Mental Health REPORT

REPORT ON
MENTAL HEALTH SERVICES PROVIDED
BY UPMB HEALTH FACILITIES IN 2018

ACTS 1:7-8
"Health in Totality"

Uganda Protestant Medical Bureau

July 2018

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Foreword

Time is Now to Promote Positive Mental Health

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On behalf of Uganda Protestant Medical Bureau (UPMB), I'm happy to introduce to you the first UPMB Mental Health Survey Report, which describes the state of mental health across the population that our Member Health Facilities (MHFs) serve. I am grateful to the trustees Jamie's Fund for raising money that went towards the construction of Ahumuza Mental Health Centre in Kisizi Hospital. I'm also grateful to the UPMB Member Health Facilities that participated in the Mental Health Survey and have agreed to initiate a UPMB Mental Health Integration Network; and to UPMB Secretariat staff for their support and expertise in developing this report.

This survey report is timely and relevant as it highlights the factors that promote and protect mental health, and those that contribute to poor mental health. This information builds on the current work to promote mental health by UPMB member health facilitaties, community partners and service delivery agencies.

The findings from this survey report will help to inform future discussions on mental health promotion, and will support policy makers, community partners, and our own endeavors to promote positive mental health.

Tonny Tumwesigye

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ACRONYMS AND ABBREVIATIONS

CHWs	Community Health Extension Workers
DHO	District Health Officer
EMERALD	Emerging Mental Health Systems in Low-and Middle-Income Countries
mhGAP	Mental Health Gap Action Programme
MoH	Ministry of Health
PHC	Primary Health Care
PNFP	Private Not –For- Profit
PRIME	Programme for Improving Mental Health Care
WHO	World Health Organization
UPMB	Uganda Protestant Medical Bureau

Dr Basangwa, Senior Psychiatrist, and Medical Director interacting with UPMB Hospitals and HCIVs Training Participants of WHO mhGAP course at Butabika Hospital.

ACKNOWLEDGEMENT

The situation assessment survey of mental health services in UPMB MFHs and report was only possible through concerted synergies of different expertise and commitment of individuals and institutions.

UPBM gratefully acknowledges the following institutions for their support and involvement in the assessment:

i. Azur HC IV
ii. Butiru Chrisco Hospital
iii. Bwindi Community Hospital
iv. Amai Community Hospital
v. Family Care Hospital
vi. Ishaka Adventist Hospital
vii. Kabarole Church of Uganda Hospital
viii. Kagando Hospital
ix. Kisiizi Hospital
x. Kiwoko Hospital
xi. Kolonyi Hospital
xii. Kuluva Hospital
xiii. Kumi Hospital
xiv. Mengo Hospital
xv. Mukono Church of Uganda Hospital
xvi. Ngora Freda Carr Hospital
xvii. PAG HC IV
xviii. Rwesande HC IV
xix. Rugarama Hospital
xx. Ruharo Mission Hospital
xxi. Rushere Community Hospital
xxii. St. Paul HC IV
St. Stephen's hospital

1.0 BACKGROUND

(L-R):Rev Hugh Burgess, Chair of Jamie's Fund, Dr Tonny Tumwesigye, UPMB Executive Director, Professor Maureen consultant psychiatrist , and Linda Shuttleworth, senior clinical psychologist from Jamie's fund. James Mwesigwa, UPMB Advocacy & Quality Advisor

1.1 Introduction

The Uganda Protestant Medical Bureau (UPMB) is a National umbrella organization for Health Facilities affiliated to Protestant Churches in Uganda. It was established in 1957 by the Church of the Province of Uganda and the Seventh day Adventist Uganda Union (SDAUU) as a Charitable and Technical Legal entity to serve as a liaison between Government of Uganda, Donors and Member health facilities. UPMB currently has a Network of 309 faith based private not for profit health facilities (including Hospitals, Health Facilities and Health Training Institutions) spanning over six decades of experience in serving vulnerable communities in Uganda with a common goal of providing preventive, promotive, curative, and rehabilitative affordable, good quality health care to Ugandans regardless of ethnicity and religious creed. Their presence is strong in rural areas reaching the most marginalized and vulnerable groups of society.

Mental illness is a problem that affects many people across the world. It is a leading cause of disability, which may last for years, and can have profound effects on those who suffer from it and those around them. It has been estimated that up to 35% of Ugandans suffer from a mental disorder and 15% require treatment [1]

Epilepsy is considered to be part of mental health care in many countries including Uganda, and there is a significant need for epilepsy treatment, which is often not being met. Epilepsy can have long term effects on children who are at risk of burns and other injuries and who may be excluded from school and later employment.

The World Health Organisation has recently reiterated the importance of mental health care as part of the coordinated approach to non-communicable diseases, which are increasingly affecting countries such as Uganda. They emphasise the importance of leadership at national and local level in order to reduce stigma and

discrimination and to increase the access to treatment. Effective treatment can be life changing, and it has been estimated that for every dollar spent on the treatment of mental illness there is a return of five dollars into the economy [2] It has been demonstrated in other African countries that much can be achieved by decentralising mental care to rural hospitals and health centres, and empowering communities and non-specialist health staff to care for those with mental illness and epilepsy. [3] This also brings access to mental health care closer to those affected. This approach is beginning to be adopted in Uganda, but progress is slow.

Mental health care in Uganda

The Ugandan Government acknowledges that mental health is a significant public health and development issue, and has included it as one of the twelve components of the national minimum Health care package, to be provided at all level of care, since the Health Sector strategic plan of 2005. [4] Uganda is participating in international research programmes such as Emerging Mental Health Systems in Low-and Middle-Income Countries (EMERALD) and the Programme for Improving Mental Health Care (PRIME) which seek not only to address the lack of trained staff by training community health workers (CHWs) in mental healthcare delivery but also to overcome cultural barriers by tailoring programmes to the specific needs and beliefs of a community. [5] These programmes tend to be focused on one or two pilot districts and, so far, have not been widely rolled out.
Possible barriers to effective implementation include: (i) that policy objectives may be unrealistic given available resources; (ii) there may be a lack of appropriate delivery systems to support the policy; and (iii) there may be insufficient support for the policy at the implementation level. [6]

Mental health service staffing

UPMB HOSPITALS& HCIVs Training Participants of WHO mhGAP course with Butabika Hospital Trainers

Research suggests that Uganda has a serious lack of trained psychiatric staff; The total number of trained psychiatric staff working in mental health facilities or private practice in 2010 per 100,000 population was 1.13, with each category as follows: 0.08 psychiatrists; 0.04

other medical doctors; 0.78 nurses and 0.2 psychiatric clinical officers [7]. The largest component of this workforce are nurses, with the majority of them working in Butabika hospital, and one district had only one trained psychiatric nurse.

