Integrating mental health into primary health care: local initiatives from Uganda

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Uganda has passed through political and bloody civil strife stretching over 40 years. Since 1987 the HIV/AIDS pandemic has compounded the problems of the country. The present paper describes some initiatives to develop mental health services in one district of the country. A bottom-up approach in the district resulted in the formation of a community-led mental health program with strong support from two self-help groups, district political leaders and district representatives in parliament. 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. These initiatives show that it is possible to empower communities to participate in the development of mental health programs in a low-income country.

Key words: Integration, mental health, primary health care

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Uganda has passed through political and bloody civil strife stretching over 40 years. Since 1987 the HIV/AIDS pandemic has compounded the problems of the country. Under these circumstances, mental health indicators would be expected to be poor (1). However, over the last 15 years, important steps have been taken to improve mental health care provision in the country (2) and promote the role of psychiatry in medical education (3).

Uganda's health policy has decentralized the provision of health services to districts, and mental health is a component of the minimum health care package. The present paper describes some initiatives to develop local mental health services in Adjumani, a district of the country.

The Adjumani district is in the north-west of Uganda, bordering with Sudan, and has a population of 201,493 (4). The district has two medical officers, three psychiatric clinical officers (registered nurses with two-year advanced training in diagnosis and management) and five psychiatric nurses.

THE INITIATIVES

Lobbying among local politicians and district health care providers convinced the Adjumani district 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. A local community voluntary organization ("Nyarima"), meaning "rush to my rescue", was initiated with technical support from the Mental Healthcare Organization of Uganda, a local non-governmental organization, to address the high level of suicide and alcohol use problems in the district. "Nyarima" held a two day sensitization seminar for local district health workers, police, prisons, teachers and the district grade one magistrate. The seminar ended with ten resolutions, emphasizing the need to take urgent steps to formulate a local policy and legislation to support mental health care at the district level, and the need to lobby the national parliament to formulate a policy and take steps to combat the problems of suicide and alcohol abuse.

Subsequently, the district established a hotline telephone service, through which a senior psychiatrist responds to specific management problems that the mental health staff might have experienced within the preceding week. The data indicate that the mental health profile and severity of psychiatric disorders in the district are similar to those seen at the only national referral hospital in Kampala. The majority of those requiring mental health services were not recognized or simply lived with their condition untreated in their villages.

Thirty-four health care providers from lower level health care facilities in the district and 11 from the district hospital have been trained in the diagnosis and management of common mental disorders at district level. A referral system has been established at the district, supported in turn with the telephone hotline. Two consumer self-help support groups, Alcoholics Anonymous and Post-test Club for AIDS, have been established to help provide support to the district initiative. Further plans based on exploratory discussions aim to involve cultural leaders, the church, traditional healers, the education department, the welfare and probation department, police and prisons and the judiciary.

DISCUSSION

The initiatives from Uganda have started as a local com-

munity response to high levels of alcohol abuse and suicide behavior. They have shown that local communities can be empowered to support themselves in accessing mental health services and thus help reduce the burden of disease attributable to mental and general psychosocial ill health. In addition, they have revealed that primary health care providers can be trained to treat persons with mental ill health at district level.

There are 21 psychiatrists in Uganda for a population of 26.8 million (4), a psychiatrist to population ratio of 1:1.3 million. Under these circumstances of dire manpower shortage, a special cadre of middle-level mental health personnel, so-called psychiatric clinical officers, with special skills in diagnosis and prescription, are being trained. There are some 50 officers in the country, giving a ratio of approximately 1:500,000 inhabitants. To improve the situation of mental health care in Uganda, the process of policy reform at the district level will need to be speeded up to make it easier for persons with mental health problems to access mental health services early within an integrated health service.

The main challenge is how to make psychiatric services acceptable, affordable and accessible to all on the basis of social justice, equity and fairness, through an integrated health service provision that involves the community and government departments. One more concern is whether and how the local experience in the Adjumani district can be sustained and replicated in the other districts, with 65 different languages and cultures, in the country.

We have to demonstrate to the public that mental health problems are treatable and that we can promote mental health in the community through specialist support supervision, adequate provision of drugs, continuing professional education for district health care providers, training and support for community volunteer counselors, and the involvement of patients and their families in the planning and provision of psychiatric services. While the role of traditional healers in the treatment of mental illness has been reported in Uganda (5-7), this role is undermined by the lack of a functional system of collaboration and liaison between these healers and modern mental health care services in the country. Research into how best to collaborate with traditional healers is urgently needed.

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