Mental Health in Family Medicine 2009;6:37–42

Article

Integration of mental health into primary health care in Uganda: opportunities and challenges

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ABSTRACT

Background Worldwide, a number of reforms have been undertaken with the intention of improving access to mental health services. Notable among these is the integration of mental health services into primary health care, which has been one of the most fundamental healthcare reform recommendations globally.

Objectives This paper describes the opportunities for and challenges to the integration of mental health into primary health care in Uganda, as identified in a wider study, aimed at exploring the policy interventions required to address the vicious cycle of mental ill-health and poverty.

Methods Semi-structured interviews and focus group discussions (FGDs) were conducted with purposefully selected mental health stakeholders from various sectors. The interviews and FGDs were audio-recorded, and transcripts coded on the basis of a pre-determined coding frame. Thematic analysis of the data was conducted using NVivo7, adopting a framework analysis approach.

Results The participants identified a number of opportunities that could be exploited to strengthen the integration process. Notable among these was the political will and prioritisation of mental health at policy level. Poor appreciation of the integration process and attitudinal problems emerged as the most pressing challenges for integration of mental health into primary health care.

Conclusion Irrespective of the various opportunities in place, the integration of mental health into primary health care has not yet been fully realised, as it faces a number of challenges within and outside the health sector. This calls for more concerted efforts to scale up activities for effective integration of mental health care into primary health care.

Keywords: integration, mental health, policy, primary healthcare, Uganda

Background

Worldwide, a number of reforms have been undertaken with the intention of improving access to mental health services. Notable among these is the integration of mental health services into primary health care (PHC), which has been one of the most fundamental healthcare reform recommendations globally.[1–3]

Providing mental health services in PHC involves diagnosing and treating people with common mental disorders within the general framework of available health services, putting in place strategies to prevent mental disorders, ensuring that primary healthcare workers are able to apply key psychosocial and behavioural science skills, as well as ensuring an efficient referral system for those who require more specialised care.[2] However, because of the inadequacy of the referral services, the same system and human resources are, from time to time, called upon to

manage severe mental disorders such as psychoses and manic-depressive illness. The training of PHC workers has therefore involved empowering them to handle some of the key aspects of the severe mental disorders to some extent.[4] The advantages of integrating mental health services into PHC include, among others: reduced stigma for people with mental disorders and their families, improved access to care, human rights protection, reduced chronicity and improved social integration, as well as improvement in the human resource capacity for mental health.[5] Mental health treatment in primary care, compared with the previous institutional care model, has been noted to improve access, availability and affordability of services, thereby producing better outcomes.[6]

Various initiatives and strategies have been adopted by countries to operationalise the integration of mental health into PHC. In Uganda, cluster 4 of the framework for delivery of the Minimum Health Care Package comprises the non-communicable diseases, of which mental health and substance abuse are key elements.[4] Primary care is the basic philosophy and strategy for national health development in Uganda, and the ministry of health has an elaborate decentralised structure for the delivery of health services, which provides a conducive environment and increased access to mental health services.[6] The activities that have been undertaken in Uganda include, among others: inclusion of mental health as one of the components of the National Mental Health Care Package, training and recruitment of mental health professionals, in-service training of general health workers in mental health, and making psychotropic medicines readily available. However, despite the efforts, effective integration of mental health into PHC has been noted to still be weak, with a number of barriers.[7,8]

In this paper, we explore the opportunities and challenges to integration of mental health into PHC, as identified by various stakeholders in Uganda. The paper is based on findings of a wider study that explored the policy interventions required to address the vicious cycle of mental ill-health and poverty in Ghana, South Africa, Uganda and Zambia, through the Mental Health and Poverty Research Project.[9]

Methods

Semi-structured interviews (SSIs) and focus group discussions (FGDs) were conducted with a variety of mental health stakeholders in Uganda. Individual SSIs were used as they are an effective qualitative method for learning about the perspectives of individuals in relation to a particular topic.[10] These interviews also allowed for detailed exploration of a particular individual's point of view. The FGDs were conducted with some relatively homogenous groups of participants (such as nurses or teachers), in order to capture a range of opinions within these groups, using the limited time and resources that were available.