Research found that only 3% of general nurse training in Uganda covers mental health and that, in reality, few nurses have any training in psychiatric nursing. Furthermore, of those nurses who have had such training, few see their role as being other than identification of mental health conditions and referral to other services.[8]
Access to continuing professional development and higher-level training for qualified nurses can also be problematic. In addition, staff shortages also contribute to healthcare professionals being refused time to attend training and development opportunities. There is evidence that, in addition to a lack of qualified psychiatric nurses, there is a need for other professionals working in Ugandan health provision to be trained in mental health care and rehabilitation. Indeed, it may be suggested that the role other professionals have in mental health care has been somewhat neglected. For example, a 2006 review of Ugandan mental health policy found no mention of allied professionals such as social workers. Research shows that there are very low numbers of psychologists, social workers and occupational therapists working in mental health care with only 0.01 from each profession per 100,000 of the population.[8]

This paucity of specialist staff has implications for individuals with mental illness and for health professionals themselves. The benefit of multi-disciplinary teams is that they can provide holistic care, promoting the recovery of individuals and in doing so also enhance the skills and experience of the team members. [8]
Appropriately trained social workers can support people in the community; perhaps even preventing hospital admission, as well as helping them reintegrate into society at hospital discharge. [8]

Psychological therapies for mental disorder have a good evidence base and may be particularly important where drug supplies are inconsistent. Similarly, occupational therapy promotes recovery and rehabilitation. Recovering patients may be supported to return to their workplaces and become economically active again. Successful rehabilitation to employment has a significant impact in reducing stigma.

While the lack of allied health professionals may reduce the effectiveness of treatment it also has a concomitant impact on nurses. Inability to refer to other services may increase their workload and the scope of issues nurses are expected to address, creating additional pressure on an already stretched workforce.[8]

Cultural aspects of mental illness and stigma

Ewan is professor of Global Public Health, Professor Maureen consultant psychiatrist Rev Hugh Burgess, Chair of Jamie's Fund, Dr Tonny Tumwesigye, UPMB Executive Director, and Linda Shuttleworth, Senior Clinical Psychologist from Jamie's fund.

Culture influences the understanding and treatment of mental illness in Uganda. It is common for lay people in Uganda to attribute a supernatural antecedent to mental illness. These supernatural causes include witchcraft, spirit possession, and failure to observe cultural traditions, and poor relationships with the dead. Some people also hold the belief that mental illness is contagious. [8] Evidence shows that these beliefs influence people's reaction to mental illness and how they seek to address it; many use traditional healers or seek help from their church before accessing mainstream medical services. Traditional healing can be patient-centred and caring, but often will include such things as chaining or tying for periods while the spirits are 'warded off'.[1]

It has been reported that as many as 80% of those within Uganda's mental hospitals have previously been to a traditional healer,[1] often delaying the onset of evidence-based care and exposing the individual to coercive practice.[8]

Stigma is a powerful force in every country. Uganda is no different, and the evidence suggests that stigma is a pervasive societal issue and barrier to treatment. A study looked at the relationship between mental illness, stigma and poverty in Uganda.(9) Detailed interviews with over 100 stakeholders in health and social care, government and the media revealed widespread stigmatising attitudes, including amongst health care staff and local leaders.
Stigma does not stop at the illness: it marks those who are ill and their families over generations, institutions that provide treatment, psychotropic drugs and mental health workers. The family members who help care for people with mental illness report feeling stigmatized as a result of their association with the loved one having mental illness. The

presence of stigma starts a vicious cycle that leads to discrimination in all walks of life, decreasing self-esteem and self-confidence, and adversely affecting social engagement. The resultant reduction in self- esteem may increase disability by reducing access to social and financial resources.[9]

Funding

Funding for health care, and for mental health care in particular, is low in Uganda. Uganda spends 9.8% of gross domestic production on healthcare, or US$146 annually per person. Less than 1% of this goes into mental healthcare.[1] Over half of the spending on mental health care is spent on the national psychiatric hospital at Butabika. This perpetuates an emphasis on institutional care. Consequently, the majority of staff trained in psychiatry are based in urban areas.

Wider effects of mental illness

According to most stakeholders interviewed in the Ugandan study (9), there is a strong relationship between poverty and mental illness; the two being mostly linked in a vicious cycle of exclusion, limited access to services, low productivity, asset depletion and diminished livelihood. This is in line with a number of earlier studies that describe the relationship between poverty and mental ill-health.

The effects of poverty on those with mental illness are significant as they are often not offered employment, are unable to access credit for equipment, land or livestock, and not able to claim state assistance. They may thus be too poor to pay for travel to clinics or for the costs of medication. Families are affected too, with relatives often having work disrupted by the need to care. Children are less likely to attend school, creating an inter-generational burden.[1]

The quality of life of caregivers for people diagnosed with mental illness is generally poor due to the added responsibilities and occupation of their time, energy and attention. This additional responsibility results in high levels of stress and caregivers may fail to have appropriate coping mechanisms. Interventions such as support groups or counselling should be put in place to aid caregivers in their role and therefore improve their quality of life. [10]

Challenges in organising mental health care

UPMB Hospitals and HCIVs Participants training on mhGAP at Butabika Hospital.

Several administrators expressed concerns over the cost of a new programme for mental health because of variability of funding from month to month. 'Mental health treatment is very expensive. The people we serve here are very poor. They can hardly afford the cost of treatment so at times they are unable to complete their visits because they are very expensive and drugs are very expensive. So basically, the program, for it to continue, it needs funding. It needs support. And that support is not there as of now.[5]

In a district where mental health services had been expanded, there was heightened awareness by health managers of the need to order a sufficient and constant supply of psychotropic medication, which was reported to be more available in the district than it had been prior to the intervention. The supply of medication was, however, erratic, with the district health officer communicating a sense of despair about the situation as reflected in the following quotation. *"For us, what we shall be doing is to order. If (the authorities) can't deliver, we just sit and wait. Because ... sometimes (it) takes long to deliver. For example, they were supposed to bring medicines to this region the whole of last week, starting Monday; but they have not yet. Currently we have no drugs at all, in all units. Not only mental health drugs, all drugs"* (District Health Officer).[6]

As reflected in the following excerpt from an interview with the mental health nurse, this resource constraint was strongly de-motivating. *"Because we the health workers are there, we are ready to attend to the patients. But the issue is drugs. You can't serve the community minus drugs... once the drugs are not there, nothing helps...I am one of those who are de-motivated. Because I look at patients, they have no money to buy the drugs. Someone had improved for the last 6 months without getting fits.*

