UGANDA

Integrated primary care for mental health in the Sembabule District

Case summary

In the Sembabule District of Uganda, primary care workers identify mental health problems, treat patients with uncomplicated common mental disorders or stable chronic mental disorders, manage emergencies, and refer patients who require changes in medication or hospitalization. These functions were implemented following the inclusion of mental health issues in the Uganda Minimum Health Care Package. Specialist outreach services from hospital-level to primary care-level facilitate ongoing mentoring and training of primary care workers. In addition, village health teams, comprising volunteers, have been formed to help identify, refer and follow up on people with mental disorders.

Mental health treatment in primary care, compared with the previous institutional care model, has improved access, produced better outcomes, and minimized disruption to people's lives.

1. National context

Uganda is a low-income country with widespread poverty, particularly in rural areas. A national survey found that 38% of the population lives under the national poverty line (2002–2003).[1] Population growth is responsible, in part, for the country's deepening poverty (see Table 2.32).[2] Uganda is home to many different ethnic groups, none of whom forms a majority of the population. Around 40 different languages are in use in the country, but English and Swahili are the official languages. The country's main employment and revenue sector is agriculture.[3]

Table 2.32 Uganda: national context at a glance
Population: 29 million (13% urban) [a]
Annual population growth rate: 3.3% [a]
Fertility rate: 7.1 per woman [a]
Adult literacy rate: 67% [a]
Gross national income per capita: Purchasing Power Parity international $ 1500 [a]
Population living on less than US$ 1 per day: data not available or not applicable [a]
World Bank income group: low-income economy [b]
Human Development Index: 0.505; rank 154/177 countries [c]

Sources:

[a] World Health Statistics 2007, World Health Organization (http://www.who.int/whosis/whostat2007/en/index.html, accessed 9 April 2008).

[b] Country groups. The World Bank (http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20421402~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html, accessed 9 April 2008).

[c] The Human Development Index (HDI) is an indicator, developed by the United Nations Development Programme, combining three dimensions of development: a long and healthy life, knowledge, and a decent standard of living. See Statistics of the Human Development report. United Nations Development Programme (http://hdr.undp.org/en/statistics/, accessed 9 April 2008).

2. Health context

Key health indicators for Uganda are displayed in Table 2.33. The leading cause of death in Uganda is HIV/AIDS, followed by malaria, lower respiratory infections, and diarrhoeal diseases.[4] Around 7% of adults aged 15 to 49 years are infected with HIV.[5]

Table 2.33 Uganda: health context at a glance
Life expectancy at birth: 42 years for males/44 years for females
Total expenditure on health per capita (International $, 2004): 135
Total expenditure on health as a percentage of GDP (2004): 7.6%

Source: World Health Statistics 2007, World Health Organization (http://www.who.int/whosis/whostat2007/en/index.html, accessed 9 April 2008).

Simultaneous to the heavy burden of infectious disease, Uganda is experiencing a marked upsurge in noncommunicable diseases such as hypertension, cancer, diabetes, heart disease, and mental disorders.[6]

Only half of Uganda's population has ready access to health care, defined as living within five kilometres of a health clinic. Rural communities are particularly affected. There are marked variations in access both within and between districts, ranging from 9% to 99%. Many facilities do not provide the full range of essential primary care services.[7]

Mental health

National surveys of mental disorders have not been conducted in Uganda. However local surveys have found between 20% and 30% of the population to be suffering from a mental disorder.[8, 9] The Government of Uganda similarly estimates that common mental disorders

account for 20% to 30% of all outpatient visits.[10] In addition, a large but unknown proportion of people are suffering from mental disorders in conflict and post-conflict areas of the country.

Historically, specialized psychiatric workers provided mental health services. Most general health workers were indifferent, sceptical, and at times harboured negative attitudes towards mental disorders.

To make mental health an integral part of the health system, changes and new developments were required at all levels. A mental health policy (2000–2010) was formulated with the objective of improving access to primary care services supported by good-quality referral services as well as psychosocial rehabilitation programmes within communities.

Other essential elements of the policy are:

- increased access to mental health services through decentralization;
- collaboration and partnership with all stakeholders including nongovernmental and community-based organizations;
- involvement of consumers of mental health services and their families;
- community participation using selected community resource people, referred to as village health teams;
- evidence-based services through inclusion of mental health indicators in health information systems, and advocacy for additional mental health research.

Although some achievements have been made in the delivery of mental health services (mainly its inclusion in the minimum health care package), persisting challenges include inadequate budget allocations, an insufficient number of health workers, and incomplete integration of mental health into primary care across the country.