Selection of the participants was done purposefully, based on a number of principles: participants represented a range of key mental health organisations in Uganda; they held specialised knowledge or had specific experience related to mental health policy, mental health services and poverty. In total, 62 semi-structured interviews and six FGDs (each consisting of 5–9 participants) were conducted over a six-month period.

The FGDs and interviews were conducted in English, except for two interviews. The two users who could not speak English freely were interviewed in the local language, and the interviews were translated to English. As required for this sort of research, ethical approval was provided by the ethics committee and the office of the Director General of Health Services in the Ministry of Health. Written informed consent was obtained from all the participants. The interviews and FGDs were audio-recorded and transcribed verbatim. The transcriptions were then coded and entered into NVivo7 qualitative data-analysis software.

Thematic analysis of the data was conducted using a framework analysis approach. This approach was explicitly developed in the context of applied research, and is gaining popularity in health policy and systems research.[10] Using this approach, certain themes and sub-themes were collectively agreed upon by the investigators at all the research sites, based on the objectives of the study. A single framework for analysis was thus developed, and the transcripts were coded on the basis of this pre-determined coding frame. Thereafter, specific themes emerging from the interviews were added into the framework in the process of conducting the analysis, and transcripts were coded accordingly.

Findings

Opportunities for integration of mental health care

In this section, we present the findings in relation to the opportunities for and challenges to the integration of mental health into primary health care.

It was noted that there is growing recognition of mental health as an important public health and development issue in Uganda. Mental disorders have

been recognised to be not only a clinical problem but also a serious public health problem in the country, resulting in the inclusion of mental health as one of the components of the National Minimum Health Care Package.

The presence of political will and commitment at the policy level were noted to provide an environment conducive for the integration process. Over the last decade, the government of Uganda has made attempts to formulate a mental health policy after recognising an increase in mental health-related problems in the country. The policy strongly emphasises the integration of mental health into general health care up to the community level as one of the strategies to strengthen mental health services in the country. Furthermore, integration is a policy requirement and the process is driven directly from national level. This therefore provides a conducive framework for integration even at the lower levels.

It was noted that the national health policy recognises mental health care as a key component of the National Minimum Health Care Package. This is backed by the fact that mental health has a separate budget line within the Ministry of Health budget.

Some of the Ministry of Health officials identified good leadership in mental health, to which they attributed significant achievements that have been realised in mental health service delivery over the past few years.

It emerged that there is wide availability of general health workers and physicians who can be trained in a well-co-ordinated plan. In addition to this, there has been improved training and recruitment of specialised and other allied health workers in mental health to facilitate the integration process. The curricula for medical training institutions were reviewed to increase the number of hours of exposure to mental health issues. A well-co-ordinated arrangement for both pre-service and in-service training of staff in mental health has greatly contributed to the smooth progress of the integration process.

It was reported that there has been an improved system of supply of medicines for the past decade, enabling the provision of psychotropic medicines. The Ministry of Health's guidelines allow general health workers to prescribe and administer psychotropic medicines on the Uganda Essential Drug List. It was further noted that at the Ministry of Health headquarters, there is a ring-fenced budget for mental health medicines.

It was further observed that there is considerable involvement of other players, such as external development partners, civil society organisations, traditional healers, and other relevant sectors. More non-government organisations (NGOs) involved in mental health work have facilitated the reduction of stigma and discrimination against people with mental illness, resulting in improved demand for services.

The existence of a decentralised health system was also believed to facilitate the integration process. It provides for an improved supervisory system from Ministry of Health headquarters to districts. Coupled with all the above, there is an improved countrywide acceptance of mental health and mental health problems as an essential component of the diseases to be handled in health facilities over the years.

It was further noted that there is increased community participation through selected community resource personnel (village health teams). Training of these resource personnel in mental health was believed to be an excellent opportunity for strengthening community-based care as well as integration of mental health into PHC.

Challenges

It was noted that integration, as a policy recommendation, has been widely accepted and proclaimed, but has not yet been fully institutionalised in a guided manner at all levels of care. This was attributed to a number of challenges and barriers.