Then he comes today and there is no medicine. He comes back the following day and there is no medicine. Then he fits in the compound there...That is so hurtful. All your efforts you have been putting in will be wasted. It really hurts" (Mental health nurse).[6]

Training of Community Health Workers (CHWs) and primary health care (PHC) staff to recognise and refer people with mental illness was not without its problems. According to a mental health nurse, while there was an improvement in identification and referral from both CHWs and PHC staff as a result of the training, neither group assisted much with treatment. This resulted in a reported increase in the number of referrals he had to deal with. While clinical officers could prescribe medication, they were not always present in PHC clinics. Further, while PHC nurses could initiate treatment in an emergency situation, they were still required to refer patients for confirmation of the prescribed treatment. Moreover, the necessary medication was not always available.[6] ask shifting cannot replace the need for essential psychotropic medication nor the need for a minimum number of mental health specialists. In Uganda, limiting application of task shifting to identification and referral, as well as limited availability of psychotropic medication and specialist mental health personnel, resulted in a referral bottleneck.[6]

1.2 Statement of the problem

In Uganda there is a large unmet need for mental health services. There is a psychiatric unit at each of the regional hospitals, but these tend to focus on inpatient care and have limited scope to work in the communities.

Despite there being an enabling national policy framework, there are glaring gaps in mental health service delivery, especially at primary care level, and an absence of district plans [4]

Uganda has draft mental health policies in place to promote integrated primary mental healthcare to varying degrees. However, this has not routinely translated into implementation.[6]

Most district hospitals and HC IVs, both government and private not for profit including those that are members of the UPMB, are not clear of their role in delivery of mental health care and are not receiving or giving much leadership in an approach to mental health services.

1.3 Rationale for the assessment for Mental health service in UPMB hospitals

The hospitals and Health centre IV's that are members of UPMB provide care approximately 1.19% of the total general patients that UPMB member health facilities provide care for. The goal of UPMB is to improve the health status of communities. Mental ill-health is a major cause of disability and illness, reducing the health status both of the individuals with the illness and those around them. Mental health care therefore falls within the scope of the work of UPMB member units.

Although mental health care is recognised by the government as an important component of health care at all levels of care, until recently UPMB has not been much involved in supporting and facilitating the development of mental health services.

The intention of this survey was to assess where there were staff trained in psychiatry, what mental health services were being provided by the UPBM affiliated units, to ask what barriers there were to providing care and what support might be helpful.

1.4 Objectives of the mental health survey

The objectives of the survey were to establish:

- Which units had staff qualified in mental health
- Which units admitted patients with mental illness and if they had dedicated beds
- Which units ran community clinics and what numbers were seen
- What obstacles were experienced by units and what might help overcome these

1.5 Expected outputs

This report has been produced which summarises the findings. This will be circulated to all the member health Facilities and used as a basis for discussion at the UPMB national symposium in 2018. It is expected that a plan of possible support to UPMB Member Health Facilities will then be produced.

2.0 SURVEY METHODOLOGY

2.1 Selection of assessment sites

A questionnaire was developed and distributed to 28 UPMB high level Member Health Facilities. The completed assessment tools were returned from twenty-three (82%) PNFP health facilities namely; Amai Community Hospital, Azur HC IV, Kagando Hospital, Butiru Chrisco Hospital, Bwindi Community Hospital, Family Care Hospital, St. Stephen's hospital, Ishaka Adventist Hospital, Kabarole COU Hospital, Kisiizi Hospital, Kiwoko Hospital, Kumi Hospital, Kuluva Hospital, Mengo Hospital, Mukono Church of Uganda Hospital, Ngora Freda Carr Hospital, St. Paul HC IV Kolonyi Hospital, PAG HC IV, Rugarama Hospital, Ruharo Mission Hospital, Rwesande HC IV and Rushere Community Hospital.

2.2 Target population

The assessment targeted both Senior administrative staff as key informants and other staff employed in the mental health service provision units across the institutions.

2.3 Data Collection tools

Self-administered electronic type of semi-structured questionnaires were used to collect quantitative and qualitative data. A questionnaire was selected for the mental health survey because it produces quick results, can be completed at respondents' convenience, offers greater assurance of anonymity and is less expensive compared to other methods of data collection.

2.4 Data Collection method

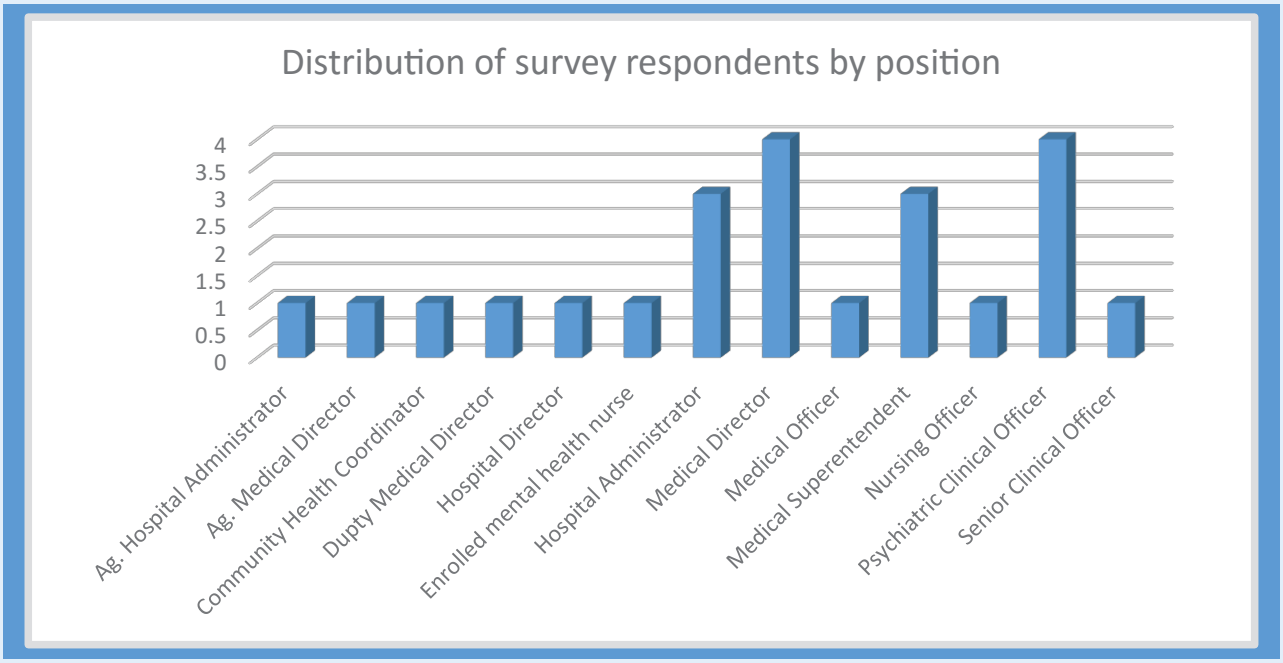
Data was collected from the respondents using questionnaires through a guided self-administration approach. Copies of data collection tools were sent by email to the respondents

2.5 Data entry, Analysis and reporting

In order to ensure that data entry, analysis and report writing are carried out on an ongoing basis, the data was periodically entered into an MS Excel customized database and MS Excel 2010 program for graphical presentations in terms of charts and tables with complementary discussion and interpretation of the results.

