ASSESS THE CAPACITY OF HEALTH CENTRE IVS TO MANAGE MENTAL HEALTH PROBLEMS: A CASE STUDY OF WAKISO DISTRICT

BY

VINCENT MUJUNE

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Declaration

I ……………………………………………….hereby declare that this study is my original work submitted in partial fulfillment of the requirements for the Master of Science in Public Health at International Health Sciences University, Kampala - Uganda. Therefore no part of this work is copied, duplicated and reproduced for the purpose of this submission.

Student's signature……………………………………………. Date……………………………

Supervisor's name……………………………………………. Signature……………………….

Dedication

I dedicate this piece of work to the persons with mental health problems in Uganda and specifically in Wakiso district whose care and treatment this study seeks to make a contribution. It is against background that I highly recommend the findings and recommendations of this study to the district health management teams and the political leadership of the district as well as the Ministry of health (MoH) whose efforts in developing guidelines for mental health integration shall be informed.

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
DALYS	Disability Adjusted Life Years
MHgaPP	Mental Health gap action Programme
HIV	Human Immuno-deficiency Virus
MH	Mental Health
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
MNSDs	Mental, Neurological and Substance use Disorders
MoH	Ministry of Health
UNMHCP	Uganda National Minimum Health Care Package
WHO	World Health Organization

Abstract

According to the Mental Health Gap Action Programme (MHGAP), mental disorders account for 14% of the global burden of disease; 75% of which are in Low Developed Countries (WHO, 2008). In Uganda, common mental disorders can be detected in 20% to 30% of all outpatient visits common in community health centres (Kigozi et al, 2005). Although it is recommended that majority of cases of mental health problems identified within community be recognized and treated within Community Health Centres, research by Holdaway (2003) shows that up to 50% of patients who present mental health problems fail to have their symptoms recognized by a general medical practitioner. The implications of this are many and present themselves in terms of human social cost and economic cost. The study assessed the capacity of Health Centres IVs to manage mental health problems as a basis for improved mental health service delivery within community Health centres in Uganda. The study uses a case study of Health Centre IVs in Wakiso district as a generalizeable study area representing urban, semi-urban and rural characteristics. The focus of this study is primarily on the capacity of Health Centre IVs, based on their jurisdiction as the main point of referral in each health sub district, to manage mental health problems.

The objectives of the study were to identify existing forms of care available for mental health problems, to analyse the capacity of primary health care workers to effectively manage cases of mental health problems and to describe existing mechanisms for resourcing the treatment of mental health problems by 2011. A cross sectional study design was chosen as applied to the case study of Wakiso district. A total of 33 respondents were interviewed. The District Health Officer, Mental Health Focal Person, Psychiatric Clinical officers and Nurses

were taken as purposive samples. The health care workers were drawn from Health Centres IVs including Buwambo, Kasangati, Namayumba, Ndejje and Wakiso.

Findings show that clinical treatment of mental health problems was the primary form of care provided by 70% of the Health Care Workers followed by psychological care provided by 80.65% of which 75% use counseling as for delivering psychological services to patients. There was limited understanding of techniques such as Cognitive Behaviour Therapy (14.29%), Narrative Exposure Therapy (14.81%), Motivational Interviewing (18.52%) and Group Therapy Sessions (14.81%) which are important for the effectiveness of any counseling interventions. In spite the government effort to recruit Psychiatric Clinical Officers and Nurses on the staff teams at the five Health Centres, the findings show a high propensity for mental health referrals by approximately 89% of health care workers which contests the capacity of the health care workers to manage mental health problems. In addition, of the cases referred, 27.59% of them are made to the resident mental health specialist at each Health Centre IV which denoted limited involvement of general health care workers in treatment on mental health problems.

The main source for resourcing mental health care is facilitated by the Government of Uganda with undocumented proportions of out of pocket expenditure by patients and care givers. Although it is evident that resources such psychotropic medicines are well stocked represented by 85% of all health care workers, constraints at the health centres are responsible for limited admissions, follow up and provision of psycho-education services to clients. In conclusion, although efforts have been made to improve the capacity of Health Centre IVs to manage mental health problems, it is important to integrate such efforts with quality control mechanism which can be done through establishment and implementation of effective monitoring and evaluation mechanisms.

Operational definitions

This section provides definitions for commonly used technical terminologies in this research.

Community Mental Health Practice: A multidimensional intervention process that effectively meets a community's need for appropriate mental health services through both engaging available local, tertiary and national resources and capabilities and stimulating multiple stakeholder awareness and commitment (Underhill, 2008).

Essential Medicines: Medicines that satisfy the priority health care needs of the population. (Laing et al, 2006).

Mental Health: A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (World Health Organisation, 2011).

Mental Health Disorders: Symptoms that affect thinking and emotions, as well as those that affects the relationships of individuals with family and society, often resulting in an inability to cope with the ordinary demands of life (Development Research and Training & Chronic Poverty Centre, 2007).

Mental Health Integration: Mental health care that is integrated into everyday primary health care practice (Reiss-Brennan et al, 2006).

Primary Health Care: The provision of essential health care accessible to individuals and families in the community and provided as close as possible to where people live and work,

based on the needs of the population, is decentralized and requires active participation of the community and the family. (Declaration of Alma-Ata, 1978).

Schizophrenia: Schizophrenia is the most chronic and disabling of the severe mental disorders, associated with abnormalities of brain structure and function, disorganized speech and behaviour, delusions, and hallucinations (Encyclopaedia of Mental Disorders, 2011).

CHAPTER ONE

1.0. Introduction

This study analysed the capacity of Health Centre IVs in Wakiso district in managing mental health problems. It was intended to assess if mental health problems can be adequately addressed at the level of Health Centre IV. Existing forms of care available for mental health problems were identified, the human resource capacity of the health centres was analysed, mechanisms for resourcing mental health care integration are described and the impact on the consumers of mental healthcare was established. Findings from the study are intended to guide the development of operational guidelines and plans for the integration of mental health care in Primary Health Care.

This chapter provides the background about mental health globally, regionally and nationally as a basis for assessing the capacity of health centre IVs to effectively manage mental health problems and chronicles attempts to reinforce integration of mental health care in Uganda. This will form the foundation for improving the capacity of Health Centres to manage mental health problems which are considered an emerging public health challenge of the 21st century. A statement of the problem is presented, objectives and research questions outlined, justification of the study and a conceptual framework.

1.1 Background

According to the Mental Health Gap Action Programme (MHGAP), 2008, mental disorders account for 14% of the global burden of disease; 75% of which are in Low Developed Countries. Furthermore, according to the global burden of disease study, mental and neurological disorders are the leading causes of disability. A report from World Health Organisation, Mental and Neurological Disorders: Public Health Challenges (2006) identifies the disorders as one of the

greatest threats to public health. The disorders are believed to be more common in the developing world due to known multiple risk factors such as malaria, malnutrition, infectious diseases and accidents.

Development Research and Training and the Centre for Chronic Poverty (2007) list the proportions of these disorders as Post Traumatic Stress Disorder (9%), common depression (20%), manic depression (3%), anxiety (4%), Epilepsy (3%) and Schizophrenia (1%); these account for 20-30% of all hospital outpatient attendance.

Since most well-defined psychological problems are common in Primary Health Care settings in every country and cause disability (Ormel et al 1994), Desjarlais, et al (1995) recommend that majority of cases of mental health problems identified in areas with limited resources be recognised and treated within Primary Health Care. However, Holdaway (2003) writes that up to 50% of clients or patients who present mental health problems fail to have their symptoms recognized by a general medical practitioner. According to the World Health Organization (2005), 1 in every 4 people develops one or more mental disorders at some stage in life and today, 450 million people globally suffer from mental disorders in both developed and developing countries. There are grave implications of this, for example the California Institute for Mental Health (2011) found that people with severe mental illness die twenty five years earlier than their peers, in part because of limited access to quality primary care, yet these are preventable or treatable medical conditions; for example 60% of deaths for people with schizophrenia can be attributed to preventable or treatable medical conditions.

In 2001, the World Health Organisation set the first minimum standards for the integration of mental health care as part of primary care in low income countries. The integration process didn't have to be a costly exercise and it would be greatly enhanced by the provision of

essential neuropsychiatric drugs and in-service training of all general Health Care personnel. Eight years later, the World Health Organisation Global perspective report (2008) proposed operational principles for mental health integration in primary care based on a global study. This entailed incorporating policy and plans for mental health in Primary Health Care, using advocacy to shift attitudes and behavior, adequate training of primary care workers, doable and limited Primary Health Care tasks, availability of specialist mental health professionals and facilities to support primary care and patient access to essential psychotropic medications in primary care.

In Uganda decentralisation of mental health services started in the 1960s with the construction of mental health units at regional referral hospitals and with the operationalisation of the National Health Policy of 2001/2002, it became part of Primary Health Care. The policy focused on delivery of health services that are demonstrably cost-effective and have the largest impact on reducing mortality and morbidity. Priority was given to major contributors to the burden of disease and these included mental disabilities; Development Research and Training and the Centre for Chronic Poverty (2007) cite that an estimated 35% of Ugandans (approximately 9,574,915 people) suffer from some form of mental disorders, at least 15% of which require treatment. Interventions intended to address the above conditions are included in the Uganda National Minimum Health Care Package (UNMHCP). In addition to this, the Health Sector Strategic Plan I (HSSP-2000/1 -2004/5) set the foundation for restoring the functional capacity of the health sector, reactive disease control programmes and re-orienting services to Primary Health Care. The development of the essential medicines list also came as a reinforcement of the policy position.

The Health Sector Strategic Plan II (2005/06 to 2009/10) was intended to guide different stakeholders on how best to deliver the UNMHCP to ensure improved health outcomes for all

Ugandans, and in particular how best to target the most vulnerable groups with public resources. The plan included activities to promote the integration of mental health into Primary Health Care such as development and dissemination of appropriate messages for improving community mental health, promotion of the rights of the mentally ill and technical support supervision at all levels. Additional reforms included the addition of major mental health conditions into the Health Management Information System report, inclusion of at least nine major mental health conditions in the National Clinical Guidelines, inclusion of mental health as a core unit of the training curriculum for general health workers and countrywide in-service training of Primary Health Care workers, as well as establishment of a referral system.

A draft mental health policy was developed in 2001 and revised in 2009 as a policy for Mental, Neurological and Substance use Disorders. An implementation plan to go with the Policy was also developed. In addition to this, a mental health bill to replace the outdated Mental Health and Treatment Act of 1964 is in the process of being finalized. All of these advocate for the provision of mental health care services in Primary Health Care level.

The structure of the health care system in Uganda is comprised of Village Health Teams, and Health Centres II, III and IV, district hospitals and national referral hospitals. However various studies have shown these to be resource constrained. The Village Health Teams are the first point of contact but in many cases these are non-existent or under resourced. The Health Centre II which operates an outpatient clinic should be able to treat common illnesses like malaria and offer antenatal care. It is supposed to be found at Parish level. It is headed by an enrolled nurse who is assisted by a midwife, two nursing assistants and a health assistant. Health Centre IIIs are found at sub county level and are led by a Senior Clinical Officer. They also operate an outpatient clinic and a maternity ward but have a bigger number of staff, and must

have a functioning laboratory. Health Center IVs serve a County or Parliamentary constituency and should be headed by a Senior Medical Officer, assisted at least by another doctor. In addition to the services offered at a Health Centre IV, it should have a theatre for carrying out emergency operations. Health policy dictates that at least one Psychiatric Clinical Offer and one Psychiatric Nurse should be stationed at every Health Centre IV but this is not usually the case (Kavuma, 2009). Hospitals should be found at each district and the national referral hospital, Mulago is found in the capital city, Kampala. The national referral hospital for mental health is Butabika, also found in Kampala.

In addition to the above, according to Government Commission Recommendations NO.9, (2003), Health centres IV are mini-hospitals and amounts to run them are defined every financial year. Fifty percent of the fund is for purchase of drugs, while the other 50% is used as follows: Allowances for outreach activities 30%, Transport (fuel, maintenance of vehicles) 30%, Facility and property costs (maintenance of buildings and minor repairs, compound, utilities, stationery and maintenance of equipment, purchase of charcoal, paraffin) 40%. However the proportion that is devoted to mental health care is usually diminutive.

While deinstitutionalization and integration of in-patient mental health care within general hospitals is an often stated policy objective, 74.4% of psychiatric beds in Low and Middle Income Countries remain in psychiatric hospitals (WHO, 2005). It is therefore evident that gaps still exist in the integration of mental health into Primary Health Care. The study is intended to assess the capacity of Health Centre IVs to manage mental health problems, and in so doing, provide evidence for developing indicators and guidelines for mental health care integration in Primary Health Care.

1.2 Statement of the Problem

Mental health problems are a global public health concern contributing to 14% of the Global Burden of Disease by 2008 and expected to reach 15% by 2015 (World Health Organisation, 2008). In Uganda, common mental disorders can be detected in 20% to 30% of all outpatient visits common in community health centres (Kigozi et al, 2005). In 2006, the Uganda Bureau of Statistics (2006) reported 7% of all households have disabled members and of which 58% have at least one person with a mental disorder. This state of affairs poses a serious responsibility to community Health Centres to identify and treatment of mental health problems at the earliest possible time. Unfortunately, the capacity of community health Centres to effectively meet the need for mental health services at community level is still an allegory as reported by Holdaway (2003) that up to 50% of clients or patients who present mental health problems fail to have their symptoms recognized by a general medical practitioner. In addition, California Institute for Mental Health (2011) found that 60% of common deaths caused by mental health problems are preventable.

The possibility of Health Centre IVs to provide the needed care for persons with mental health problems is also met with human resource challenge where the World Health Organisation, (2005), reports that the ratio of psychiatrists to the population is estimated at 1:1,900,000 in Uganda while other resources like admissions were noted to be poorly distributed as reported by Kigozi et al, (2010) that sixty two percent (62.4%) of the psychiatric beds in Uganda are located in or near the largest city. This distribution pattern limits access for rural users. These indicators pose serious challenges to the management of mental health problems in community health centres.