3. Primary care and integration of mental health

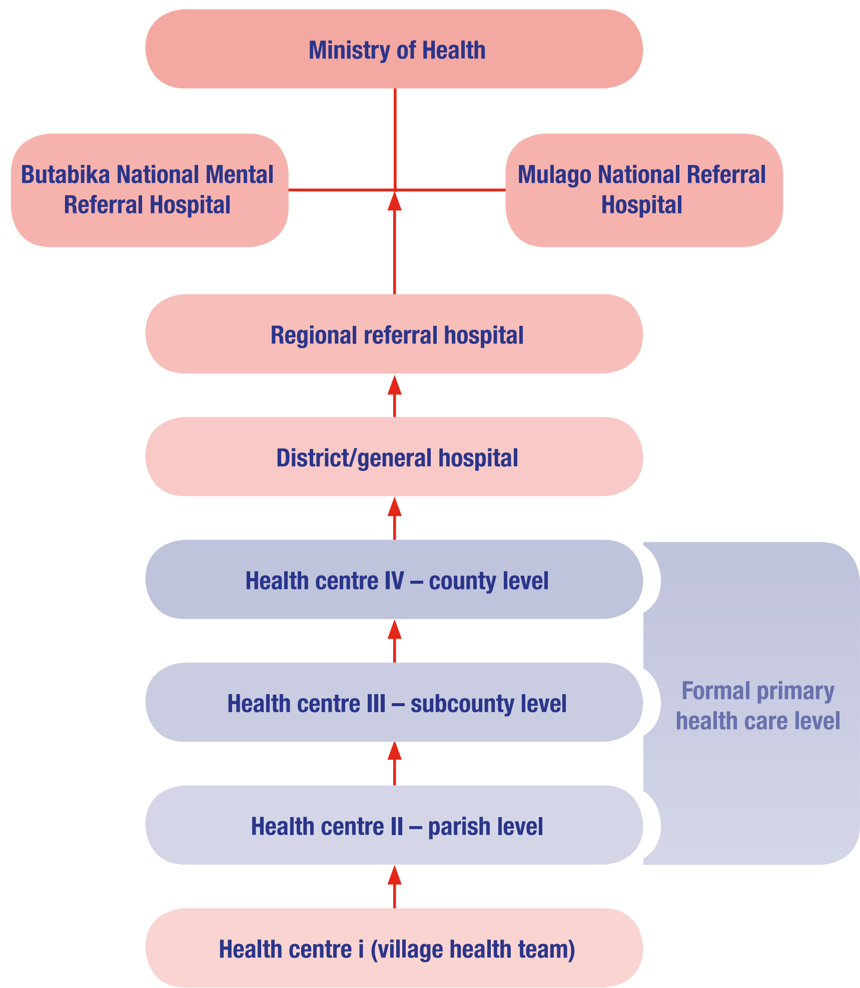
Primary care is the basic philosophy and strategy for national health development in Uganda. The Ministry of Health is the national body responsible for planning, provision of policy and guidelines, quality control and supervisory support. The ministry has an elaborate decentralized structure for the delivery of health services (see Figure 2.4). Each level in the structure has different mandates and varying capacities (health workforce, budget, and infrastructure) to deliver health services to a defined catchment population.

Health centres II, III and IV comprise the primary care system in Uganda (see below).

- Health Centre IV – County Level – includes general doctors, general clinical officers, general nurses, and midwives. Recently, psychiatric nurses have been placed in 30% of districts. Plans are under way to expand this service.
- Health Centre III – Subcounty level – includes clinical officers, general nurses, and midwives. Mental health specialists are not present at this service level.
- Health Centre II – Parish level – includes general nurses or midwives helped by nursing assistants who do not have formal training.

The Uganda Minimum Health Care Package (UMHCP) includes control of communicable diseases, integrated management of childhood illnesses, sexual and reproductive health and rights, immunization, environmental health, health education and promotion, school health, epidemics and disaster prevention, nutrition, interventions against diseases targeted for eradication, and strengthening mental health services and essential clinical care.

Figure 2.4 Uganda: decentralized health structure



Mental health

At the national level, strong political will exists to integrate mental health into primary care. Because mental health has been included as a component of the UMHCP, it is now part of the health budget.

Health centres below district level (health centre levels I–IV) are encouraged to manage mental health problems. Around 600 general health workers based in primary care services have been trained and equipped with necessary skills and knowledge to identify and manage mental health problems, and to refer complicated cases to higher levels of care. All trained health

workers, including general doctors, nurses and midwives, are permitted to prescribe psychotropic medication on the Uganda Essential Drug List. The Ministry of Health's guidelines allow general health workers to prescribe and administer psychotropic medicines for chronic patients, after the treatment has been initiated by a mental health professional. General health workers are usually not allowed to prescribe injectable psychotropic medicines or newer atypical antipsychotic medication, however injections are permitted to control highly aggressive patients.

Challenges in integrating mental health into primary care included the following.