3.0 GENERAL OVERVIEW OF THE RESULTS

3.1 Positions of survey respondents

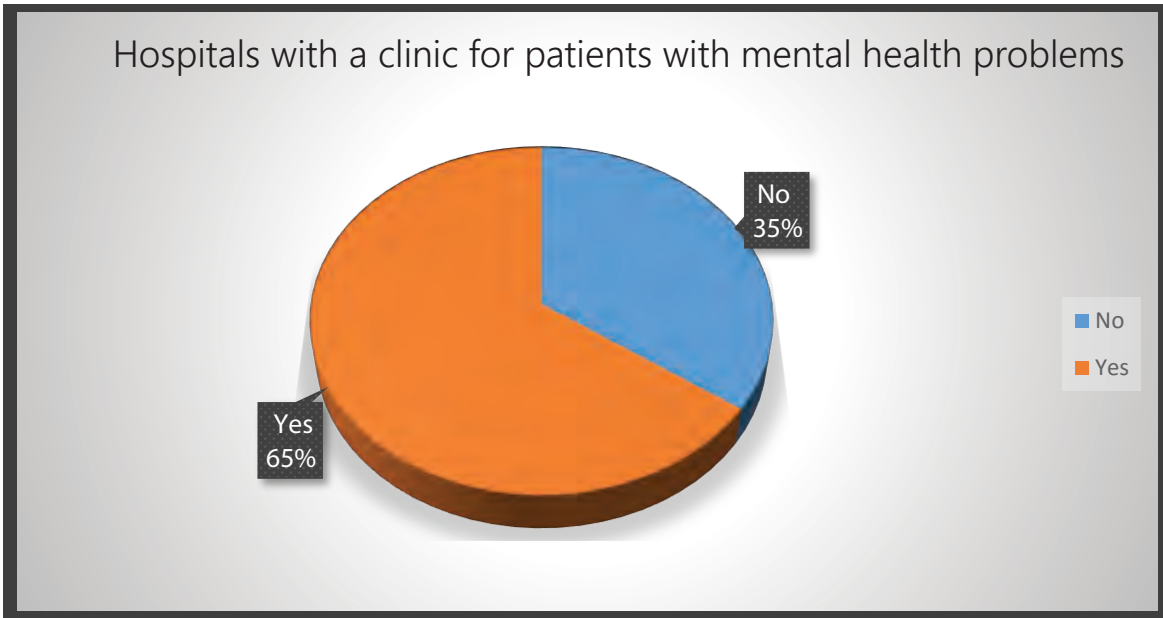


A total of 28 questionnaires were distributed by Email and re-submitted and 23 data collection tools (82%) were returned as complete. A large proportion of the respondents were psychiatric clinical officers (4/23) together with medical directors (4/23), medical superintendent, and hospital administrators each with (3/23). Kisiizi Hospital had the highest number of trained staff in psychiatry with a total of 5 staff followed by Kagando hospital and Bwindi Community Hospital.

3.2 Positions of survey respondents

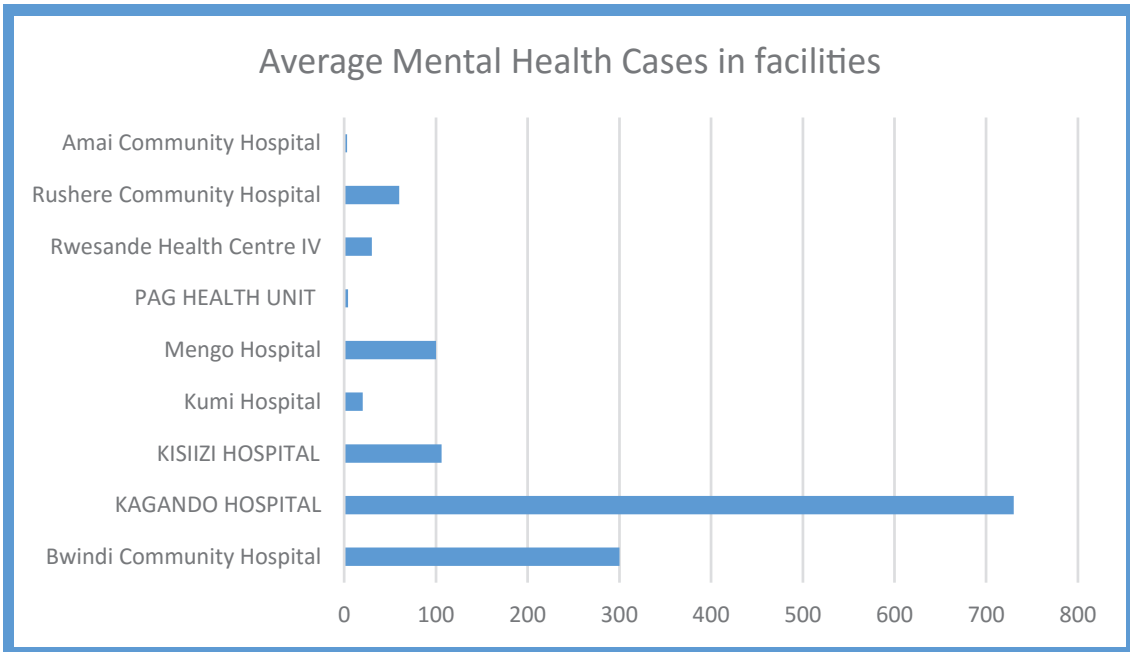
Less than half of the health facilities assessed (11/23) have at least one staff trained in psychiatry.