Therefore, capacitating Health Centre IVs in Uganda to provide mental health services within each Health Sub District, will provide an early intervention to combat the adverse effects of mental health problems which present with a complex of costs which according to Source of Hope for all Touched by mental illness International, (2007) include human cost: suicide claims a life every 30 seconds, social costs: stigma and exclusion and economic costs: treatment and opportunity cost of economic contribution for patients and caregivers. This affects the livelihood of affected families.

In spite, government effort to integrate mental health care in Primary Health Care as a strategy for increasing access to mental health services, the existing forms of care, human resource capacities and mechanisms for resourcing mental health care at community health centres require a thorough assessment as a precursor to needs based planning and development of evidence based integration guidelines for mental health services in Uganda. Finally, Kirunda, (2008) warned that the assumption that mental health services are reasonably well-organised and health unit staff at both micro and macro levels know their roles in the integrated health care delivery has proved wrong because only a limited number of general healthcare workers appreciate this policy requirement to that effect. The assumption of this study is that, if Health Centre IVs in their jurisdiction as the main point of referral in each health sub district have sufficient capacity to manage mental health problems, then a sustainable solution will have been found for early detection and treatment of mental health problems in Uganda to remedy the emerging public health concern regarding mental health mental health problems, this is timely.

1.3 Study objectives

1.3.1 General objective

To assess the capacity of Health Centre IVs in Wakiso district to manage mental health problems.

1.3.2 Specific objectives

1) To identify existing forms of care available for mental health problems at Health Centre IVs in Wakiso district during 2011.
2) To assess the capacity of Health Care Workers at the Health Centres IVs in Wakiso district to effectively manage cases of mental health problems during 2011.
3) To describe existing mechanisms for resourcing the treatment of mental health problems at the Health Centre IVs in Wakiso district during 2011.

1.4 Research questions

1) What forms of care are available for persons with mental health problems at Health Centre IVs in Wakiso district?
2) What is the capacity of primary health care workers at the Health Centres IVs in Wakiso district to effectively manage cases of mental health problems?
3) What are the existing mechanisms for resourcing the treatment of mental health problems at the Health Centre IVs in Wakiso district?

1.5 Significance of the Study/ Justification

The findings of this study are essential in informing the district about the unmet need for mental health care services within the 5 health Sub districts in order to guide efforts geared towards improving access and capacity to manage mental health problems at health Sub district, district and national levels. The results will equally provide contextual evidence necessary for

developing needs based guidelines for mental health integration in Uganda as earmarked in the Health Sector Strategic Plan III (2010/11 -2014/15).

The existing mechanisms for monitoring and evaluating health sector performance by Ministry of Health (MoH) through Annual Health Sector Performance Monitoring and other monitoring mechanisms implemented at district level do not comprehensively report on the management of mental health problems in Health Centres across Uganda. Since the primary focus of the study is to assess the capacity of Health Centre IVs to manage mental health problems makes the findings of this study are not only important for District Health Team planning but also for Ministry of Health (MoH) to ensure that the findings and recommendations inform mental health policy development, and planning in Uganda.

The study outcomes shall guide strategies for investment in human resources for health, task shifting, and allocation of financial resources for mental health care within at district level. As a result, Wakiso district and indeed other districts within Uganda will be brought upto speed with the integration of mental health in primary health care which forms the foundation for improved access and capacity of Health Centre IVs to manage mental health problems.

The study results shall provide feedback information to government of Uganda particularly the Ministry of Health about the effectiveness and impact created through initial investments into the integration of mental health care in Primary Health Care through in-service training, addition of mental health medicines on the list of essential medicines and health workers' training curriculum reforms.

1.6 Conceptual Framework

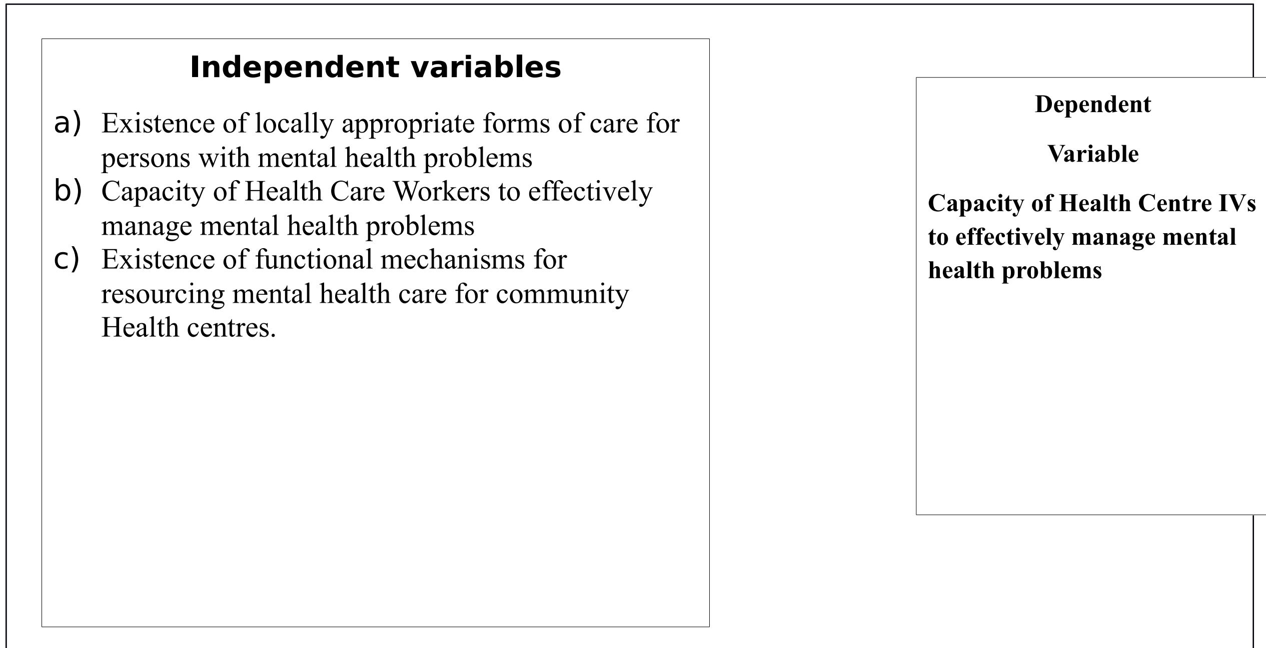
The framework below presents a set of actions required for the management of mental health problems as the independent variables that directly affect the capacity of Health Centre IVs to effectively manage mental health problems as the dependent variable. These actions are spelt out in the World Health report published in 2001 as guide to low income Countries to ensure that mental health care is integrated in existing Primary Health Care. The following key actions are important for Health Centre IVs:

a) Recognize mental health as a component of primary health care through tested forms of care
b) Include the recognition and treatment of common mental disorders in training curricula of all health personnel
c) Provide refresher training to primary care physicians (at least 50% coverage in 5 years)
d) Ensure availability of 5 essential drugs in all health care settings
e) Provide community care facilities (at least 20% coverage)
f) Train Health Care Workers i.e. psychiatrists and psychiatric nurses
g) Include mental disorders in basic health information systems

These minimum standards have been the foundation for national and lower level interventions for integrating mental health in primary care as a basis for improving capacity to manage mental disorders in Uganda . under the Support to Health Sector Strategic Plan project (2004/5-2009/10). Therefore the mandate of this study is to assess the capacity of health centre IVs in managing mental health problems with a case study of Wakiso District. The assumption that management of mental health problems in primary health care units shall be effective upon implementation of the above minimum conditions in Uganda was central in the design of this study.

From the above minimum standards, the research identified three fundamental independent variables that may influence the capacity of Health Centre IVs to effectively manage mental health problems as shown in the conceptual model below;

Figure 1: Conceptual framework



Since Wakiso district has been a beneficiary of all government interventions to integrate mental health services in Primary Health Care, provides the decision makers within the district and national level a synopsis of the changes that have taken place in order to plan and intervene accordingly.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents submissions of scholars and researchers whose contribution to the body of knowledge has informed the design and discussion of study findings. The literature review is presented according to themes developed from the objectives and research questions of the study using research work and articles written about mental health care in developed and developing country contexts. The review further traverses important assumptions, gaps, standards, scholarly ideas and theories for the effective management of mental health problems in primary health care settings in Middle and Low income Countries.

2.2 Forms of care available for mental health problems at Health centre IVs

The researcher accentuates numerous innovative forms of care recommended for providing care to persons with mental health problems in Low and Middle Income Countries coupled with specific best practices from the developed world. These are presented in the text below.

Griffiths & Christensen (2008) write that in Australia there is demonstrated commitment to the reduction of the prevalence of mental illness and its risk factors and to increase access to appropriate healthcare and engagement, employment, education and accommodation in the community. Focus is on management in general practice and community settings rather than specialist services and mental health programmes are based on evidence of effectiveness. Approaches that are not based on evidence risk being discontinued. Key areas of action include the support of mental health promotion, prevention and early intervention programmes and the integration and improvement of the care system for people with mental health problems. These

services are guided by a national mental health policy and action plan and are also federal funded, for example 1.9 billion dollars was dedicated to the implementation of the plan for 2003-2008.

In addition to the above developments in Australia, one of the conclusions of their subsequent research on mental health integration in primary care is that care management and consumer centered models that emphasise guided self-management and consumer empowerment be adopted. They suggest that this approach may improve the strain on human resources for health and contribute to the delivery of better outcomes at affordable cost. They also advise a reorganisation of current systems of delivery in primary care, as well as development of implementation strategies and institution of funding models to make it happen.

Lazarus & Freeman (2009) presented four models of primary mental health care and the first is mental health in primary health care where mental health is fully integrated with primary level general health care services with staffing by general health workers as part of their routine function or as part of other health programmes operating at the primary care level. The second is mental health at primary health care where mental health services are located on site with staffing by specialist mental health workers and the third is mental health community outreach where mental health care is provided in community setting by staff such as community health workers based in the community or operating on outreach from a health service. Finally, they present mental health care provided through other sectors where statutory or non-statutory services in areas other than health may provide mental health care. Here staffing may be general or on call mental health professionals. While some practice principles may vary across the models, some are crosscutting, for example screening is an important first step for all the models.

In their paper, they explore best practice for these models from Chile, Belize, Pakistan, Brazil, and India.

Stakeholder ownership has also been found to play a big role in ensuring effective management and integrating mental health in Primary Health Care in Chile, the Islamic Republic of Iran and Saudi Arabia. However, this takes rigorous sensitisation of national and local political leadership, health authorities, management, and primary care workers about the importance of managing mental disorders within primary care settings (WHO, 2008).

In addition to stakeholder involvement, there has also been considerable interest in recent years in the prompt identification and treatment of first- or early-episode cases of psychosis. Much of this research has focused upon the time between the first clear onset of symptoms and the beginning of treatment, referred to as the 'duration of untreated psychosis'; other studies have placed more emphasis upon providing family interventions when a young person's psychosis is first identified (Addington *et al*, 2003; Raune *et al*, 2004). However this may be a limited due to poor knowledge of and negative attitudes towards mental illness within the community which often prevents people with mental illness or epilepsy and their families from seeking help (Gureje et al., 2005).

A review of 12 different randomized controlled trials of enhanced care for major depression in primary care settings established that interventions directed solely towards training and supporting general practitioners have not been shown to be effective. It was argued that interventions should focus on low-cost case management, coupled with flexible and accessible working relationships between the case manager, the primary care doctor and the mental health specialist. In other words, the whole process of care needs to be enhanced and reorganized to

include the following key elements: active follow-up by the case manager, monitoring treatment adherence and patient outcomes, adjustment of treatment plan if patients do not improve, and referral to a specialist when necessary (Von Korff & Goldberg, 2001). This status works on the assumption that availability primary care doctors and mental health specialists is obvious. This is not uniform across all health centres IVs in Wakiso District.

Outreach mental health care services could be essential in bridging access constraints for consumers of mental health care. Suffice to say, Community Mental Health (CMH) services as a non-facility based method for delivering mental health care is reported to be a major success in accessing services to communities living far from health units and hospitals through outreach mental health services (Saraceno et al., 2007). However, while research shows that many CMH programmes have been effective in increasing access to mental health treatment in certain areas, CMH initiatives are also commonly criticized for existing in isolation, allowing little opportunity for growth (Saraceno et al., 2007).

Wait & Harding (2006) observed that mental ill-health in Europe is second only to cardiovascular disease in its toll on morbidity and mortality and accounts for nearly 20% of the total burden of illness and that there has been significant progress in treatment options for different forms of severe mental illness in recent years, the mainstay of treatment is medication. They however, propose psychosocial interventions as recognised form of care which is central to the success of treatment. They can include cognitive behaviour therapy, psychotherapy, family therapy and counselling and community-based services including employment assistance. It is important that treatment approaches are tailored to each individual and adapted on a regular basis.

According to the World Health Organisation/ Wonca joint Report (2008) entitled Integrating mental health into primary care: a global perspective, thirty years after the adoption of the Alma Ata Declaration on primary health care, the vision of primary care for mental health has not yet been realized in most countries. The report reaffirms the urgent importance and advantages of redressing this deficit and integrating mental health into Primary Health Care systems around the world, similar to the presentations in this chapter. The conclusion is therefore that health system transformation can be achieved through detailed description and replication (where applicable) of best practices from around the world.

Over the last 15 years, important steps have been taken to improve mental health care provision in the Uganda and promote the role of psychiatry in medical education. In Adjumani, lobbying among local politicians and district health care providers convinced the district administration about the need to be self-reliant and generate resources from within the district in order to respond to the psychosocial needs of the population. Primary health care providers at all levels of health care in the district were trained in order to make services accessible to the rural population. Further plans based on initial exploratory discussions aim to involve the education department, the welfare and probation office, prisons and police, the military, church and cultural leaders and traditional healers. (Emilio Ovuga, Jed Boardman, and Danuta Wasserman 2007). These developments emphasise the importance of taking a multi-stakeholder approach in ensuring that mental health problems are effectively managed.