- Patient demand. A study in north and north-east Uganda indicated that 59% of respondents went to religious leaders for help with depression, compared with 0.6% who went to traditional healers, and 2.3% who went to health facilities.
- Health worker attitudes and readiness. Most general health workers had negative attitudes towards mental disorders. Moreover, their pre-service training had not equipped them to provide mental health services.
- Access to medicines. Frequently, psychotropic medications were not available in health centres. As a result, many people with chronic mental disorders discontinued their treatment.

To facilitate the transition, a mental health focal point was appointed in each district. This person became part of the district health management team. In some cases the focal point was a mental health professional, but in other cases the focal point was a general health professional.

4. Best practice

Local context

Sembabule District is located in central Uganda. It has a population of 184 000 people, comprised of Baganda and Banyankole, mostly farmers.

In Sembabule, there are two health centre IVs, one of which also acts as the district hospital. It is housed in a three-room structure, consisting of one office and two wards. The district also has five health centre IIIs, and 20 health centre IIs. Among these, Ntete health centre II serves around 30 000 people and is located about 62 kilometres from the general hospital that provides inpatient services through admission to general health wards.[a]

Many of the organizational changes described in this best practice example occurred throughout Sembabule District; however, the example focuses mainly on the experiences at Ntete health centre II.

Description of services offered

Prior to mental health integration, patients in Sembabule District with severe mental disorders were sent to a referral hospital, while those with common mental disorders received no care whatsoever. Negative attitudes, misunderstandings and stigma among health workers and communities enabled this situation to continue until the national government designated mental health an integral part of the health system.

[a] Plans are under way to build a dedicated psychiatric unit, but until that time, patients continue to be admitted to general wards.

As a result of organizational changes, primary care workers now undertake a range of important mental health functions. They identify mental health problems, treat patients with uncomplicated common mental disorders or stable chronic mental disorders, manage emergencies, and refer patients who require changes in medication or hospitalization. Specialist outreach services from hospital-level to primary care level facilitate ongoing mentoring and training of primary care workers. In addition, village health teams, comprising volunteers, have been formed to help identify, refer and follow up on people with mental disorders.

The process of integration

Inclusion of mental health into basic minimum health care package

The inclusion of mental health as part of the country's UMHCP was crucial to facilitate the integration of mental health into primary care. Subsequently, mental health issues were included in planning and implementation guidelines for all service levels. Curricula for medical training institutions were also reviewed to increase the number of hours of exposure to mental health issues. Clinical officers, nurses and midwives now obtain one month of practical experience at the national mental referral hospital, in addition to mental health lectures at their training institutions.

Sensitization of political leadership

Political leaders at district, sub-county and parish levels were sensitized to the new policy. They were informed about the foreseen changes and also given background information about the importance of mental health and the reasons that the policy had been adopted. Stigma, fear and ignorance emerged during some discussions. Traditional misunderstandings about mental disorders, for example that they are caused by witchcraft, also surfaced occasionally. However, after careful discussions all leaders agreed that mental health integration was a logical step.

Sensitization of district health managers

The next step was to sensitize district health managers. In some instances, they also held prejudicial beliefs and negative attitudes towards people with mental disorders. Further resistance was generated because managers were required to shift schedules, rosters, and time allocations to accommodate the changes. Despite these difficulties, district health managers accepted that it was their responsibility to ensure that mental health was integrated into general health care. One district manager expressed hope that repeat visits by patients with medically unexplained symptoms could be reduced through improved identification and treatment of mental disorders.

Training of general health workers

Training of general health workers was based on a training manual developed by the mental health programme especially for general lower-level health workers. Complex psychiatric terms and other language were simplified with the help of experienced adult trainers, nurse tutors, and clinical officers.

In-service training was difficult to negotiate because health centres were invariably understaffed and training time meant more work for those who remained. Reluctance among some health workers added to the difficulty. Nonetheless arrangements were made and as a result of train-

ing, many health workers changed their views and were pleased to have had the opportunity to learn about mental health issues.

Training of village community resource people (village health teams)

Communities selected volunteers (13 in Sembabule) to form village mental health teams. The volunteers were trained in basic community mental health, identification of mental disorders, and referral of cases to local health centres.

The formation of village health teams turned out to be a key step in the mental health integration process. They were able to identify and refer many people who previously would have been left untreated.

Monthly meetings are held with the village health teams to provide ongoing training and education. The village health workers are able to discuss difficulties, and they also receive ongoing training and support for their work.

Outreach

An outreach service was initiated from the regional hospital (Masaka Hospital). Psychiatric health professionals, including psychiatric clinical officers and psychiatric nurses, started making monthly visits to the health centres. They worked alongside nurses to build their confidence, handle difficult cases, and conduct in-service training. Over time, the nurses' competence grew slowly. They now require less supervision and can manage more difficult problems. The monthly visits are continuing, but are sometimes hampered by lack of transportation to the health clinics.