3.3 Availability of a clinic in the hospitals for patients with mental health problems



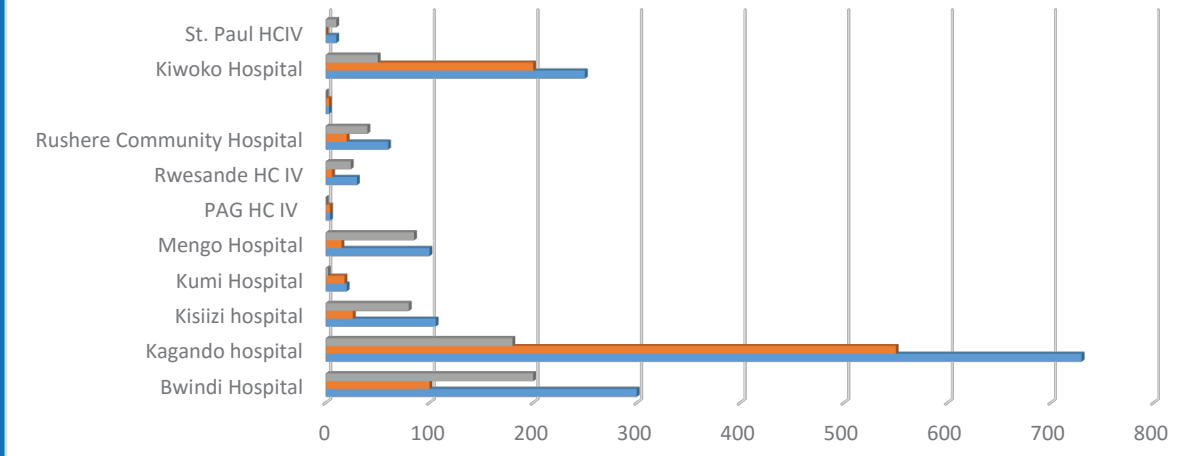
Only 8 out of 23 health facilities assessed (35%) didn't have clinics for patients with mental health problems. Therefore, this resulted in complex handling of patients since these are admitted when they are violent and difficult to handle within the OPD ward.

3.4 Average monthly number of patients with mental health problems in assessed facilities



From the assessment, Kagando Hospital reported the highest monthly average cases (730) followed by Bwindi community hospital (300) and the last is Amai Community hospital.[3]

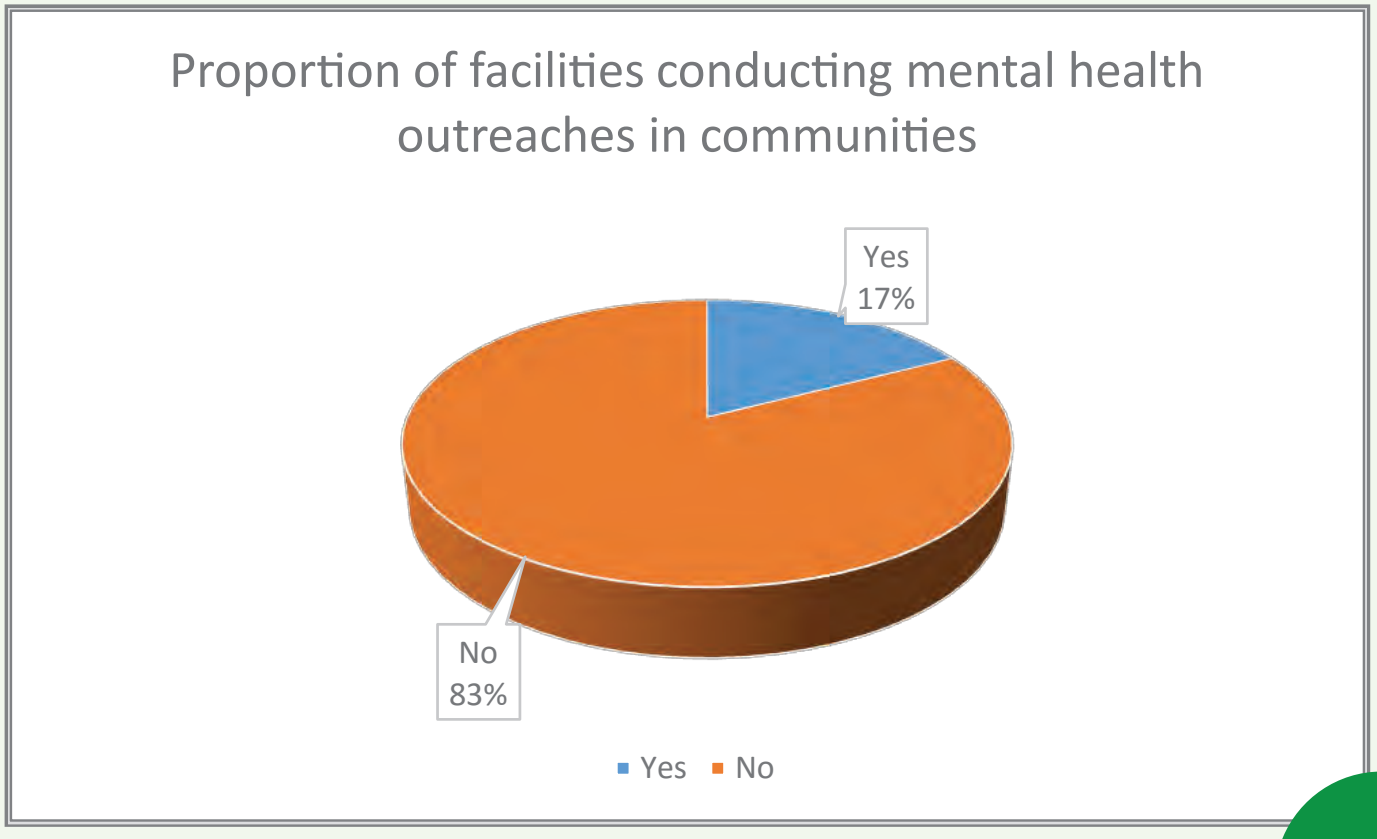
3.5 Distribution of patients with mental health problems



	Bwindi Hospital	Kagando hospital	Kisiizi hospital	Kumi Hospital	Mengo Hospital	PAG HC IV	Rwesande HC IV	Rushere Community Hospital	Amai Community Hospital	Kiwoko Hospital	St. Paul HCIV
Mental Illness	200	180	80	2	85	0	24	40	0	50	10
Epilepsy	100	550	26	18	15	4	6	20	3	200	0
Total Cases	300	730	106	20	100	4	30	60	3	250	10