Although research shows that many Community Mental Health (CMH) programmes have been effective in increasing access to mental health treatment, such initiatives are also criticised for existing in isolation, allowing little opportunity for growth (Saraceno et al., 2007). Development Research and Training and the Centre for Chronic Poverty, (2007) reported that the

cost of treatment for mental health problems ranges from Uganda shillings 20,000 ($13) to 100,000 ($63) per person per month, and traditional treatments yet these require long term treatment which is expensive for the individual, their families and the nation. This affects the livelihood of affected families. This demonstrates the urgency of appropriate care mechanisms in community health centres to ensure that the dismal effects of mental health problems on the local population.

2.3 Capacity of primary health care workers to effectively manage cases of mental health problems

This section documents the contributions of scholars and researchers in the field of mental health care regarding the capacity of health care workers to manage mental health problems especially from the context of Low and Middle Income Countries. In as much as government of Uganda has made major investments in ensuring that basic capacity is provided to primary care workers, it remains a study worthy challenge for the success of mental health integration interventions.

While a move from institutionalisation to community mental health is evident, common misconceptions about mental illness still exist. Recognition of the importance of choosing the right treatment remains low, even among many treating physicians and this is compounded by the frequency of non-compliance with prescribed medication, shame, self-stigmatisation and a reluctance to 'dare to care' on the part of persons affected by severe mental illness and their families. Therefore, the researchers propose that effective policies and their subsequent implementation can be used to remove barriers to appropriate care and social inclusion for persons with severe mental illness across Europe (Wait & Harding 2006).

Quality improvement has also been found to have positive implications on mental health care delivery models (Reiss Brennan et al, 2006). A demonstration entitled Mental Health Integration carried out in Utah was successful in realigning resources, enhancing clinical decision making, measuring impact and building a business case to determine the actual value of added quality. In this context, mental health integration is understood as a comprehensive approach to promoting the health of individuals, families and communities based on communication and coordination of evidenced based primary care and mental health services. Health practitioners treat mental health as any other health condition from identification to recovery and this involves healthcare delivery redesign that is team based, outcomes oriented and follows a standardized quality process that facilitates communication and coordination based on consumer and family preferences and sound economics.

Murray et al, (1996) in their research findings on bridging the access gap for mental health care in primary health care units propose that training primary care workers can lead to a significant improvement of treatment for patients with mental disorders.

Globally, only 1800 psychiatrists exist per 702 million people in Africa, whereas 89,000 psychiatrists practice in Europe per 879 million people. Similar inequities are evident in all other mental health professional groups such as psychiatric nurses. Furthermore, the World Mental Health Survey revealed that between 76.3 and 85.4% of people with mental illness or epilepsy in Low and Middle Income Countries (LMICs) received no treatment in the 12 months prior to the interview (Demyttenaere et al., 2004). A situation that is responsible for constraints in quality of care for persons with mental health problems in Uganda.

In Ugandan the mental health system is very small. A bare bones network of 22 psychiatrists and about 200 psychiatric clinical officers holds together the entire country's

psychiatric infrastructure. That's one psychiatrist to over a million people and one clinical officer to about 150,000 people. However, only five of them work outside Kampala. The system's biggest challenge is lack of personnel which creates lack of access to psychiatric services. (Sunday Vision, December 19, 2011). This explains the factor of low expert support supervision for community health workers which affects their ability to effectively manage mental health problems at their respective health centre IVs.

Murray et al, (1996) also observe that management of mental disorders at primary care is crucial in all parts of the world because of the sheer scale of psychiatric morbidity, and especially in sub-Saharan Africa where specialist expertise is very scarce. For example Tanzania only has 13 psychiatrists for a population of 37 million, and nine of these psychiatrists are in Dar es Salaam. They also report that effective and relatively cheap treatment methods for mental disorders do exist when mental health services are integrated in primary health care.

In the light of low human resource supply, innovative methods like task shifting which is primarily driven by a shortage of human resources for health (HRH) are recommended. USAID (2010) study undertaken on task shifting provided many examples of task shifting within the Ugandan health system, such as medical doctors conducting surgical procedures that are typically handled by specialist surgeons, nurses and clinical officers taking on the clinical duties of medical doctors, and Community Health Workers treating malaria cases. However, numerous barriers to task shifting exist, including the reluctance of some health professionals to change their views on which cadres should perform which services, protection of professional turf, professional boundaries and regulations, heavy workload and high disease burden, poor planning, the lack of task shifting champions, the possibility of task shifting undermining certain professions, the lack of guidelines, lack of recognition and reward for those who take on

additional tasks, the name “task shifting” itself, inadequate health worker remuneration and poor conditions of service.

It is recommended that primary care workers function best when their mental health tasks are limited and doable. Decisions about specific areas of responsibility must be taken after consultation with different stakeholders in the community, assessment of available human and financial resources, and careful consideration of the strengths and weaknesses of the current health system for addressing mental health. Functions of primary care workers may be expanded as practitioners gain skills and confidence (World Health Organisation/ Wonca joint Report 2008).

The need to improve the capacity of community health workers to manage mental health problems remains a major challenge in Uganda and other Low and Middle Income Countries (LMCIs). Their ability to effectively identify underlying mental health problems that may co-exist with other common illnesses calls for wide integration of mental health care. World Health Organisation/ Wonca joint Report (2008) reported that, in a large-scale national community survey, 52% of people with cardiovascular disease displayed symptoms of depression and among these, 30% met the criteria for a major depressive episode. Diabetes and hypertension frequently coexist with depression and dementia. Anaemia is found frequently in the elderly and may be a risk factor for cognitive impairment. A diagnosis of HIV/AIDS increases the risk of having a mental disorder.

In situations where the quality of care for persons with mental health problems is poor and unreliable, the community has always taken on traditional alternatives whose forms of therapy to a large extent are medically questionable. Emilio Ovuga, Jed Boardman and Elizabeth G. A. O. Oluka, (1999) reported that in Nigeria spiritual healers, traditional healers and general

practitioners were the first to be contacted by 13%, 19% and 47% of patients respectively (Gureje et al, 1995). Those dissatisfied with the results of orthodox medicine often take themselves to traditional healers (Patel *et al 1997a)*

The average adherence rate for long-term medication use is just over 50% in high-income countries, and is thought be even lower in low- and middle income countries. Patients are too often blamed when prescribed treatment is not followed, in spite of evidence that health workers and health systems can greatly influence patients' adherence (BasicNeeds, 2008). The requirement for expert follow up on clients on long term medication is still a myth in Uganda since integrated primary Health Care outreaches in Wakiso are inconsistent due to limited financing. Further still, when finances are available, the outreaches tend to focus more on immunization and malaria control as compared to other conditions such as mental health problems.

2.4 Mechanisms for resourcing the treatment of mental health problems at Health Centre IVs

The mental health culture has traditionally been the fort of expert opinion and this compelled the Group Health Cooperative of Puget Sound and the National Institute of Mental Health to lobby for evidence driven clinical guidelines in the context of mental health integration (American Psychiatric Association, 2011). Such guidelines are part of the target interventions for the government of Uganda in the Health Sector Strategic Plan III (2010/11 to 2014/15). These guidelines will form an important resource guide for policy direction on integration of mental health care.

According to Wait & Harding (2006), in Europe policy appears to be at the forefront of the efforts to deliver mental healthcare in primary care as demonstrated in the European Commission 2005 Green Paper 'Improving the mental health of the population - Towards a strategy on mental health for the European Union'. The paper represents an excellent framework for action and it is hoped that it will lead to a new generation of policy reforms across Europe. Similarly, Uganda's experience in ensuring that mental health care is well managed was guided by a series of policy reforms such as the National Health Policy 2001 and the subsequent health Sector Strategic Plans I (2000/1 to 2004/5) and II (2006 to 2010) which prioritised integration of mental health care in Primary health Care as a basis for ensuring that care for persons with mental health problems is effectively resourced through inclusion of mental health medicines on the list Essential Drugs List in Uganda 2001(EDLU) and the Uganda Minimum Health Care Package (UMHCP).

In the United States Department of Health and Human Services (HHS) administers the public mental health system. HHS forms national-level policy and administers funds to each state's own health department. All of these must follow national policy but also tend to have different rules. State mental health departments allocate sums of money to local administrators in state sub-regions or counties. These administrators then contract with local providers (i.e. doctors on the ground) to provide psychiatric services to people, based on what patients need. This process can get very complicated. (Sunday Vision, December 19, 2011). However the case of Uganda, a specific policy form mental health care is not in existence.

In Canada, since the mid-1980s, provinces have pursued various courses of action to develop mental health care systems that can better support individuals with severe mental illness, maximizing their community tenure, independence and quality of life. There has been

remarkable consistency in the goals and value bases that are cornerstones of reform. Factors that facilitate change were found to include clearly articulated conceptual bases, wide stakeholder involvement, political vision and will, infrastructure supports, the reallocation of funds and personnel from institutions to community, partnerships beyond health, reduction in stigma, enthusiastic leaders and skilled staff, and the Canadian Mental Health Association National Framework for Support.

It was further stressed that best practices be used as guidelines for systems planning, a criteria for assessment of performance, specific monitoring mechanisms be identified and a separate single funding envelope that combines various funding streams for the delivery of mental health care be established. In addition to this, the possibility of achieving national consensus about selected priority issues should be explored (Health Systems Research Unit Clarke Institute of Psychiatry, 1997). This withstanding, Uganda has not been able to establish a consistent ring-fenced fund for mental health services.

MoH, (2009), Uganda still spends less than 1% (0.07%) of its health budget on mental health. Mental health is not given the priority it deserves, although it was accredited at the policy development level. Mental health policy development was not based on any significant research findings and not much has been done to evaluate its implementation in the country.

Ministry of Finance, Planning and economic development, 2009 discussion paper 18 on decentralisation also demonstrates the challenge districts are facing particularly in regard to attracting highly trained health workers with any area of specialisation such as Doctors, Assistant Medical Officers and Nurses with specialized training such as Psychiatry. This situation affects the recommendation by Desjarlais *et al*, (1995) that areas with a low level of resources the large

majority of cases of mental disorder should be recognized and treated within primary health care in some locations within Uganda.

Most mental health resources are concentrated in psychiatric hospitals in urban and affluent areas where poor people, especially those who live in rural areas, cannot access services. Though deinstitutionalization and integration of in-patient mental health care within general hospitals is an oft-stated policy objective, 74.4% of psychiatric beds in Low and Middle Income Countries (LMICs) remain in psychiatric hospitals (WHO, 2005).

The Milibank Memorial Fund (2006) documents success in adapting the techniques of managed care to the needs of persons with mental illnesses in the United States of America as it has been found to improve the quality and cost effectiveness of behavioral health services while off-setting risks by protecting consumers. The greatest successes are known to come when policy makers envision goals for the service system engage in comprehensive planning with stakeholder groups and then use managed care to achieve goals. However the extent of achievement is constrained by limits to how much organizational structures can be changed and the amount of financing available. Managed care may also however give rise to problems such as focus on care rather than rehabilitation and people with serious disorders being underserved as an incentive to a risk based contract among others.

Conclusion

The capacity to manage mental health problems has been a challenge for Primary Health Care Units not only for Uganda but the world over. The fact that mental health problems still pose a major public health problem leaves most governments and decentralized administrative units grappling with the challenge. The literature presented above attests to the above situation but also provides a framework for comparing and discussing previous research evidence with

current findings in order to come up with deductions and inferences necessary for guiding the improvement of mental health care within Uganda and specifically Wakiso district.

WHO WONCA report (2008) review of the integration of mental health care in primary health care in some Low and Middle Income Countries including Uganda. The report recommended operational principles for ensuring effective management of mental health problems especially in primary care namely; Policy and plans need to incorporate primary care for mental health, advocacy is required to shift attitudes and behaviour, adequate training of primary care workers is required, Primary care tasks must be limited and doable, Specialist mental health professionals and facilities must be available to support primary care, Patients must have access to essential psychotropic medications in primary care, integration is a process, not an event, a mental health service coordinator is crucial, Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required and financial and human resources are needed. Therefore in reviewing the extent of mental health integration in primary care, the researcher will also pay specific attention to the way each district has adapted these principles in integrating mental health.

CHAPTER THREE

METHODOLOGY

3.1. Introduction

This chapter explains the methodology that was followed to arrive at the study results. The methodology description includes the study design, research strategy, sources of data, study population, sample size calculation, sampling procedures, study variables, data collection techniques, data collection tools, plan for data analysis, criteria for interpretation of results, quality control issues, ethical issues, limitations of the study and a plan for dissemination.

The decision to conduct the study at health centre IV level (Health Sub districts) was guided by the policy provision that allows for the recruitment of at least a Psychiatric Nurse and use of at least 6 (six) essential psychotropic medicines at that level. This implies that Health Centre IVs are the highest referral point within a Health Sub district.

Wakiso district was chosen based on the basis of geographical location and the fact that it has Health Centre IVs situated in communities with characteristics of urban, peri-urban and rural settlements. Wakiso and Kasangati Health Centers represent Health Centre IVs in urban settings, Ndejje Health Centre for the peri-urban communities while Namayumba Health Centre is representative of rural Health Centre IVs. Therefore, the study results can be generalized to more districts in Uganda which exhibit similar characteristics as specified in Wakiso district.

3.2. Study design

This is cross sectional study aimed at assessing the capacity of Health Centre IVs to manage mental health problems level in Uganda with a case study of Wakiso district. The study was designed to capture the forms of care available for persons with mental health problems, capacity of health workers and the existing mechanisms for resourcing mental health care in the district.

The study was informed by several health sector policy positions as a basis for assessing the capacity. The study covered all five health centre IVs in the district to ensure that study results can be generalized with similar health care settings in Uganda.

3.3. Research strategy

Cross sectional study design was used in order to assess the management of mental health problems in non-specialist Primary Health Care settings at Health Centre IV level in Uganda using a case study of Wakiso district. The study was also intended to establish the contextual environment in which care for persons with mental health problems is done, in terms of infrastructure, human resources for health, essential medicine availability. Case study of Health Centre IVs in Wakiso district was especially used to provide a detailed contextual analysis of the study variables. Through the use of this study design, the researcher was able to bring out key issues regarding the management of mental health problems within Wakiso district as a homogenous sample for many districts in Uganda.