Making psychotropic medications available

It was important to ensure sufficient availability of psychotropic medicines. Audits were conducted of the number of people attending each clinic on different days and their medical needs. From this information, requirements for each clinic were determined. Medication needs for patients with chronic mental disorders were relatively easy to calculate; however anticipating needs for psychiatric crises, new patients, or medication changes was more challenging. Meetings were held with primary care workers and pharmacists to ensure that psychotropic medication was included in their routine ordering and distribution. Moreover, meetings were held with psychotropic medication suppliers to ensure that adequate supplies would be available for distribution at the clinics.

Forming consumer associations

A consumer organization was formed in the district with the aim of performing patient support and advocacy functions. With support of existing nongovernmental organizations, consumers started income-generating projects, which not only provided economic assistance, but also gave consumers a sense of purpose and dignity.

Inclusion of mental health in the information system

The inclusion of different categories of mental disorders in the health information system increased the awareness of mental disorders and their importance as health problems to be managed in primary care.

5. Evaluation/outcomes

Services available

Table 2.34 displays the number of people seen at Ntete health centre II for different mental disorders from 2003 to 2007.

Table 2.34 Ntete health centre II: mental health visits, 2003 to 2007

Year	2003	2005	2006	2007
Diagnosis				
Schizophrenia	0	16	10	17
Bipolar disorder	0	18	12	22
Depression	0	8	6	13
Alcohol abuse problems	0	2	1	1
Epilepsy	0	283	343	262
Total	**0**	**327**	**369**	**315**

The programme was initiated in 2004, but visits were not properly recorded. Attendance since 2004 has remained stable, perhaps indicating that all patients likely to attend the clinic have been mobilized.

Since the introduction of the programme, attendance has increased at Masaka Hospital, especially for the outpatient service. Subsequent to primary care worker training, patients who previously would not have received treatment, or who might have been inappropriately referred to the central psychiatric hospital, are now being referred and treated at the regional level.

Patient satisfaction

Patients expressed their satisfaction with the primary care model, as indicated by the following quotes.[11]

Janet (not real name) is a 45-year-old woman who suffers from bipolar disorder:

"In 1991, before becoming ill, I had a poultry project, a grocery business and charcoal selling business. When I was admitted at Butabika Hospital, my husband took charge of my businesses and mismanaged them. On my return, he had married another wife and my projects had stalled. He told me that the businesses had failed because he had used all the money for my treatment. He claimed that he had started similar projects using his own money. I was reduced to a labourer! I fetched water and fed the poultry, but was not allowed to make decisions pertaining to the project or domestic issues. I did not even share from the proceeds of the projects…".

Three months after accessing treatment from a mental health outreach clinic in her community, Janet's story changed:

"I am glad that I do not have to go to Butabika for treatment. At least I can get my medication from the outreach clinic and be close enough to monitor my businesses. While at Butabika, someone taught us (women) to make crafts. That is what I now do for a living. I make mats, bags,

pocket wallets and hats from which I earn £ 2 to £ 5. I have started teaching women in my community to weave and I do hope that I can teach people with mental disorders in the user group. With my earnings, I have been able to build a new poultry project."

6. Conclusion

The integration of mental health into general health care has resulted in services that are more accessible, affordable, acceptable, and available. Instead of hospitalization far from home, patients are now being treated in their own communities.

Primary care for mental health is essential but does not exist in isolation. Services provided by village health workers, nongovernmental organizations, and the regional hospital are also crucial elements of the mix of services.

Key lessons learnt

- Integration that begins at national level provides a conducive framework for integration at lower levels.
- Political commitment, a clear policy and plan, and a high-level coordinator in the Ministry of Health are important for driving the process and convincing lower-level managers to integrate mental health into primary care.
- The inclusion of mental health as part of the minimum basic health care package was essential for ensuring that health workers received training and that essential psychotropic medicines were available at primary care centres.
- Collaboration between government and nongovernmental organizations was useful for facilitating the integration of mental health into primary care.
- Outreach services from hospital-level to lower-levels were important for mentoring, monitoring, facilitating referrals, and increasing effectiveness.
- Village health teams, comprising volunteers, can be used to identify, refer and follow up on people with mental disorders.
- Providing mental health treatment in primary care, compared with a institutional/custodial care model, improves access, produces better outcomes, and minimizes disruption to people's lives.
- Regular supply of psychotropic medicines and a system that allows general health workers to administer these medications are essential for mental health to be successfully integrated into primary care.
- Consumer organizations that advocate for mental health services at local levels increase the success of primary care programmes.
- Holistic care, including resettlement and reintegration, is easier to provide within primary care than from institutional settings.

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