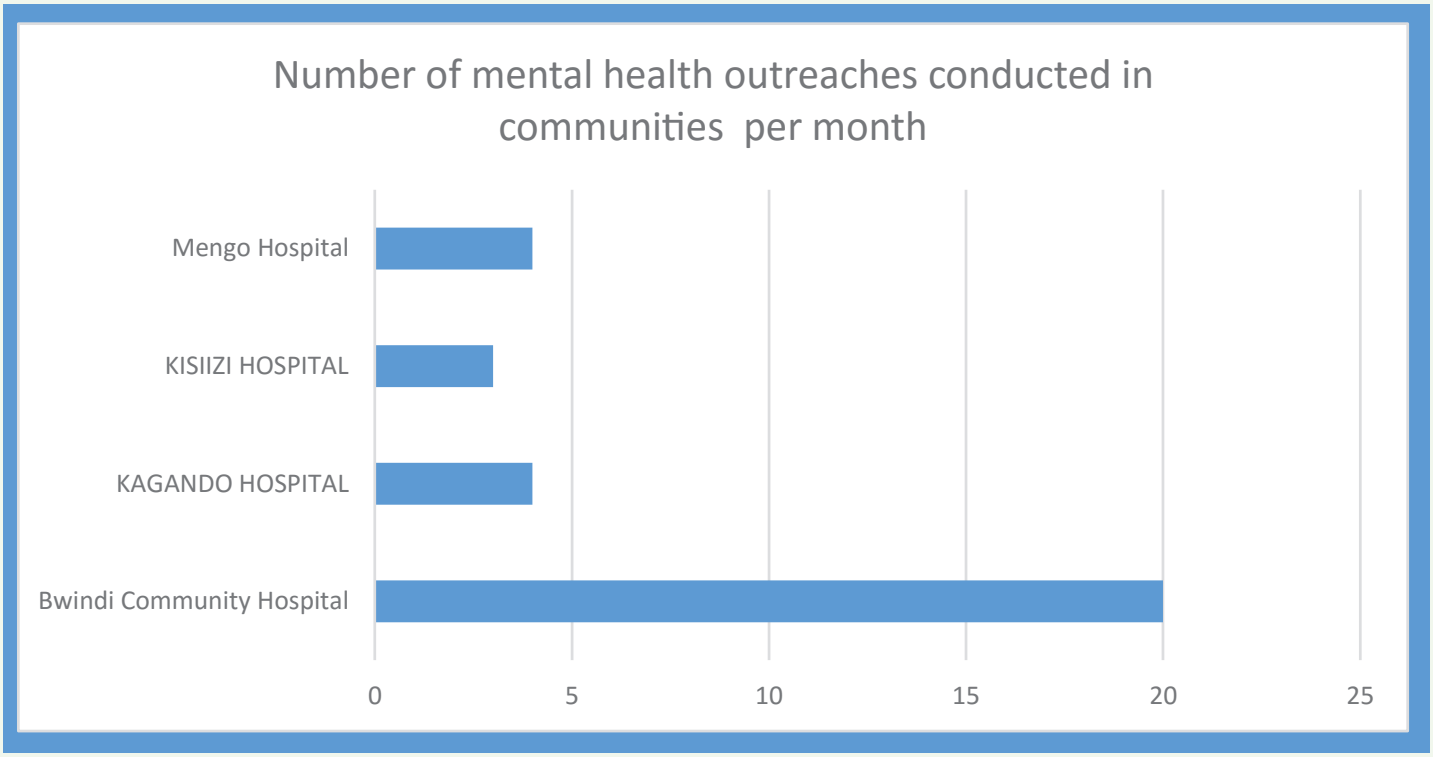
Averagely, monthly mental illness cases are reportedly higher in 6 e.g. Bwindi hospital, Kisiizi hospital, Mengo hospital, Rwesande HC IV, Rushere hospital and St. Paul HCIV out of 11 health facilities which reported while in 4 facilities including Kagando hospital, PAG HCIV, Amai hospital and Kiwoko had their epilepsy cases were higher than the mental illness cases.

3.6 Mental health outreach clinics in the community



Health Facilities conducting mental health outreaches in communities were only 4 (17%) compared to a significantly larger number of 19 (83%) health facilities that do not conduct mental health outreaches in their communities. Many hospitals raised the issue of lack of facilitation to conduct mental health outreaches. They also added that the cost of the drugs for treatment is also high hence a big challenge to conduct the outreaches in the communities.

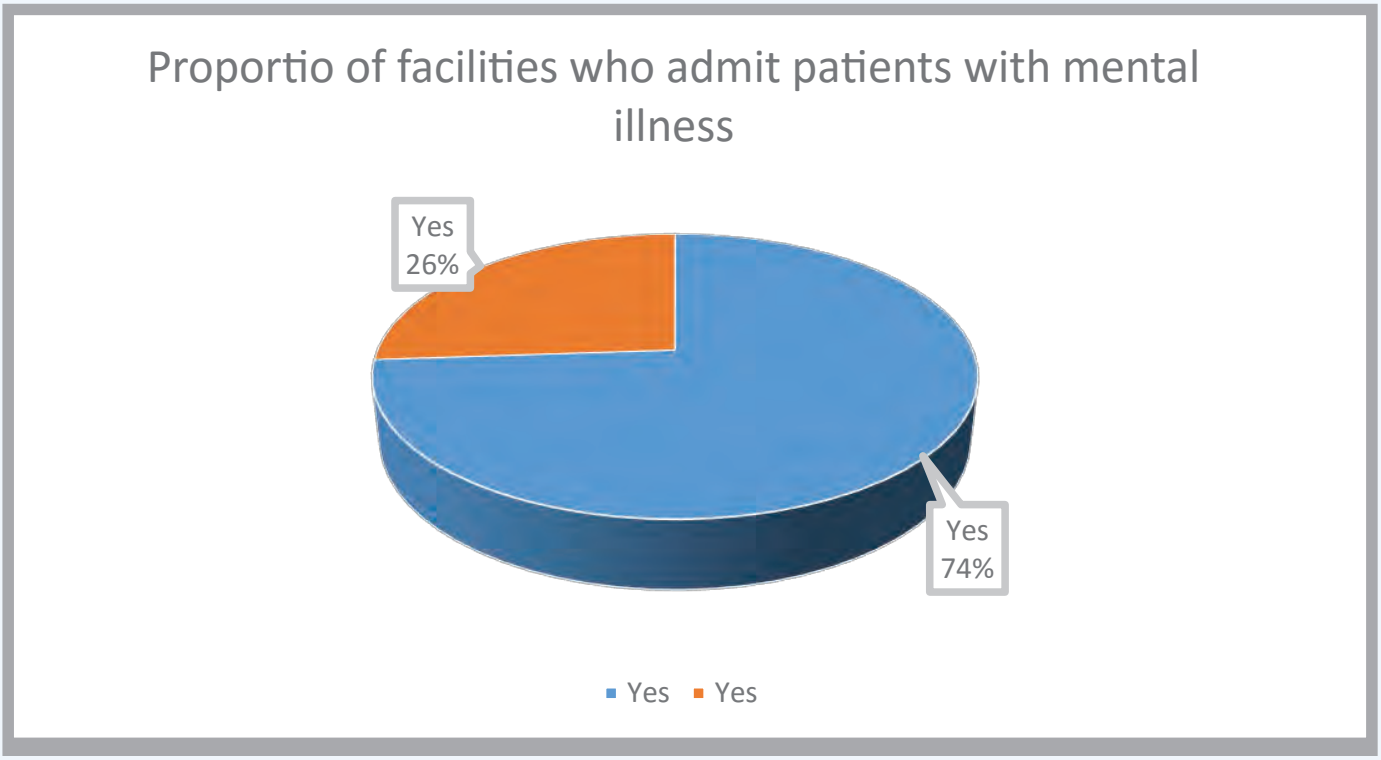
3.7 Monthly average frequency of mental health outreaches in the communities