3.4. Sources of data

Primary data was captured from respondents such as the District health Officer of Wakiso district, the Mental Health Focal Person of Wakiso district, and all Health Care Workers, available at the health centres earmarked for the study. Primary data was also obtained from observations of the researchers using the observation checklist tool. Secondary data was captured from National Health Policies 2001 and 2009, Health Sector Strategic Plans I, II and III, HMIS reports for health centres, stores records for antipsychotic medicines stocked, list of Health Care Workers deployed at the health centre, financial transfer mechanisms for Health Centre IVs and District Health Department reports.

3.5. Study Population

A random sample was carried out for health workers found at the health centre on a normal working day. This was based on the consideration/assumption that if a person with a mental health problem came for help at the health centre, the health workers available on site would take full responsibility to provide the care needed by the patient.

Table 1: Designations of Health Care Workers

Designation	Frequency	Percent (%)	Distribution per Health Centre				
			Buwambo	Kasangati	Namayumba	Ndejje	Wakiso
District Health Officer	1	3.03					
Mental Health Focal Person	1	3.03					
Senior Medical Officers	3	9.09			1	1	1
Senior Medical Assistants (Clinical Officer)	2	6.06	1	1			
Psychiatric Clinical officer	1	3.03	1				
Registered Psychiatric Nurses	2	6.06			1	1	1
Enrolled Psychiatric Nurses	3	9.09	1			1	
Anesthetic Assistant	1	3.03					1
Nursing Officers	6	18.18	2		2	2	1
Enrolled Comprehensive Nurses	3	9.09	1		1		1
Laboratory Technicians	2	6.06				1	1
Dispenser	1	3.03				1	
Enrolled Midwives	4	12.12	1		2	1	
Pharmacy Technicians /Stores Assistant	2	6.06	1	1			

Total	33	100	8	2	7	8	6

Source: Study interview respondents

The purposive sample population included the District Health Officer for Wakiso district and the Mental Health Focal Person and all Health Care Workers with Psychiatric qualification at each Health Centre IV.

3.6. Sample size Calculation

The sample size was calculated for the Health Care Workers found on site on a given working day at each Health Centre. Our observation was that approximately 30% of Health care workers were physically always available at the health centre for the day the researcher visited each health centre. The sample size was calculated from the above population. The calculation was made using the formula below;

$$n = \frac{N}{1 + Ne^2}$$

Where "n" represents the desired sample

"N" represents the population (The number of health workers found at each Health Centre during the researcher's visit.

"e^2" level of significance which was fixed at 5% (the permissible error which we propose to be fixed at 5%)

The table below provides a breakdown of Community Health Workers Interviewed according to their health centre of deployment.

Table 2: Community Health Workers interviewed at each health centre

Health Centre	Health care workers employed by district	Population found at Health Centre during our visit	Respondents interviewed		Sample size calculated
			Male	Female	
Buwambo HC IV	24	8	6	2	7.84 or 8
Namayumba HC IV	21	7	1	6	6.88 or 7
Kasangati HC IV	26	2	1	1	only 2 seen
Ndejje HC IV	24	8	5	3	7.84 or 8
Wakiso HC IV	20	6	3	3	5.91 or 6
Total	119	31	16	15	31

Source: Health Centre IVs in Wakiso District

Although the calculated sample size population was 38, the researcher could only capture data from only 31 Health Care Workers. This was due to the challenges experienced in Kasangati Health Centre IV where only 2 respondents accepted to be interviewed.

3.7. Sampling procedures

Multiple sampling procedures were utilized during the study. The researcher random visits to the health centre IVs on a non appointment basis. There were no pre-organized appointments with the Health Care Workers apart from the Health Centre In-charges and other respondents that were identified purposively. The 31 respondents interviewed were chosen randomly from the Health Care Workers physically found at the health centre on the day for the researcher's visit. The visits were made on the following days; Wakiso Health Centre IV (Monday), Namayumba Health Centre IV (Tuesday), Buwambo Health Centre IV (Wednesday), Kasangati Health Centre IV (Thursday), and Ndejje Health Centre IV (Friday).

The other respondents such as the District Health Officer, district Mental Health Focal Person and Health Care Workers with Psychiatric qualification were purposively selected by virtue of their roles regarding the delivery of mental health services.

3.8. Study variables

The main variables considered by the researcher in assessing the capacity to effective manage mental health problems within Health Centre IVs in Wakiso district included: review of the forms of care available for persons with mental health problems, capacity of community health care workers to effectively manage mental health problems and the resources available for mental health care within each health centre. These characterized the specific independent variables for the study. The dependent variable was the capacity of health centre IVs to manage mental health problems in Wakiso district.

3.9. Data collection techniques

During data collection, all the Health Centre IV units within Wakiso district were covered in order to promote reliability. While each health unit was studied individually, results are collective to the whole study. Cross case examination was used to ensure external validity so as to determine if study results are generalizeable to other primary health care settings. The techniques used included:

3.9.1. Review of relevant documents

Several documents were reviewed in the process of data collection. The choice of documents was determined by study objectives and standard practice guidelines. These included the current National Health Policy 2009, Health Sector Strategic Plans I, II and III, Allocation principles, formulae, modalities and flow of Central government transfers, Health Management

Information System reports (HMIS) and World Health Organisation reports. The literature review was compiled using desk research.

3.9.2. Administering key informant interviews

Key Informant interviews were held using semi-structured questionnaires for the District Health Officer of Wakiso district, Mental Health Focal Person, Health Care Workers with Psychiatric qualifications and other Health Care Workers at the targeted Health Centre IVs.

3.9.3. Observation checklist

Observation was used to verify physical the existence of essential elements for providing care for persons with mental health problems and for performing visual surveys. An observation checklist was used for this purpose.

3.10. Data Collection tools

The tools used were designed in order to capture both qualitative and quantitative data. The researcher used information from resource materials about mental health to develop options for structured question. However, provisions were still made to include any issue that may not have been captured in the structured responses. This was done by adding a section for specifying other issues for each question. The tools used for collecting data included a health centre observation checklist and Key informant interview guides. The checklist was intended to verify basic information about the capacity of Health Centre IVs to provide mental health care using nationally recognized indicators and standards. The checklists were completed with the guidance of the Health Centre IV In-charges for Wakiso, Namayumba, Buwambo, Ndejje and Kasangati. Structured questionnaires were administered for three categories of respondents namely: District

health Officer, Mental Health Focal Person, Health Centre In-charges and Health Care Workers. These were designed to capture the forms of care available, capacities of health workers to provide mental health care and trace the resource sources for mental health care at each centre.

3.11. Data analysis

The data from the 31 Community Health Workers was analysed using STATA Version 11 statistical package in order to generate frequencies and percentages through bi-variate and multi-variate data analysis of study data. The statistical package was programmed to analyse additional responses from respondents to specify any other responses that were not structured in the questionnaire. This data was also analysed in to generate frequencies and percentages.

3.12. Criteria for interpretation of results

Analysed data was used to make deductions, inferences and recommendations based on emerging trends or frequencies and established associations.

Interpretation of results was also guided by comparisons with background information and the literature review which respectively represent standard practice guidelines and previous knowledge. The variations in the management of mental health problems among the 5 health units was calculated in order to show individual results in as much as averages are consolidated to achieve district figures. A research report, detailing the research process and key findings and conclusions shall be presented to the research panel of International Health Sciences University as partial fulfillment of the requirements for the award of Masters in Public Health with a community health specialization.

3.13. Quality Control Issues

The quality control was maintained by ensuring that all the 2 data assistants recruited for the study were able to effectively administer the questionnaires to arrive at a uniform interpretation of the question through simulation of study tools. The process of developing the questionnaire involved consultation with a Psychiatric Clinical Officer/Mental health Focal Person from Sembabule District to check accuracy of questions in the tools. As a result, amendments were made both on the content and composition of the study tools. During data analysis the questionnaire responses were triangulated with the checklist findings in order to validate and confirm reliability of the data provided by study respondents.

3.14. Ethical Issues

Consideration was made for all ethical requirements for undertaking research on a subject that involves more stigma and social discrimination. In order to maintain a high standard for observing ethical issues during the study, the researcher included matters relating to ethics within the training for the Research assistants and Data Entry person. Matters of consent, confidentiality were emphasized along with the possible benefits of the study.

Clearance for the study was given by International health Sciences University, Wakiso District Health Department and at Health Centre IV level in their respective jurisdictions. The In-charge for each health centre was the point of entry and clearance for the research team.

During data collection written and or/ verbal consent was sought from all study respondents before interviews were conducted. Assurance was also given to each respondent regarding the level of confidentiality with which their responses were treated. To this end, it was a requirement that respondents' names are not captured in order to guarantee their protection from any unexpected negative outcomes from their responses.

3.15. Limitations of the study

The study experienced some limitations during data collection phase and these included the realisation of the possibility of slight exaggerations in communicating the status of mental health care at the health centres, possibly due to an ill perceived need to demonstrate a positive image to overall district authorities. However this was addressed by the design of questions that required data that was specific to technical issues and constant comparison of respondents' statements with initial information acquired through the observation checklist.

In Kasangati Health Centre IV apart from the In-charge and the pharmacist at the health centre none of the other staff members on duty were willing to participate in the study. This affected the study sample for Kasangati was affected as a result. In spite of the explanations about the confidentiality clause which was a prerequisite for administering each questionnaire, the Health Workers still felt uncomfortable to respond to the study questions.

3.16. Plan for dissemination

Dissemination of study findings was a critical condition upon which the researcher was granted permission by the District Health Team (DHT) to conduct the study. Following the presentation of the study proposal to the district health team, the meeting agreed that dissemination would be carried out in two ways namely;

1. Presentation of study findings to stakeholders of the District Health Team (DHT) upon completion of study report before end of January 2012.
2. Dissemination of hard and soft copies to the District Health Officer's and the Mental Health Focal Person before end of January 2012.
3. Further dissemination of hard and soft copies of the study results shall be done at Ministry of Health with the Principal Medical Officer mental health services by February 2012.

4. The researcher further intends to submit the findings to the British Journal of Psychiatry (BJP) for enhancing community mental health practice in low and middle income Countries by March 2012.

The results of this study shall be disseminated upon review and approval by the academic committee of International Health Sciences University.

CHAPTER FOUR

PRESENTATION OF STUDY RESULTS

4.1 Introduction

This chapter presents research findings on the basis of study objectives. The study generated both quantitative and qualitative data. The results are presented with the aid of statistical analysis diagrams including tables, graphs and pie charts.

4.1.1 Description of the health sector in Wakiso district

The District Health Directorate's mission is; Improve health services delivery to all people of Wakiso District so as to live a socially and economically productive life. The district has 19 Government dispensaries/Health centre (II), 12 health centres (III), 5 health centres (IV) and 2 hospitals. The government hospitals include; Entebbe Grade-A hospital and Entebbe Grade-B hospital. The private sector has 20 Private/NGO dispensaries, 58 clinics and 15 health centres and 2 hospitals. The private/NGO hospitals include; Kisubi hospital and Mildmay hospitals.

4.1.2 Characteristics of study respondents

A total of 33 respondents participated in the study. These included the District Health Officer of Wakiso district, the mental health Focal Person of Wakiso district and 31 Health Care Workers.

A total of 31 Health Care Workers were found at each health centre IV except for Kasangati Health Centre where 7 of the Health Care Workers declined to participate in the study. The age distribution of the Health Care Workers is presented in table 3.

Table 3: Age group of the respondent Community Health Care Workers

Age group	**Frequency**	**Percent**
20-25 years	6	19.35
26-30 years	11	35.48
31-35 years	3	9.68
36-40 years	9	29.04
41-45 above years	2	6.45
	31	100

Source: Study interview respondents

Table 3 shows that a large proportion of Health Care Workers are at the prime of their health care careers (below the age of 35 making 64.51%) while those above 35 years were 35.49%.

4.1.3 Designations of Community Health Workers

The Health Care Workers interviewed have a role to play in the management of mental health problems at their respective health centre IVs as required by the Health Sector policy regarding the delivery of the Uganda Minimum Health Care Package (UMHCP) which includes mental health care. Of the five Health Centre IVs, three (3) are managed by Senior Medical Officers while two (2) are managed by Senior Clinical Officers. All the five health centres have got at least a Psychiatric Nurse while Buwambo Health Centre IV also has a Psychiatric Clinical Officer on its team. This implies that each health centre has a middle-level technical person for basic consultation on mental health problems.

4.1.4 Common mental health problems at health centres

It was reported that patients with mental health problems attending at the health centres are treated for disorders which include Bipolar Affective Disorder, Schizophrenia, sub normality, psychosis, Attention Deficit Hyper Disorder, Post Traumatic Stress Disorder, HIV related psychosis, childhood mental health disorder, substance abuse, mental retardation and depression. Epilepsy, neurological disorders and headaches were also reported. Some psychiatric officers reported that most patients with mental disorders and their caregivers and the community at large still believed that mental health problems were a result of witchcraft. The range of patients received at the health centres are reported in figure 2 and 3.

Figure 2: Patients seen on average in a day

Source: Study interview respondents

Figure 3: Patients with mental health problems seen each week

Source: Study interview respondents

There was low turn up or attendance of persons with mental health problems at Health Centre IVs in Wakiso; while 500 patients are seen on average per week at each health centre, only 6 of these are persons with mental health problems. It was found that attendance numbers

are higher at the District Referral Hospital in Entebbe where the District Mental Health Focal Person is based. This suggests that the quality of care at the health centres is inadequate.

4.2 Forms of care available for mental health problems at the Health Centre care IVs

The findings regarding the forms of care available for persons with mental health problems show two major forms of care namely the clinical and psychological care whose application is represented in the following sub sections: Use of diagnostic tools for mental health assessment, use of psychotropic medicines, Facility-based weekly mental health clinics, Expert supervised mental health outreaches, Integrated Primary Health Care outreaches, Out-patient and In-patient care client services, Psychological care or psychotherapy, Referral services for persons with mental health problems, Follow up of patients in the community and Psycho education.

