are already marginalised or excluded by being poor, with no education and unable to be heard by those in power.

We travelled to India in October 2004 to understand for ourselves more about BasicNeeds. This was indeed a challenging trip for both the adults and the children - Thea aged 12 and seven year old Sassy - but Naidu and his team cared well for us.

In Bangalore we visited a horticulture centre which trained and supported the mentally ill by providing them with employment opportunities which are essential if they are to contribute to the family economy. Our children remember with happiness the colourful Divali festival!

We spent several days with BasicNeeds staff at Anantapur and the work they do in partnership with Sacred. This was a rural experience where we visited people who had benefited from BasicNeeds support. Of particular interest was the story of the tailor who was schizophrenic and had been deserted by his family because they could not manage his illness. These families do not understand the issues and can do nothing but despair. He was supported to seek medical advice - most of which is a hundred miles away - and BasicNeeds assisted him to follow a drug regime and now he has opened a second shop and can provide for his family. He can also ensure that others do not fall into the same situation that he did. It is clear that when a person is mentally ill, the ramifications spread far and wide and impact on the whole of the local community.

We visited self help groups and learnt how BasicNeeds leverages outside support to ensure far reaching and sustainable solutions in a holistic way to individuals and their communities. All of this is done in a professional, rights based and highly cost effective manner. We learnt from this experience and we appreciate the information we gained."

Abby and Thea Mathias wrote a diary while in India and this can be visited on the website

www.basicneeds.org.uk

Sri Lanka Programme Manager (right) Chintha Munasinghe observes: "The Health Foundation, UK, joins our efforts in rebuilding the lives of Tsunami survivors"

SIÂN EDWARDS

Chris Underhill writes:

We have wanted to lay down a pattern of programmes which would permit us to speak with authority about mental health and development in different settings. I think the main development funders support us because they increasingly see that we are proposing an approach to mental health in the community which seems to make sense and is effective. The generosity of the Andrews Charitable Trust (formerly World in Need) and the Joel Joffe Charitable Trust, acting as our launch funders, still strikes us as tremendously generous and supportive. Their example has made it possible for us to have effective programmes on the ground which in turn has meant that we have been able to appeal for funds from Comic Relief, the Health Foundation, the Department for International Development, the Big Lottery and the Diana, Princess of Wales Memorial Fund, to name some of our very generous supporters. From our perspective, the fact that the same funders also support what might be called mainline development work precisely and neatly makes the point. Mental health and development is part of the mainstream of poverty reduction.

During the terrible period of the Tsunami, in early 2005, many people recognised that emotional support would need to be given to Tsunami survivors. Individual donations were given generously and together with some Companies, Trusts and Foundations, our own appeal reached £76,225. This generosity encouraged us to work with our Bank (CAF Bank Ltd) so as to enable our website to receive donations online. Now, a number of donations are made on a regular basis to our work through this means. Just

MAGAWA ABDALLAH

Chris Underhill, Founder Director of BasicNeeds inaugurating the first outreach mental health clinic, Lisekese, Tanzania

as we have developed and grown our field programme from September 2000 to date, so we have grown our fundraising programme and the necessary skills required. We now receive support through five income streams, these being Institutional Donors, Trusts and Foundations, Special Supporters, Direct Mail and Corporate giving. We are always overjoyed by the support that we receive, often from unknown sources. Obviously we feel that the work is valued and, perhaps more importantly, that the approach is validated.

Listen! Support BasicNeeds and receive your copy of 'Listen' the newsletter that keeps you in touch with our new initiatives in mental health and development. Write to the Assistant Director: jane.cox@basicneeds.org.uk

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Should you wish to support BasicNeeds, please write to Chris Underhill, Founder Director, at the address below or e-mail: chris.underhill@basicneeds.org.uk

For the latest copy of our audited accounts, please apply to Jane Cox, Assistant Director, e-mail: jane.cox@basicneeds.org.uk

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Valli and Amelia; two trusts one family D.M.NAIDU

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The BasicNeeds review : Community My Community
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Sponsors Statement:

Once again Molecular Products Group plc is delighted to sponsor this years BasicNeeds Review. This year's theme 'Community, my Community' has a particular resonance with Molecular Products. The values and activities of Molecular Products Group, a business based in local communities but operating on a global scale, has direct parallels with the work, aims and objectives of BasicNeeds. In both organisations communities are defined by relationships, not geography. We believe respect, individual liberty and family values are key to developing and maintaining fulfilling relationships.

The unstinting work of BasicNeeds in tackling global mental health issues through local community programmes provides a positive re-enforcement of the values we aspire to in our busy business life.

We wish BasicNeeds further continued success in their most challenging of endeavours for the coming year.

Ian McKernan

Chairman and Group CEO

Molecular Products Group plc

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