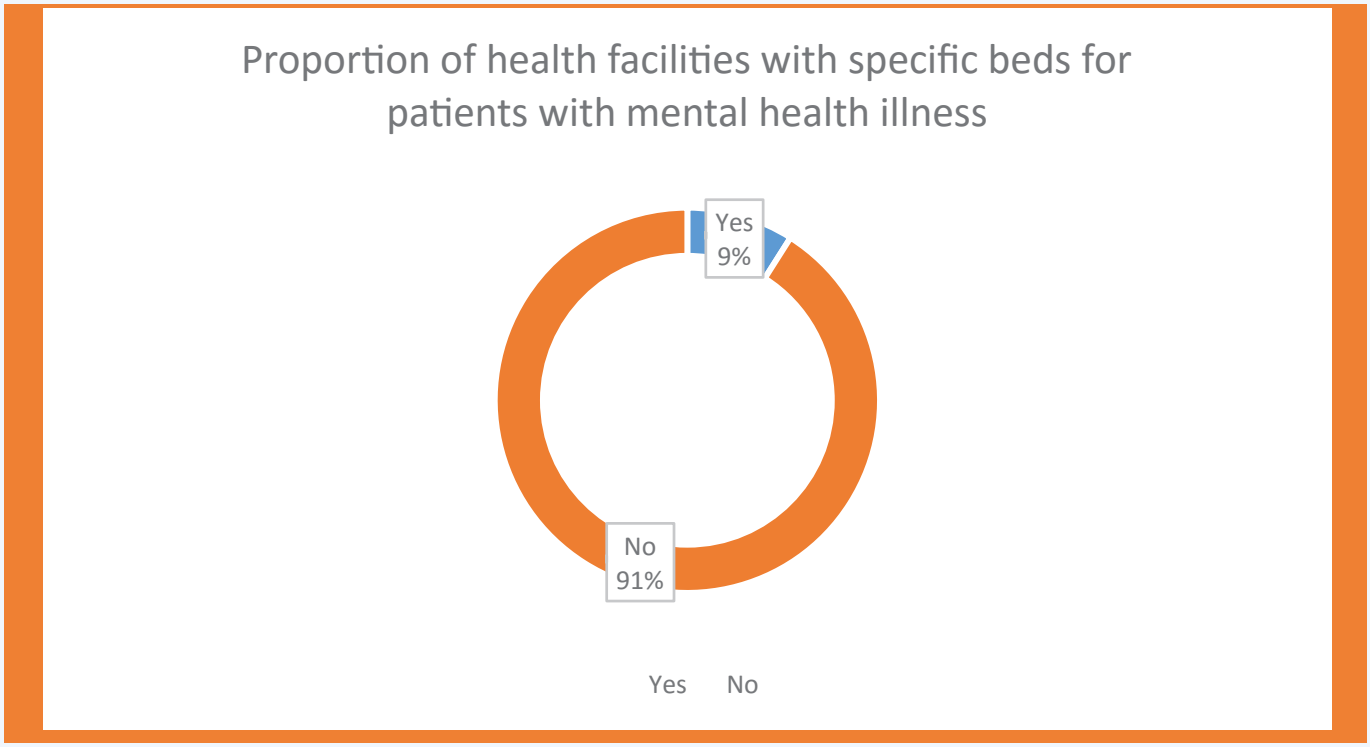
As illustrated, only 4 hospitals conduct monthly mental health outreaches however with varying frequencies with Bwindi community hospital conducting the highest (20) outreaches while the lowest was Kisiizi hospital with 3 outreaches per month. The average monthly outreaches conducted by Kagando and Mengo hospitals are 4 per month.

3.8 Admission of patients with mental health illness

A majority (16/22) of the health facilities (73%) assessed do admit patients with mental health illness as opposed to the 6 (27%) facilities who do not admit mental health patients namely Kolonyi, Mengo hospital, Azur HC IV, Butiru Chrisco hospital, Family Care hospital and Rwesande HC IV.



3.9 Comparison of admission with availability of specific beds for patients with mental health illness



In the contrast, while a majority of hospitals offer admission to patients with mental health illness, a significantly high number, 21 out of 23 hospitals (91%) have no specific beds for these patients with mental health illness as compared to only 2 hospitals with specific beds at Bwindi community hospital and COU Kisiizi hospital.

3.10 Difficulties cited in providing care

Ahumuza Mental Health Centre - Kisizi Hospital

Staffing

Staffing is a major difficulty. Just over half of the units with specialist psychiatric staff trained, said that staffing is a problem, as one or two staff can't be available all the time.
Almost all the units without specialist psychiatric staff said the lack of trained staff was a difficulty. In some cases, this is linked a lack of funds for salaries.
In addition, one unit with a mental health service reports that the lack of rehabilitation facilities and equipment together with access to occupational therapy trained staff is a limiting factor

Accommodation

Only one unit has specific inpatients beds for patients with mental illness.
Almost all units do admit patients with mental illnesses, despite not having specific beds. Not having designated space is an issue for most hospitals.
One hospital reports using their private rooms when necessary

Funds

The cost to patients and/or families of the service, including medicines, is a significant difficulty, with several units saying that families are not willing to pay for them. Medicines are expensive for units and families to purchase.
The money for urgent referral of disturbed patients is not always forthcoming.
Lack of funding for work in, and with, the community is cited by a few units. This includes the cost of transport as well as staff time.
One unit is currently providing free care to those with epilepsy and mental illness, but is aware that this limits the numbers that can be treated and that it is depending on external funding which may not be sustained.