4.2.1 Use of diagnostic tools for mental health assessment

The respondents reported use of various tools and guidelines for carrying out mental health assessments for persons suspected to have mental health problems based on the history taken during their normal visit to the health centre. Among the tools used for assessment are shown in the table 4:

Table 4: Use of standard assessment tools by respondents

Type of mental health assessment guideline used	Responses	Proportion		Total
		No	%	
International Classification of Diseases 10 (ICD 10)	Mentioned	4	12.9	100%
	Not mentioned	27	87.1	
Diagnostic Screening Manual IV (DSM IV)	Mentioned	2	6.45	100%
	Not mentioned	29	93.5	
MINI	Mentioned	0	0	100%
	Not mentioned	31	100	
Uganda National Clinical Guidelines (2003, 2005,2010)	Mentioned	16	51.61	100%
	Not mentioned	15	48.39	
Other guidelines used	Mentioned	6	19.35	100%
	Not mentioned	25	80.65	

Source: Key informant Interviews for Health Care Workers

Other commonly used practice guidelines mentioned by respondents related to HIV/AIDS, STIs, Tuberculosis and Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT).

4.2.2 Use of Psychotropic medicines

The respondents reported the use of Psychotropic medicines in the treatment of mental health problems. Psychotropic medicines were available at the Health Centres and common varieties included Haloperidol, Chlorpromazine, Imipramine, Diazepam and Amitriptyline. Other medicines used for patients included Carbamazepine, Phenytoin, Phenobarbitone, Artane and Folic acid. Up to 76% of respondents reported that Psychotropic medicines were adequately stocked at their health centres as represented in the proportion of Health Care Workers who strongly agreed and those that agreed as shown in figure 4:.

Figure 4: Adequacy of psychotropic medicines at health centres according to respondents

Source: Key informant Interviews for Health Care Workers

Figure 5: Frequency of psychotropic medicine stock at health centres

Source: Key informant Interviews for Health Care Workers

The proportion of respondents that strongly agree and those who agree that Psychotropic medicines were usually stocked at health centres was 85%.

4.2.3 Facility-based weekly mental health clinics

All the health units sampled had mental health units which run clinics with the frequency of about two days a week but they are also open on the other days of the week. These are organized for new patients and continuing patients for their review and replenishment of their stock of medicines. They were managed by resident psychiatric personnel and these are predominantly Psychiatry Nursing Officers. Other clinical support like dispensing medicines is provided by general Health Care Workers. Some heath units had two Psychiatric Nursing Officers who work in shifts. The Mental Health Focal Person is a Psychiatric Clinical Officer and sits at the District Referral Hospital in Entebbe.

Table 5: Schedules for mental health clinics at Health Centre IVs in Wakiso District

Health Centre	Weekly Schedule
Buwambo HC IV	Wednesdays
Namayumba HC IV	Wednesdays
Kasangati HC IV	Wednesdays
Ndejje HC IV	Wednesday
Wakiso HC IV	Tuesdays and Wednesdays

Source: observation checklist for Mental Health services

4.2.4 Expert supervised mental health outreaches

At one health centre (Ndejje), visiting psychiatric specialists also attended to patients once a month and this activity is dubbed as a mental health outreach. These specialists come from the National Mental Health Referral Hospital and provide support supervision, sensitisation on management and treatment of mental, neurological and substance use disorders as well as free treatment to patients suffering from these disorders. The last outreach documented during this study was held on 7th December 2011.

4.2.5 Integrated Primary Health Care outreaches

The Health Sub District is also mandated to carry out integrated primary health care outreaches in different communities within their area of jurisdiction and three health centres (Buwambo, Wakiso and Ndejje) reported having programmes to this effect. In Namayumba it was reported that there was no facilitation for community outreaches whilst there was no comment from the respondent in Kasangati. However it should be noted that mental health is only a part of the whole programme and in most cases priority may be given to seemingly more urgent health issues.

4.2.6 Out-patient and In-patient care client services

Study findings showed that outpatient care is the predominant form of care over in patient care at Health Centre IVs. However, Health Management Information System (HMIS) records at the Mental Health Unit at Entebbe District hospital shows a higher distribution of Out-patients over in-patients. Some of the reasons given for the low In-patient numbers for persons with mental health problems at Health Centre IV level included:

a) Low bed capacities (usually approximately 12 beds),

b) Inability for persons with aggravated mental illness to share wards with general patients,

c) A no admission policy for persons with mental health problems at one health centre

d) and an incapacity of even psychiatric personnel to handle cases of aggravated mental illness.

The researcher compared the outpatient visits with the inpatient admissions made from January to June 2011 as demonstrated in figure 6:

Figure 6: Total Outpatient and inpatient visits from January – June 2011

Source: District Mental Health data HMIS reports.

4.2.7 Psychological care or psychotherapy

Psychotherapy was also reported as a form of care available at these health centres the most common form being individual counseling. The study findings show that 80.65% of the respondents were able to use psychotherapy to care for persons with mental health problems and the common methods used to provide this care are detailed in figure 7:

Figure 7: Methods used for Psychotherapy by health workers

Source: Key informant Interviews for Health Care Workers

The observation from this data is that 22 of 31 respondents reported understanding counseling as a method of care than any other methods used in psychotherapy. This is partly because counseling skills have been particularly applied in the providing Voluntary Counseling

and Testing, provision of Prevention of Mother to Child Transmission of HIV programme and for Tuberculosis patients. These skills have been reported to be applied by health workers to care for clients with mental health problems particularly psychological problems.

4.2.8 Referral services for persons with mental health problems

Referral was another form of care reported at the health centres and this was usually by general health workers to resident psychiatric staff. Both general and psychiatric staff reported making referrals to the District Referral Hospital, National Referral Hospital and the National Mental Health Referral Hospital. Reasons for referral included lack of specialist knowledge, lack of specialist equipment and lack of admission facilities.

Figure 8: Health worker referrals of cases of mental health problems

Source: Key informant Interviews for Health Care Workers

The proportion of Health Care Workers that occasionally referred persons with mental health problems for mental health care was 51.61% while 22.58% always refer and 16.13% often refer. Therefore the propensity to refer clients to other points for care is quite high for the health centre IVs in Wakiso district.

Figure 9: Places of referrals for cases of mental health problems

Source: Key informant Interviews for Health Care Workers

The places where persons with mental health problems are commonly referred included; District Referral Hospital in Entebbe, Mulago National Referral Hospital, and Butabika National

Mental Health Hospital whiles others were mainly internal referrals within the health centre to the resident Psychiatric Nurse or Clinical Officer.

4.2.9 Follow up of patients in the community

Follow up in the community was also found to be done in varying degrees across the health centres. Wakiso Health Centre was found to have an integrated Primary Health Care outreach programme which includes mental health care. However, scarcity of resources hinders the success of this programme. Limited feedback is generated from patients regarding their recovery and /or stabilization through the outreach programme. Most follow up information about the patients is usually obtained on their subsequent visit to the health centres. Figure 10 shows the proportion of Health Care Workers involved in following up clients.

Figure 10: Follow up of patients in the community

Source: Key informant Interviews for Health Care Workers

4.2.10 Provision of Psycho education

Psycho education is another form of care offered at these health centres. Mental health education is offered to clients on an individual basis, to patients as groups and also to communities during outreaches.

Figure 11: Psycho education offered at health centres

Source: Key informant Interviews for Health Care Workers

Psycho-education is offered in form of rehabilitative counseling for persons with mental health problems in order to bring them in touch with the realities of their mental health problem.

4.2.11. Other forms of care provided to persons with mental health problems

In addition to the above forms of care, patients with mental health problems also have access to general clinical services, for example antenatal care, prevention of mother to child infection of HIV, malaria treatment, theatre services, control of Tuberculosis among other health care interventions.

The forms of care reported are dependent on the availability of a mental health specialist at the health centre. It was reported that cases of persons with mental health problems reported during the absence of the mental health expert are either asked to return during the weekly mental health clinic or referred to higher referral points such as Mulago and Butabika Hospital respectively.

4.3 Capacity of Health Care workers to handle cases of mental health problems

The study accounted for the capacity of Health Care worker to manage mental health problems using the following parameters: Self reported adequacy of health workers to treat mental health problems, frequency of Health care workers treating mental health problems, use of psychological techniques, use of standard practice guidelines when treating mental health problems, propensity to refer persons with mental health problems by Health care workers and the circumstances that prompt health workers to refer clients.

4.3.1 Health Care Workers' training in mental health care

The respondents generally reported having been exposed to mental health issues during their professional training. Additional training in mental health care was attained by only 13.79% of Health Care Workers through in-service training in the management of mental disorders in their communities facilitated by the Ministry of Health (MoH). Based on this background, Health Care Workers gave their individual assessment of their ability to treatment mental health problems as shown in figure 12:

Figure 12: Self assessment of the ability to treat mental health problems

Source: Key informant Interviews for Health Care Workers

Figure 12 above shows that 56.67% of the Health Care Workers felt capable to provide treatment to persons with mental health problems as compared to 43.33% who felt unable.

4.3.2 Frequency Health Care Workers handle mental health problems

The capability of Health Care Workers to provide care to persons with mental health problems was further assessed based on the frequency of with which they handle cases that require mental health care. The results of their individual assessment are shown in figure 13:

Figure 13: Frequency of health workers treating mental health problems

Source: Key informant Interviews for Health Care Workers

4.3.3 Availability of Health Care Workers with Psychiatric training

According to the study findings shown in table one (1), 6 Health Care Workers have specialist training psychiatry as either Psychiatric Clinical Officers or Nurses. This covers for the need for support supervision and expert attention for persons with severe cases of mental disorders. It is against that background that the health centres are able to conduct weekly mental health clinics as reported earlier. It is probably for that reason that a few respondents (32.14%)

felt the inadequacy of specialist knowledge on mental health as a major constraint for providing care for persons with mental health problems as demonstrated in figure 14.

Figure 14: Inadequate mental health specialist knowledge

Source: Key informant Interviews for Health Care Workers

4.3.4 Propensity to refer persons with mental health problems

It was also established that approximately 89% of health care workers refer cases of mental health problems while 27.59% of the referrals are made to the resident mental health specialist at each Health Centre IV as compared to referrals made to District Referral Hospital in Entebbe (6.90%), National Referral Hospital of Mulago (24.14%) and the National Mental Health Referral Hospital in Butabika (41.38%).

Referrals are carried out under circumstances: where there is no mental health specialist (35.71%), no medicines (10.71%), no admission facilities (25.00%), no specialist equipment (3.57%) and other reasons (25.00%) that included aggression of the patients. One health centre reported complete inability of general Health Care Workers to handle or interact with patients with mental health problems and the psychiatric personnel attached to the health centre declined to be interviewed.

4.3.5 Application of standard mental health assessment guidelines by Health Care Workers

The capacity of Health Care Workers to systematically assess and prescribe treatment for persons with mental health problems was checked amongst all respondents. As a result, 89.66% of them indicated the use of practice guidelines when assessing mental health problems while only 10.34% reported not using the guidelines as demonstrated in figure 15.

Figure 15: Health worker use of standard practice guidelines when screening patients

Source: Key informant Interviews for Health Care Workers

However, the use of specific assessment guidelines was noted among a low proportion of respondents; 51.61% of the Health Care Workers referred to the National Clinical Guidelines, 12.9% to the International Classification of Diseases (ICD10), 6.45% to the Diagnostic Screening Manual (DSM) IV and none reported having used MINI diagnostic tool. The latter three tools are specifically used for identification of mental health problems. One (1) respondent referred to the In-Service Training Manual for the Management of Mental Disorders in the Community which was developed by the Ministry of Health.

4.3.6 Competences for providing psychological care

The majority of Health Care Workers (80.65% in the figure below) reported using psychological techniques in providing care to persons with mental health problems. However, knowledge of the various techniques used in psychotherapy was identified in a few respondents. Although a large proportion (75%) mentioned counseling as their main method applied for psychological care, there was limited understanding of techniques such as Cognitive Behaviour Therapy (14.29%), Narrative Exposure Therapy (14.81%), Motivational Interviewing (18.52%) and Group Therapy Sessions (14.81%) which are important for the effectiveness of any counseling interventions. Therefore this study cannot confirm the quality of the psychotherapy services provided to persons with mental health problems.

Figure 16: Use of psychological techniques

Source: Key informant Interviews for Health Care Workers

4.3.7 Health Care Workers' assessment of the quality of mental health care

As far as the quality of mental health care was concerned, respondents individually made their assessment of the quality by rating the services on the basis of Very High, High, Moderate and Low as shown in the results in figure 17:

Figure 17: Respondent assessment of adequacy of quality of care at health centres

Source: Key informant Interviews for Health Care Workers

In summing up the findings regarding the capacity of health care workers to provide care for persons with mental health problems, it is important to note that the responses of health workers' turn out to be quite paradoxical especially where majority of health workers reported to occasionally provide care for persons with mental health problems yet the propensity to refer clients was also reported at 89%. This gives the impression that health workers also regard their involvement in referring clients with mental health problems as part of the care they are able to provide.

4.4 Mechanisms for resourcing the treatment of mental health problems at Health Centre IV level

The government of Uganda is the primary financier of health services in public Health Centre IVs. Although a consolidated budget is availed for all health services, the proportion that goes to mental health care is still minimal as explained by the District Mental Health Focal Person. Various mechanisms reviewed by the researcher included; mechanisms for human resource improvement, mental health coordination and support supervision, acquisition of mental health medicines and supplies, inpatient care and factors responsible for improving mental health resourcing.

4.4.1. Mechanisms for human resource recruitment and development

The recruitment of Health Care Workers is coordinated by the office of the Chief Administrative Officer and personnel are appointed by the Health Service Commission. According to the observation Checklist, only 3 health centres were headed by Senior Medical Officers (Wakiso, Ndejje and Namayumba) as required by policy while 2 Health Centres were headed by Senior Clinical Officers (Buwambo and Kasangati).

The outcomes of the observation checklist applied in each of the five health centre IVs demonstrates that despite the absence of a visiting Psychiatrist for support supervision in all the health centres, there were positive indicators for mental health resources in each health centre. Evidence from key informant respondents confirmed that the care for mental health problems at Health Centre IVs is greatly under-resourced. Currently four (4) Health Centres are missing a Psychiatric Clinical Officer as required by policy.

4.4.2. Mechanisms for mental health coordination and support supervision

The district has a person designated as a mental health focal person based at Mental Health Unit at Entebbe Hospital. The focal person is responsible for coordinating planning and providing support supervision to all Health Sub Districts on matters related to mental health care. However, the focal person reported that his activities in the district are severely restricted by lack of resources allocated to his activities within the district health sector budget. Therefore, the role of the focal person is significantly reduced as evidenced in the responses of Health Care Workers in figures 18.

Figure 18: Health worker contact with the mental health focal person

Source: Key informant Interviews for Health Care Workers

Figure 18 demonstrates that only 25% of the Health Care Workers had ever contacted the Mental Health Focal Person while 75% have never been in contact. Besides the limited contact of Health Care Workers with the Focal Person, the respondents who had never had contact with the mental health focal person did not even know the existence of such a position and the role he plays in the district. On the other hand, of the 25% respondents that reported having had contact with the mental health focal person had the following types of contact. See figure 19;

Figure 19: Type of contact with Mental health focal person

Source: Key informant Interviews for Health Care Workers

The other types of contact reported by the respondents include reports about mental health cases seen during each quarter, appeals for missing mental health medicines especially the long acting treatment, invitations for in-service training and referral procedures for the Mental Health Unit.

4.4.3. Mechanisms for acquisition of mental health medicines and supplies

The Government was found to be the major source of resourcing the treatment of mental health problems at Health Centre IVs in Wakiso district. This is done through the Medicines Credit Line System and Primary Health Care funds releases. Health centre funds are received through district transfers. Medicines are acquired through an outlined requisition process by credit line system where requests are submitted to the National Medical Stores while medicines procured under the Primary Health Care funds are determined by the priorities of the Health Centre. Although allocations are made for the acquisition of mental health medicines, the resources available are usually inadequate to cover all the competing priorities at Health Centre

IV. In addition to this, psychotropic medications were reported to be relatively more expensive than drugs.

Some of the reasons noted by the respondents regarding the supply of mental health medicines at their respective centres include; Health Care Workers' knowledge of requisition mechanisms for stocking medicines, level of demand for mental health medicines, health centre's budget ceiling and the limited knowledge of mental health medicines by Health Care Workers as illustrated in table 6.

Table 6: Reasons affecting supply of mental health medicines

Reasons affecting supply of mental health medicines	**Responses**	**Proportion**	**Total**
Health Care Workers' knowledge of requisition process	Know	25%	100%
	Do not Know	75%	
Low demand for Psychotropic drugs affects their supply	Yes	66.67%	100%
	No	33.33%	
Limited health centre annual budget	Yes	40.74%	100%
	No	59.26%	
Limited Knowledge of mental health medicines by Health Care Workers	Yes	22.22%	100%
	No	77.78%	
Health Sector Policy position on supply of medicines	Yes	28.57%	100%
	No	71.43%	
	Not mentioned	100%	

Source: Key informant Interviews for Health Care Workers

Table 6 shows that the majority (75%) of Health Care Workers did not know the process for requesting medicines as a hindrance to stocking medicines. A large proportion of the Health Care Workers (66.67%) believe that the low demand for mental health medicines partly affects the supply of such medicines at the Health Centres. Only 22.22% of the respondents felt that limited knowledge of mental health medicines is currently affecting the supply of medicines. Although the health sector policy is an important determinant for the supply of medicines, the majority (71.43%) of the respondents did not think so.

4.4.4. Mechanisms for inpatient care (admission of patients)

Inasmuch as all health centres have admission facilities, the bed capacity caters for 10 patients on average. However, it was noted that the nature of some mental disorders, makes such patients affected by these illnesses unable to share wards with majority of other general patients as they may be loud and aggressive. The main form of help given to such patients is referral. It was noted that all the Health Centre IVs in Wakiso district were in a distance of at least 10 Kilometers to the nearest referral facility. Consequently, more patients with mental health problems incur higher costs to access their treatment than their counterparts suffering from other conditions spelt out in the Uganda Minimum Health Care Package (UMHCP).

4.4.5. Out of pocket financing for treatment by the patients and care givers

Although the researcher did not have direct interface with the patients and their care givers, out-of pocket financing was mentioned by the District Health Officer and In-charges of Health Centre IVs as one important mechanism through which individual patients and care givers finance care for persons with mental health problems in the district. The common areas funded

through out-of pocket expenses included; purchase of medicines during drug stock outs, payments for specialist services which are not provided at Health Centre IV level such as EEG and ECT procedures, contribution to ambulance services in cases where a patient is referred specialized care in another hospital among others.

4.4.6. Mechanisms recommended by respondents for improving mental health care

The study respondents pointed out the following issues as essential for improving resourcing for Health Centre IVs to effectively manage mental health problems. These included; planning for in-service training for Health Care Workers in the management of mental health problems, Recruitment of more mental health specialist staff at Health Centre IVs, Increasing allocation of financial resources for mental health care in Health Sub Districts,

Table 7: Factors for improving resourcing for mental health care

Factors for improving resourcing for mental health	**Responses**	**Proportion**	**Total**
Increased resource allocation for mental health services	Mentioned	66.67%	
	Not mentioned	33.33%	
In-service training for health workers	Mentioned	86.21%	100%
	Not mentioned	13.79%	
Recruitment of more mental health specialists	Mentioned	51.85%	100%
	Not mentioned	48.15%	
Others	Mentioned	100%	100%
	Not mentioned	0	

Source: Key informant Interviews for Health Care Workers

Although it was reported by the District Health Officer and the Mental Health Focal person that in-service training in the management of mental health problems had been carried out for some general Health Care Workers by the Ministry of Health, a significant proportion of the respondents (86.21%) felt it was quite necessary, while 66.67% highlighted the need to increase resources allocated for mental health care and 51.85% felt it necessary to recruit more mental health specialist staff. Among the other suggestions by the respondents was the need to advocate for improved mental health care both at district and national levels.

It was also evident that less attention was paid to other important interventions such as inpatient care, patient follow up, provision of psychotherapy services, use of standard guidelines for assessment and treatment among others issues yet they are fundamental in determining the quality of care provided to persons with mental health problems.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.1 Implications of findings for policy and practice

The findings of the study suggest that the capacity of Health Centre IVs in Wakiso district to effectively manage mental health problems is less than ideal. This substantiates the claim of Petersen et al (2011) that while decentralised and integrated primary mental health care forms the core of mental health policies in many low and middle income countries, implementation remains a challenge. This is also the opinion of many other studies done.

5.2. Forms of care available for mental health problems at Health Centre IVs in Wakiso district

At these health centres mental health care is largely clinical and this is synonymous with the observation of various researchers like Kigozi et al (2008). However this is contrary to the findings of Wait & Harding (2006) that psychosocial interventions are recognised as central to the success of treatment. It is interesting to note that while 80.65% of respondents reported to using psychological techniques whilst interacting with patients, of these only 75% could relate to individual counselling, 18.52% to Motivational Interviewing, 14% to Cognitive Based Therapy and 14.8% to Group Therapy. This implies that the use of psychotherapy is not as predominant as respondents suggest. It is however important that interventions such as family therapy and counselling and community-based services are adapted to individual clients because of unique needs. For example health workers reported that in the light of scarce resources, follow up in communities is done based on the severity of the illness of individual patients. Like in Europe, while a move from institutionalisation to community mental health is evident, common misconceptions about mental illness still exist. At every health centre apart from one, the general health workers referred the researchers to the mental health departments even if it was explained that the study was meant to assess the management of mental health problems in general health care settings Such as Health Centre IV.

While Griffiths and Christensen (2008) suggest that political will is an important enabling factor for the success of integration of mental health, in Uganda the revised mental health bill is yet to be passed. In addition to this, they suggest the management of mental disorders in general practice which is backed by evidence based policies and plans. While the National Clinical Guidelines outlines criteria for the assessment and treatment of some common mental health

problems, study findings show a limited application of these guidelines in actual practice at Primary Health Care level. What is more the plans have to have defined monitoring and evaluation structures but study findings show that the monitoring and evaluation mechanisms in Wakiso are greatly restricted by scarcity of resources. Without monitoring and evaluation, there cannot be quality control.

Of the four models that Lazarus and Freeman (2009) present, only two could be identified in practice at health centre IVs in Wakiso district. These are mental health care provided by resident psychiatric specialists and community outreaches. However in Wakiso these specialists are usually Psychiatric Nursing Officers all of whom have admitted to being compelled to refer severe cases of mental illness largely because of a lack of advanced skills for their treatment and infrastructural inadequacies at the health centres. It would help if intersectoral responses are developed and facilitated to be functional as not all persons with mental illness report to health centres. For example the involvement of the health sector, law and order sector and community development sectors are involved. Ovuga and Wasserman (2007) also defend the attributes of political will, evidence based policies, training of health workers and multisectoral involvement that also includes bringing traditional healers on board.

There are newer and more effective psychotropic medications which also have less side effects than the ones currently stocked at these health centres. Severe side effects posed by current medications have been found to incapacitate patients more. For example medicine Chlorpromazine may make patients drool and feel subdued and patients on this medication have to spend more on artane which reduces the severity of these side effects.

The high propensity for Health Care Workers to refer persons with mental health problems for care to other hospitals is likely to present a huge financial burden for the patients

since most of the referral points are located at least 10 Kilometers from any of the Health Centre IVs.

The absence of proper care for some of the persons with mental health problems from their Health Centre IV (the highest referral point in a Health Sub District) is likely to prompt the patients into looking for alternative sources of treatment. This is evident in the high propensity for referrals in all the Health Centre IVs. This may expose patients to other untested choices such as traditional healers as hinted by Emiliano Ovuga, Jed Boardman and Elizabeth G.A.O.Oluka (1999) reported about traditional alternatives as the main form of care that patients go for treatment although their forms of therapy are largely questionable. Patel et al, (1997) further explains that the majority of patients with mental health problems dissatisfied with the results from orthodox medicine often take the option of traditional healers.

The community should be more empowered to be able to manage cases of mental health problems as they were reported to play significant positive roles which include referral (83.87%), inclusion (13.79%) and sensitization (31.03%). They were also reported to play the role of caregivers and Village Health Teams were given specific credit by 40% of respondents. This is similar to recommendations by Saraceno et al (2007) that Community Mental Health services are a major success in accessing services to communities through outreach services. However it should be understood that community health teams are not necessarily specialists and efforts should be taken to avoid situations where patients in the community are personalised as belonging to such initiatives, which may isolate these patients from more sustainable interventions and offer them limited opportunities for growth.

Although Health Care Workers in the five health centre IVs showed a high commitment to provide appropriate assessment and treatment of mental health problems with the help of

standard clinical guidelines, absence of patient centred approach to care for persons with mental health problems which pose challenges to patient adherence. Further still, the use of standard psychiatric guidelines is can be a lot complicated for majority cadres of health care workers available at health centre IV which poses a challenge to the accuracy of the assessments and treatment provided. The World Federation for Mental Health, (2009) recommends improvements in diagnosis, treatment and outcomes, healthcare providers must find new ways to build partnerships that create a more creative and collaborative practice that focuses on patient centred and whole body care.

5.3. Capacity of Health Care workers at the Health Centres IVs in Wakiso district to effectively manage cases of mental health problems

Health workers reported having problems diagnosing mental health problems, making prescriptions and dispensing psychotropic drugs. This is similar to observations by Wait and Harding (2006) that oftentimes health workers make wrong diagnoses and consequently prescribe wrong treatment with the consequence of compounded health problems for patients. In as much as the new mental health policy embraces mental, neurological and substance use disorders, when asked to name mental health drugs in stock, the most common listings made by study respondents were phenytoin and phenobarbitone which are largely used as anti convulsants. Therefore like in Europe, policies and their implementation can be used to remove stigmatisation both on the part of the patients and their caregivers and health workers as well as other barriers like poor adherence to medication which hinder appropriate care and social inclusion for persons with mental health problems. This reiterates conclusions of the study by the Research Programme Consortium in Uganda that the assumption that mental health services are

reasonably well-organised and that the health unit staff at both micro and macro levels know their roles in the integrated health care delivery has proved wrong.

Kirunda (2008) is proven right when he writes that only a limited number of general healthcare staff appreciate the policy requirement for the integration of mental health care into primary health care. Therefore, the partnerships between general health care and mental health care must be improved and/ or strengthened in order to improve health outcomes as suggested by the World Federation for Mental Health in 2009. In this context, only 56.67% of health workers interviewed felt that they had the adequate skills to manage mental health problem and over 89% reported referring patients with mental health problems.

The fact that an average 6 persons with mental disorders are identified in 500 visits by patients to the health centre IVs shows that the proportion of mental health problems identified on outpatient basis is still very low compared to the findings of F. Kigozi et al (2005) who noted that while mental health problems can be identified in 20-30% of all outpatient visits, majority of health workers in Uganda lack the skills to recognize them. The low number of persons with mental health problems identified in the Health Centre IVs within the study area may be pointing to capacity challenges especially by the health workers.

In addition to this, respondents reported having trouble interacting with persons with mental health problems, for example difficulties are found when laboratory technicians attempt to take tests or when clients with mental health problems have to attend maternity clinics. They suggest that training of health workers can improve this state of affairs. This is quite similar to the suggestion made by Murray et al (1996) found that training primary health care workers can lead to a significant improvement of treatment of patients with mental disorders. Tanzania and Uganda share similar constraints when it comes to the availability of mental health specialists.