Drug supplies

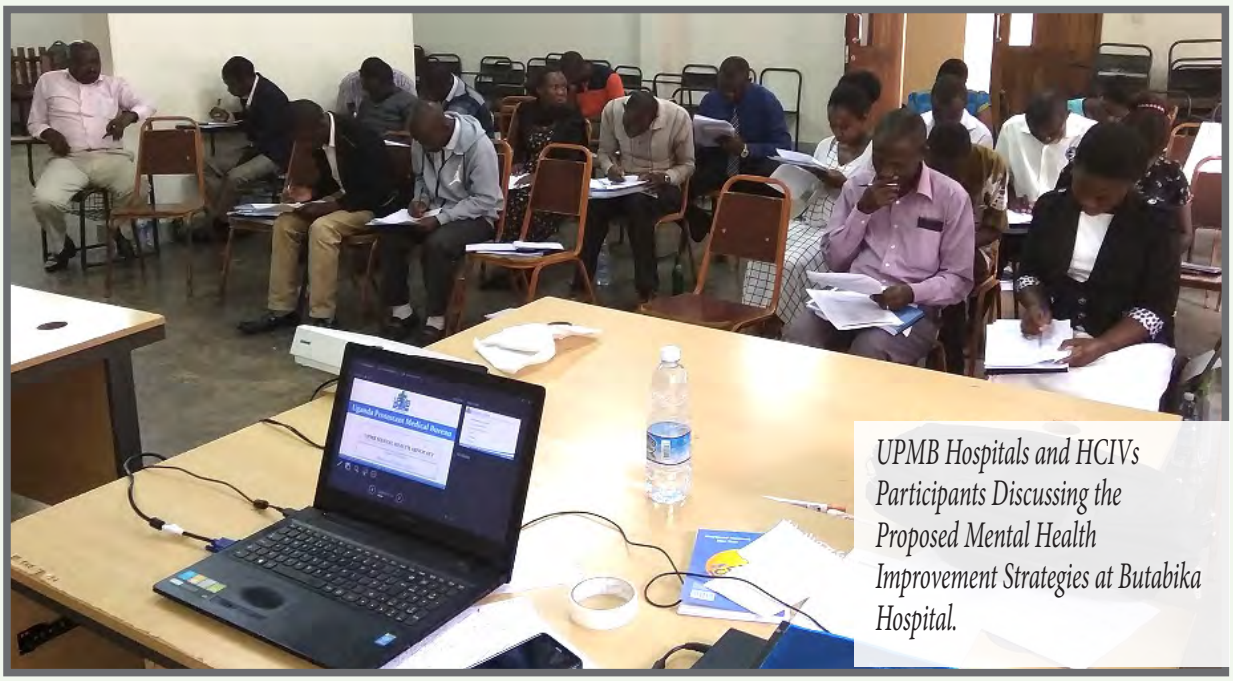
The cost and lack of supply of psychotropic drugs to the health units is also a problem.

Stigma and cultural issues

Several units' state that people in their community are reluctant to seek help due to cultural issues: "cultural beliefs on mental illness are limiting people from accessing the service" and "the biggest problem is stigma causing these people not to seek care"

One unit is aware that alcohol dependency is common, but they are only just beginning to address this with psycho-social group therapy.

3.11 Possible support to a hospital mental health service



UPMB Hospitals and HCIVs Participants Discussing the Proposed Mental Health Improvement Strategies at Butabika Hospital.

Training and recruitment

Training is seen by almost all units as helpful. Suggestions for training include updating those already trained in psychiatry, training other clinical staff either to be more aware of the different presentations of mental illness, for example by use of the WHO mhGAP programme or for individuals to be trained in psychiatry. There is also a request for training in administration. One suggestion is to identify and mentor a mental health focal person who could later be trained in psychiatry.

There are also requests for training and support in working with communities and developing suitable materials to use including videos, brochures, audio adverts, radio talks etc.

Support with recruiting staff is requested by a third of the units. Some are asking for the funding to employ them.

Two units are fairly close to regional psychiatric units, but are still interested in developing community services, if support were available.

Accommodation.

Over a third of units ask for support to construct a mental health unit or ward.

Funding

Funding of most aspects of a mental health is mentioned. This includes the

cost of staff salaries, psychotropic medicines, running community outreach clinics, resources to sensitize the public, feeding and clothing patients, and sponsoring psychiatric training.

Drugs

One unit suggests an improved drug spectrum to improve compliance and reduce side effects would be helpful.

Stigma and cultural issues

Several units request support to help them work with their local communities to increase understanding of mental illness and to increase the acceptability of appropriate treatment, as there is a low awareness of the scope of mental health care on offer.

Visit from a psychiatrist with experience of international mental health.

All but one of the units said that they would like a visit from a psychiatrist with experience of international mental health to discuss possible support for developing mental health services in primary care.

4.0 CONCLUSION

There is a significant burden of disability and stigma due to mental disorders in Uganda. Half of the hospitals and HC IV's that responded already employ staff with psychiatric training. Of all the units that responded, many are already providing some care to people with mental illness including admissions, and almost all of them are willing to consider developing community mental health services.

There is considerable interest in support for training for different groups:

- Updating and development for existing specialist mental health staff
- Training in mental health for non-specialist clinical staff (WHO mhGAP training)
- Specialist training in psychiatry for individual non-specialist clinical staff,
- Training for the delivery of community sensitization programmes

However, there are a number of constraints in mental health service delivery, for example:

- A lack of designated beds for seriously disturbed mentally ill people
- Limited facility space for therapeutic interventions, e.g. psychotherapy, counselling, group therapy, occupational therapy

- The high cost and limited availability of drugs for treatment of mental illness
- Limited financial support to facilitate mental health outreaches
- Low numbers of staff caring for mental health patients.

A systematic approach to training different groups should be planned and resources identified. Such an approach could include shared experience and joint training on a regional basis. The establishment of a mental health network, within UPMB, could facilitate this sharing.

With the development of effective primary care mental health services, serious mental illness can be identified early and, following such assessment patients can be maintained on treatment in the community. This will reduce the need for specialist beds and so the requirement for designated beds may not be as great as is currently anticipated,

5.0 RECOMMENDATIONS

- A mental health network should be established under UPMB by the end of 2018 if there is sufficient interest. This would enable units currently providing mental health services and those who are interested to share ideas, experience and training,

- A more detailed assessment of the training needs of different groups should be carried out by February 2019. This will enable proposals for different training programs to be 12
developed. This training assessment will need to be done in conjunction with discussions with each unit to understand what their aspirations are in developing a mental health service in primary care, and what resources they already have to build on. This is to ensure a coherent plan is developed.

- Discussions with the Ministry of Health with regard to ensuring that there is a dependable, regular supply of psychotropic and anticonvulsant medication to member units and associated health centers. These discussions should be initiated before the end of 2018 and the results shared with the member units.

- Scale up other units that are not providing mental health services starting the next financial year.

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UPMB

ACTS 1:7-8

"Health in Totality"

Uganda Protestant Medical Bureau

July 2018

Jamie's Family and Dr Diana Atwine, Permanent Secretary, MOH Cutting the Cake to Mark Opening Celebration of Ahumuza Mental Health Centre.

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