The study results show that general health workers whose professional and in-service training involved mental health care still refer clients suspected to have mental health problems to either their in-house Psychiatric Nurse or refer (89%) clients to neighboring hospitals such as Mulago Hospital, National Mental Referral Hospital Butabika and Entebbe District Hospital. This indicates that not much integrated care for persons with mental health problems strongly exists in the Health Centre IVs. In addition, the most common form of care for persons with mental health problems is availed during mental health clinics which are managed by the resident Psychiatric Nurses. This also indicates that the role of general health care workers in the provision of mental health services is still minimal. This implies that mental health care is still far from being a service provided by all health care workers in an integrated manner.

The above state of affairs still poses a major challenge on the practicality of general health workers in providing the needed mental health care given the limited knowledge acquired during their professional training. It is therefore important that a thorough assessment of the abilities of general health care workers to provide mental health care in the use of strategies such as task shifting which was highlighted by USAID (2010) as a formidable solution to human resource challenges in Uganda.

The existence of stigma was evident at all health centres visited as was exhibited by Health Care Workers who openly expressed that mental healthcare was not their forte and therefore they were reluctant to participate in the study. This is similar to findings by Gureje (2005) that negative attitudes still exist and cripple efforts towards effective management of mental health problems in Primary Health Care. In addition, a study by the Research Programme Consortium in Uganda found that the assumption that mental health services are reasonably well-organised and that the health unit staff at both micro and macro levels know their roles in the

integrated health care delivery has proved wrong. This is because only a limited number of general Health Care Workers appreciate this policy requirement to that effect (Kirunda, 2008). this was a common observation throughout the study.

5.4. Existing mechanisms for resourcing the treatment of mental health problems at the Health Centre IVs in Wakiso district

Like many Governments the world over, the Ugandan Government allocates specific resources for the health sector and again, like many of these Governments, these resources are severely inadequate. While the Abuja Declaration of 2003 stipulates that at least 15% of national budgets should be allocated to the health sector, in Uganda this hovers around the 7% mark. As a result the funds allocated to national mental health are less than 1% and this figure becomes even less at individual health centres. The implications of this is that many clients with mental health problems fail to have their symptoms recognized and treated by primary health care workers yet it is advised that in the light of scarcity of resources it is advised that majority of mental health problems identified in areas with limited resources be treated within Primary Health Care (Desjarlais et al, 2005). Since the little resources being allocated are not being used effectively, it is difficult to expect more resources for the cause of integration of mental health into Primary Health Care. Even when more resources are allocated, they are usually absorbed in administrative and logistical costs.

Since most health centres reported the demand for drugs as one of the prerequisites for decisions to stock medicines, the low levels of attendance in comparison with patients with other health problems (only 6 out of 500 patients attending at the health centres on average per week

are persons with mental health problems) works against the availability of drugs for patients with mental health problems.

The respondents reported that one of the influencing factors for stocking mental health medicines is the national policy on medicines. In Canada and in Australia, consistent dedication to prioritizing mental health services has been instrumental in better health outcomes. Policies are regularly revised and the necessary amendments made to national budget allocation. The Ministry of Finance, Planning and Economic Development (2007) also made the observation that inadequate resources have made it difficult to attract competent staff and the Clarke Institute of Psychiatry recommends ring fenced funding for mental health care. This would also work well in Uganda.

In terms of infrastructure, the study found that almost all psychiatric beds are at psychiatric hospitals hence the near non existence of inpatient care at health centre IVs. This is reminiscent of assertions by WHO that the world over 74% of psychiatric beds in Low and Middle Income Countries remain in psychiatric hospitals. Dedication to infrastructural development for mental health care so that services are brought nearer communities is essential.

Finally, the observation that much of the care costs for persons with mental health problems are essentially out of pocket expenses implies that the illness imposes a higher economic burden on the affected people and their families than their counterparts suffering from any of the other conditions treated at Health Centre IV such as Malaria, Tuberculosis, diabetes among others. This reflects an imbalance. This is consistent with the findings of Development Research and Training and the Centre for Chronic Poverty (2007), who found out that most patients with mental health problems and their families are also usually afflicted by poverty because of an inability to engage in income generating activities and the high costs of treatment

yet research has shown that on average it costs $ 13 to $ 63 to treat one person with mental illness per month. Yet this does not include other in -kind payments given to traditional healers.

Like the case was Utah, investing in quality improvement of mental health services in Uganda can have positive implications on mental health care delivery at Health Centre IV level as outlined by Reiss Brennan et al (2006). This may include realigning resources, enhancing decision making processes, delivery of needs based services and effective monitoring and evaluation mechanisms. Such efforts may result in better mental and overall health outcomes in a situation where general health workers are able to effectively manage mental health problems in a standardised and cost effective manner. However in Uganda, the implementation of policy is still a major challenge. Petersen et al (2008) have made similar generalizeable conclusions in the context of policy implementation the world over. The current policy and practice trend is a situation where mental health care is largely influenced by expert opinion as observed by the American Psychiatric Association (2011).

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This chapter documents the conclusion of the researcher as well as recommendations for each of the objective areas covered in this study. The researcher further makes proposals for possible studies that could be carried out to bring out a holistic picture about the capacity of Health Centre IVs to manage mental health problems.

6.1. Conclusion

In spite of the various efforts made towards improving the capacity of Health Centre IVs to manage mental health problems by the government of Uganda and the district, the evidence from this study strongly points to the need for such efforts to be aligned with effective monitoring and evaluation mechanisms that consistently assess the capacity of health centre IVs to provide mental health care. It is important to note that the district has put in place basic structures necessary for ensuring that patients with mental health problems can find some form care at Health Centre IV. However, the current situation shows little involvement of general health care workers in the provision of mental health care which defeats the key motives and principles behind mental health integration in Primary Health Care settings like Health Centre IVs. The mechanisms for resourcing mental health are equally responsible for causing several constraints in the management of mental health problems at Health Centre IV level. In the absence of quality mental health care services, the right to health for persons with mental health problems is compromised. The findings generalize the quality of care for mental health problems as less than ideal. Therefore the researcher strongly recommends the following as viable strategies for bridging existing gaps in capacity of Health Centre IVs to effectively manage mental health problems.

6.2. Recommendations

The results of this study imply that Health Centre IVs are making an effort to ensure access to mental health care through their management. However there is a strong need to focus on improving the quality of the care given to patients in order to realize greater recovery and confidence of patients in the health centre services. The recommendations of this study are presented in the sections below:

6.2.1 Recommendations for existing forms of care for mental health problems at Health Centre IVs in Wakiso district

a) Strengthening the psychotherapy aspect of treatment by building the capacity of health workers to administer these techniques.

b) Psychotherapy services should be integrated as part of the minimum health care package to ensure that holistic care is availed for persons with mental health problems.

c) Increasing the scope of medications available at the health centres to include new and improved medications which have fewer side effects, for example a shift from generic medicines to more effective brands would improve patients' response to medication.

d) The need for more Health Care Workers especially with Psychiatric training should be given consideration due to the existing gap of nearly 4 Psychiatric Clinical Officers in four health centres.

e) Increasing the involvement of other sectors such as education, community development and production in the delivery of mental health care will help in developing holistic care package for persons with mental health problems.

6.2.2. Recommendations for improving capacity of primary health care workers at the Health Centres IVs in Wakiso district to effectively manage cases of mental health problems

a) In-service training and refresher training of general Health Care Workers so that they are able to manage mental health problems.

b) Ensure application of available standardized service delivery guidelines across all health centres in the district. While at national level, such standardized guidelines should be needs and outcome based.

c) Recruitment of more psychiatric specialists coupled with strengthening of professional supervision capacities at health centre IVs as a basis for improving capacity to effectively manage cases of mental health problems.

d) Increased support supervision to ensure that appointed personnel are available at their duty stations as required by their contractual obligations so that clients of mental health care services receive expected services.

e) Increased advocacy for integration at health centres where health workers are recipient to patients with mental health problems

f) Explore the possibility of task shifting in mental health care especially at Health Centre IV level with proper guidelines and scope of work for each cadre in health care system.

g) Investing in actions geared towards addressing the negative attitudes of health care workers towards mental health care and persons with mental health problems.

6.2.3. Recommendations for existing mechanisms for resourcing the treatment of mental health problems at the Health Centre IVs in Wakiso district

a) Increased resource allocations for mental health care at national level. This shall involve recognizing mental health as a crucial public health concern and increased allocations to the national and district health care budgets which will subsequently reflect in increased allocation to mental health care at district level.

b) Facilitation of the district mental health focal person to make regular visits to lower health centres. Some of the respondents were not aware of the existence of a district mental health focal person

c) Facilitation for follow-up of patients with mental health problems in the communities. Some health workers reported that sometimes they are forced to use their own resources

to undertake community visits, after which they requisition to be paid back at the health centres.

d) Increased infrastructural development to accommodate the needs of persons with mental health problems because the nature of some mental health problems is synonymous with violence and aggression. Specifically, the facilitation of separate wards for persons with mental health problems, like is the case at most district hospitals, is recommended.

6.2.4. Recommendations for national mental health integration guidelines

a) The guidelines should be needs and outcomes based. That is, they should be accommodative of the treatment and care needs of persons with mental health problems.

b) The guidelines should be operationalised with strong quality control measures coupled with effective monitoring and evaluation mechanisms evident at national and district levels.

c) For the mental health integration guidelines to be effective, the development stages should consider contextual factors such as the limited interest of general health workers to provide care for persons with mental health problems, low budgetary allocations to mental health, cultural settings, human resource gaps and training gaps evident in this study.

6.3. Areas of further research

a) Costing mental health care due to the need to establish the actual cost involved caring for an individual with a mental health problem to guide proper planning and budgeting.

b) Skills assessment for mental health care among general health worker. This is envisaged as an important gap that should be filled in order to fully appreciate the limit for which general health workers can care for persons with mental health problems.

c) Task shifting in mental health care. Since this approach has been adapted in Uganda's health sector especially in HIV/AIDS response, it is important to assess the applicability of task shifting in the field of mental health care especially at Primary Health Care levels.

d) Mental health care in private health facilities. It was a fact that more private health care providers exist in Wakiso district. It is essential that a study is conducted to establish the capacities of private health care providers to provide mental health care.

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Appendices

Appendix One; Instruments

DISTRICT HEALTH OFFICER QUESTIONNAIRE

Introduction

I am a Masters student at the International Health Sciences University and I am carrying out a research to assess the capacity of Health Centre IVs to manage mental Health Problems in Wakiso district. The results of this study will provide an evidence base for district and policy makers for use in the development of need based services. I seek your involvement in this research by completion of this questionnaire and your cooperation will be highly appreciated.

Your identity and personal information will be treated as confidentially as possible.

Do you agree to be asked and provide answers to the questions?

1. *Yes*……………………………………..
2. *No*……………………………………….

If yes, go ahead and conduct interview. If no, thank the respondent for their time and end interview.

Information on the Study Area

Date of interview …………………………………………………………………….

Duration of employment …………………………………………………………….

No	Questions and filters	Coding categories	Coding label	Skip
101	Sex of the respondent **(Do not Ask)**	Male ……………………… Female……………........	M F	
102	Age group of the respondent	Under 20 years……….. 21 -25 years…………… 26 – 30 years………….. 31 – 35 years………….. 36 -40 years…………… 41-45 years……………. 46-50 years……………. 51-55 years……………. 56-60 years…………….	1 2 3 4 5 6	
103	Qualification of respondent	MBCHB ……………………...... Bachelors Nursing……….. Dip Nursing………………….. Dip clinical…..………....... Enrolled Nurse…………….. Midwifery Cert……………… Others specify……………	1 2 3 4 5 6 7	

1. What role do you play in the integration of mental health care into Primary Health Care?
    a) Support supervision
    b) Lobbying and advocacy
    c) Contributing to policy and decision making processes

d) Tracking mental health data

e) Other, Please specify……………………………………………………………………

2. Mental health care services are integrated into Primary Health Care at Health Centre IVs in the district.

a) Strongly agree

b) Agree

c) Not sure

d) Disagree

e) Strongly disagree

3. District decision making and policy development processes support mental health care integration.

a) Strongly agree

b) Agree

c) Not sure

d) Disagree

e) Strongly disagree

4. Efforts are made to consult stakeholders when decisions are being made about mental health care in the district.

a) Strongly agree

b) Agree

c) Not sure

d) Disagree

e) Strongly disagree

5. Health Centre IVs are adequately facilitated to manage cases of mental health problems.

a) Strongly agree

b) Agree

c) Not sure

d) Disagree

e) Strongly disagree

6. Mental health medicines are usually adequately stocked at district Health Centre IVs in the district.

a) Strongly agree
b) Agree
c) Not sure
d) Disagree
e) Strongly disagree

7. Clear referral systems exist for persons with mental health problems in the district.
   a) Strongly agree
   b) Agree
   c) Not sure
   d) Disagree
   e) Strongly disagree
8. If yes, where are these patients referred?
   a) District Referral Hospital
   b) National Referral Hospital
   c) National Mental Health Referral Hospital
   d) Other, please Specify……………………………………………………………
9. What role does the community play in the care for persons diagnosed with mental health problems? Please tick off as many as apply.
   a) Sensitisation
   b) Inclusion
   c) Referral
   d) Other, please specify………………………………………………………..
10. What challenges do you think hinder the integration of mental health care into Primary Health Care? Please tick off as many as apply
    a) Poor logistical support
    b) Unclear referral systems
    c) Mental health specialist unavailable
    d) Stigma
    e) Health worker training gaps
    f) Health centres not capacitated to manage cases of mental health problems
    g) Other, please specify…………………………………………………………….

11. What recommendations, if any, do you suggest to increase the integration of the treatment of mental health problems at Health Centre IVs? Please tick off as many as apply.
    a) Increased resource allocation
    b) In-service training
    c) Recruitment of specialists
    d) Other, please specify…………………………………………………………

Thank you for your time.

MENTAL HEALTH FOCAL PERSON QUESTIONNAIRE

Introduction

I am a Masters student at the International Health Sciences University and I am carrying out a research on the integration of the treatment of mental health problems into primary health care at Health Centre IV level in Wakiso district. The results of this study will provide an evidence base for district and policy makers for use in the development of need based services. I seek your involvement in this research by completion of this questionnaire and your cooperation will be highly appreciated.

Your identity and personal information will be treated as confidentially as possible.

Do you agree to be asked and provide answers to the questions?

3. *Yes……………………………………..*
4. *No……………………………………….*

If yes, go ahead and conduct interview. If no, thank the respondent for their time and end interview.

Information on the Study Area

Date of interview ………………………………………………………………

Duration of employment ………………………………………………………

No	Questions and filters	Coding categories	Coding label	Skip
101	Sex of the respondent **(Do not Ask)**	Male ……………………… Female…………….........	M F	
102	Age group of the respondent	Under 20 years………. 21 -25 years…………… 26 – 30 years………….. 31 – 35 years………….. 36 -40 years…………… 41-45 years……………. 46-50 years……………. 51-55 years……………. 56-60 years…………….	1 2 3 4 5 6	
104	Qualification of respondent	MBCHB …………………...... Bachelors Nursing………. Dip Nursing………………….. Dip clinical…..………....... Enrolled Nurse…………….. Midwifery Cert……………… Psychiatric Clinical Officer……….. Psychiatric Nurse………………… Others specify……………	1 2 3 4 5 6 7 8 9	

1. What activities do you carry out as part of your role as a Mental Health Focal Person? Please tick off as many as apply.
   a) Visiting at health centres
   b) Home visits
   c) Community mental health education
   d) Referral
   e) Involvement in planning and reporting on mental health services

f) Contributing to policy and decision making processes

g) Tracking mental health data

2. You are adequately facilitated to perform your role as a mental health focal person in the district.

   f) Strongly agree

   g) Agree

   h) Not sure

   i) Disagree

   j) Strongly disagree

3. District decision making and policy development processes support mental health care integration.

   f) Strongly agree

   g) Agree

   h) Not sure

   i) Disagree

   j) Strongly disagree

4. Efforts are made to consult stakeholders when decisions are being made about mental health care in the district.

   f) Strongly agree

   g) Agree

   h) Not sure

   i) Disagree

   j) Strongly disagree

5. Health Centre IVs are adequately facilitated to manage cases of mental health problems.

   f) Strongly agree

   g) Agree

   h) Not sure

   i) Disagree

   j) Strongly disagree

6. Mental health medicines are adequately stocked at district Health Centre IVs.

   f) Strongly agree

g) Agree

h) Not sure

i) Disagree

j) Strongly disagree

7. Mental health medicines are usually stocked at district Health Centre IVs.

a) Strongly agree

b) Agree

c) Not sure

d) Disagree

e) Strongly disagree

8. Clear referral systems exist for persons with mental health problems in the district.

f) Strongly agree

g) Agree

h) Not sure

i) Disagree

j) Strongly disagree

9. If yes, where are these patients referred?

e) District Referral Hospital

f) National Referral Hospital

g) National Mental Health Referral Hospital

h) Other, please Specify…………………………………………………………………

10. What role does the community play in the care for persons diagnosed with mental health problems? Please tick off as many as apply

e) Sensitisation

f) Inclusion in community activities

g) Home visits

h) Referral

i) Other, please specify……………………………………………………………..

11. What challenges do you find in performing your role as a mental health focal person? Please tick off as many as apply

h) Poor logistical support

i) Unclear referral systems

j) Mental health specialist unavailable

k) Training gaps

l) Health centres not capacitated to manage cases of mental health problems

m) Other, please specify…………………………………………………………….

12. What recommendations, if any, would you suggest to facilitate an increase in your performance as a mental health focal person?

a) Increased resource allocation

b) In-service training

c) Recruitment of specialists

d) Other, please specify……………………………………………………………

13. What recommendations, if any, do you have to increase the integration of the treatment of mental health problems at Health Centre IVs? Please tick as many that apply.

e) Increased resource allocation

f) In-service training

g) Recruitment of specialists

h) Other, please specify……………………………………………………………

Thank you for your time.

HEALTH CENTRE CHECKLIST

Introduction

I am a Masters student at the International Health Sciences University and I am carrying out a research to assess the capacity of Health Centre IVs to manage mental Health Problems in Wakiso district. The results of this study will provide an evidence base for district and policy makers for use in the development of need based services. I seek your involvement in this research by assisting in my completion of this questionnaire and your cooperation will be highly appreciated.

Information on the Study Area

Health Centre Name:……………………………………………………………..

Date: ………………………………………………………………………...

Variable	Yes	No	Remarks
Headed by a Senior Medical Officer.			
At least one other doctor present			
Resident Psychiatric Clinical Officer.			
Resident Psychiatric Nurse (Registered or comprehensive).			
Visiting mental health specialists to the centre			
Staff Number			

Operating theatre onsite			
Operating theatre functional			
Admission wards available			
Mental health medications in stock.			
Counseling services for persons with mental health problems.			
Other counseling services offered.			
Health education for mental problems offered.			
HMIS system regularly updated.			
Standard mental health guidelines referred to when screening all patients.			
Outlined referral system in place for severe cases of mental health problems.			
Follow up of patients with mental health problems for at least 6 months.			
Involvement of VHT in mental health problems			

HEALTH WORKER/HEALTH CENTRE IN-CHARGE QUESTIONNAIRE

Introduction

I am a Masters student at the International Health Sciences University and I am carrying out a research to assess the capacity of Health Centre IVs to manage mental Health Problems in Wakiso district. The results of this study will provide an evidence base for district and policy makers for use in the development of need based services. I seek your involvement in this research by completion of this questionnaire and your cooperation will be highly appreciated.

Your identity and personal information will be treated as confidentially as possible.

Do you agree to be asked and provide answers to the questions?

5. *Yes……………………………………..*
6. *No………………………………………..*

If yes, go ahead and conduct interview. If no, thank the respondent for their time and end interview.

Information on the Study Area

Health Centre Name…………………………………………………………..

Date of interview ……………………………………………………………….

Designation of respondent………………………………………………………

Duration of employment …………………………………………………….

No	Questions and filters	Coding categories	Coding label	Remark
101	Sex of the respondent **(Do not Ask)**	Male ………………………. Female…………..........	M F	
102	Age group of the respondent	Under 20 years……….. 21 -25 years…………… 26 – 30 years…………..	1 2 3	

		31 – 35 years………….. 36 -40 years…………… 41-45 years……………. 46-50 years……………. 51-55 years……………. 56-60 years…………….	4 5 6	
104	Qualification of respondent	MBCHB …………………...... Bachelors Nursing……….. Dip Nursing………………….. Dip clinical…..……….....… Enrolled Nurse…………….. Midwifery Cert……………… Others specify……………	1 2 3 4 5 6 7	
105	Title of respondent	Senior medical Officer………… Medical officer……………………… Senior N/Officer…………………… PH Nurse………………………………. Senior Clinical Officer………….. Clinical Officer……………………… Nursing Officer/Nursing………. Nursing Officer/midwifery…… Psychiatric clinical Officer……….. Psychiatric Officer Psychiatric Nurse…………………. Enrolled Nurse…………………….. Enrolled Midwife………………….. Others specify……………………..	A B C D E F G H I J K L M	

1. How many patients do you see on average each week? Please tick one box
   a) 0-50
   b) 51-100
   c) 101-150
   d) 151-200
2. How many patients with mental health problems do you receive each week?

a) 0-10
b) 11-20
c) 21-30
d) 31-40
e) 41-50

3. Do you refer to any standardised practice guidelines when screening patients who attend at the health centre?
   a) Yes
   b) No
4. If yes, does this include any of the following to screen patients for mental illness? Please tick
   a) International Classification of Diseases 10
   b) Diagnostic Screening Manual IV
   c) MINI
   d) National clinical guidelines for Uganda (2003 or 2010 versions)
   e) Others specify.............................

5. How often do you treat mental health problems yourself?
   a) Never
   b) Occasionally
   c) Often
   d) Almost always

6. Do you as an individual feel that you have the adequate skills to treat mental health problems?
   a) Yes
   b) No
7. Do you use any psychological techniques used while interacting with patients at your health centre?
   a) Yes
   b) No

   If yes, please tick any number of times from the list below:
   a) Cognitive Behavioural Therapy (CBT)
   b) Narrative Exposure Therapy (NET)
   c) Motivational interviewing
   d) Group therapy sessions

e) Individual Counselling

f) Other (please specify)

8. Do you refer patients with mental health problems?

a) Never

b) Occasionally

c) Often

d) Almost always

9. If yes, where are these patients referred?

i) District Referral Hospital

j) National Referral Hospital

k) National Mental Health Referral Hospital

l) Other, please Specify………………………………………………………………

10. Under which circumstances do you refer cases of clients with mental health problems to the above places?

a) No mental health specialist

b) No medicines

c) No admission facilities

d) No specialist equipment

e) Other, specify....................................

11. Mental health medicines are adequately stocked at district Health Centre IVs.

k) Strongly agree

l) Agree

m) Not sure

n) Disagree

o) Strongly disagree

12. Which mental health medicines do you have in stock? Please list them

…………………………………………………………………………………………………

……………………………………………………………………………

13. Mental health medicines are usually stocked at district Health Centre IVs.

f) Strongly agree

g) Agree

h) Not sure

i) Disagree

j) Strongly disagree

14. The following considerations influence decisions about stocking of mental health medicines at the health centre. Please tick off as many as apply.
    a) Knowledge of requisition process
    b) Demand for drugs
    c) Health centre annual budget
    d) Knowledge of health workers about mental health medicines and their prescription
    e) National policy
    f) Other, please specify..
15. Do you have contact with the District Mental Health Coordinator/ Focal Person?
    a) Yes
    b) No
16. If yes, what sort of contact do you have?
    a) Feedback on referred patients
    b) Clinical advice
    c) Social
    d) Joint management of patients
    e) Health education
    f) Other (please specify)
17. Apart from the clinical treatment given to client during the visit to health centre, which other care do you provide patients diagnosed with mental health problems?
    Please tick off as many as apply.
    a) Follow up of client in community
    b) Individual patient counselling
    c) Good antenatal care
    d) Psycho education
    e) Other (please specify)
18. How long is the follow up for individual patients with mental health problems?
    a) There is no follow up
    b) 1 month
    c) 2-4 months
    d) 4-6 months
    e) 6-8 months
    f) Other (please specify)

19. Would you say that the care for persons diagnosed with mental health problems is adequate at this health centre?
    a) Strongly agree
    b) Agree
    c) Not sure
    d) Disagree
    e) Strongly disagree
20. What role does the community play in the care for persons diagnosed with mental health problems? Please tick off
    j) Sensitisation
    k) Inclusion in community activities
    l) Referral
    m) Other, please specify…………………………………………………………..
21. What challenges do you find in providing care for persons diagnosed with mental health problems? Please tick off as many as apply
    n) Poor knowledge of diagnostic techniques
    o) No medicines
    p) Mental health specialist unavailable
    q) Training gaps
    r) Little or no resources
    s) Other, please specify…………………………………………………………….
22. What recommendations, if any, do you suggest to increase the integration of the treatment of mental health problems at this health centre? Please tick off as many as apply.
    i) Increased resource allocation
    j) In-service training
    k) Recruitment of specialists
    l) Other, please specify……………………………………………………………

Thank you for your time.

Appendix Two: Introduction letters and Research approval letters

Appendix Three; Budget

No.	Item	Units	Unit cost	Frequency		Total
1	Research assistants allowance	2	35,000	6	Man days	420,000
2	Transport to field fuel (Litres)	10	3,900	14	Days	546,000
3	Vehicle hire	1	50,000	14	Days	700,000
4	Meals and drinks for Research Assistants	3	5,000	6	Days	90,000
5	Mobilisation of District Health Team members	1	40,000	1	Day	40,000
6	Photocopying tools	40	400	1	Once	16,000
7	Data Entry, Analysis,	1	6,400	31	Tools	198,400
8	Preparation of Report	1	150,000	3	Drafts	450,000
9	Dissemination of results	1	100,000	3	Times	300,000
	Grand total					**2,760,400**

Appendix Four: Personnel

a) Principal Researcher

b) Research Assistants 2

c) Mental Health Focal Person for Sembabule District

d) Data Analyst

e) Driver

Appendix Five Work plan

Task & Persons In-charge	Activities	Days
1. Preparation of research proposal	Consultation with research supervisor	1
	Review of documents and development of study instruments	1
	Pre-visit to Wakiso district	1
	Pre-test of tools with Psychiatric Clinical Officer	1
	Letter of approval from University for data collection	1
2. Present study proposal and instruments to District Health Team (Researcher)	Fix appointments with district health team members	1
	Presentation of proposal	1
	Review study design to include comments of the DHT	1
	Approval by District health Officer to carry out study	1
3. Train research assistants and pre-test instruments (1 Team Leader, Co-investigator and 2 Research Assistants)	Identify select and conduct a orientation for research assistants on the application of questionnaires	1
	Simulate and pre-test instruments with research assistants	1
4. Finalize and produce Instruments (Researcher)	Finalize instruments and Photocopy all relevant instruments	1
5. Collection of quantitative and qualitative data (Researcher and 2 Research Assistants	Administer Questionnaires; Conduct key informant interviews in Wakiso, Namyumba, Buwambo, Entebbe, Ndejje, and Kasangati.	14
6. Data Entry, Analysis, and Preparation of draft Report (Researcher and 1 Data Entry Person).	Researcher’s meeting with data entry and analysis person. (Use of Stata statistical package version 11)	1
	Developing Coding Sheet and Schedules	1
	Data Entry	2
	Data Cleaning and Analysis	1
	Report Writing	12

7. Finalize study Report (1 Researcher).	Presentation of findings to research supervisor (Draft one)	1
	Presentation of draft two to research supervisor	4
	Submission of Final Report	1
	Defending study report before University committee	6th January 2011
11. Dissemination of study results	Present hard copy report to the district	January
	Present research findings to DHT and Ministry of Health	Jan/Feb
	Application to present findings in the British Journal for Psychiatry	March