First, it emerged that there is limited appreciation of integration, and what integration actually entails. Some healthcare managers claimed to have integrated mental health services into PHC but could not identify any mental health aspects in their health programme, further arguing that mental health features indirectly in the general healthcare activities:

> '... if you look through my work plan here, you will not easily tease a bit of mental health; but it is integrated within. I mean we have the health sector strategic plan of which we are looking at how we really spell out which direction we should be taking for mental health. So, that is basically it. We have it in plan, but implementation may be rather different.' (SSI, district health services manager)

A particularly striking finding was that even in the absence of mental health personnel, PHC workers trained in mental health, and explicit mental health plans, some health managers maintained that mental health care is part of the service delivery as an integrated component; this point was echoed by one of the context informants:

> '... as of now, I wouldn't say that its activities are really teased out. They are completely integrated into our work of PHC. Well, as a district we don't have a particular unit that handles mental health as such and I would say we don't have many specialists. But by and large, it doesn't mean that mental health is not completely taken care of ... in one way or another we may not be so specialised

but we can do something about mental health.' (SSI, district health services manager)

He added:

'... indirect ... indirectly integrated within the network of treatment and care that we have. We may not be particularly targeting mental illness but we are treating a person holistically.'

The health managers further believed that all health workers receive some training in mental health during their pre-service training, and are therefore able to attend to the mental health needs of patients, although this was not clearly demonstrated in practice. This casts doubt as regards their understanding of integration, and their enthusiasm to have mental health services in place.

In relation to knowledge and skills in mental health, most general health workers are ill-equipped, with very few having had some training in mental health care. With the limited knowledge on mental health, many general health workers admitted knowing mental illness only by the severe forms – characterised by psychotic features. They thus fail to identify and attend to those whose mental health problems do not present with obvious psychiatric symptoms, resulting in fewer cases being reported. This has implications regarding resource allocation, to the disadvantage of mental health.

Furthermore, the general health workers exhibited poor appreciation of what their role is in relation to care for people with mental illness. It emerged that most PHC workers with basic training in mental health do not regard managing people with mental illness as their primary role, other than identification and referral to the mental hospital. Problems of understaffing were noted to be further complicated by the fact that there are still few experts to provide technical support and supervision, particularly to the health workers at the lower levels of care. Even where support supervision is carried out, it has been noted to be quite irregular.

The widespread negative attitude towards mental health and mental disorders was noted to play a significant role. It emerged that interest in mental health among most general health workers was still very low. Most of the general health workers who received orientation in mental health never had an interest in mental health, and never developed an interest later, as they continue to disregard mental health. One PHC doctor affirmed that although they currently spend relatively longer time training in mental health at the medical school than in the past, their interest still remains low and the attitude would take longer to change.

'... Yes, we get the orientation in mental health but the attitude doesn't change easily. The time is not enough to change the attitude and develop interest.' (SSI, PHC doctor, urban district)

Another important barrier that was either pointed out directly or alluded to was the fact that mental health care is still under-prioritised at the lower levels, which is partly reflected by a reluctance to recruit mental health professionals at lower levels, and very limited or no financing of mental health activities. Some of the health managers admitted disregarding mental health when it comes to resource allocation. This is further complicated by the fact that there are limited resources for the health sector generally, which makes it hard to balance community and hospital-based mental health care. At district level, the small budgets intended to facilitate mental health activities in some health facilities are often not realised for that purpose. Some health managers argued that mental health draws from the general PHC budgets as an integrated component, but with no pre-determined budgetary allocations.

It was noted that mental health drugs are included on the essential drug list and efforts are made to distribute these drugs. However, supply was reported to be irregular, with frequent emptying of stocks, which interferes with smooth service delivery. Restriction on prescription of psychotropic medicines by the PHC nurses was also identified as an obstacle to service delivery at the lower levels of care, which greatly depends on these nurses.

Some of the participants, however, believed that demand for mental health services also constitutes a significant challenge as regards the integration of mental health services. They cited poor help-seeking behaviour, whereby many patients tend to seek help from traditional healers or faith healers instead of the health facilities. However, the problem of poor help-seeking behaviour was also partly attributed to the fact that the public believes that specialised mental health services are not readily available in all health facilities.

Discussion

According to the study findings, it was clear that some health managers believe the integration of mental health into PHC occurs automatically, even in absence of deliberate efforts for its operationalisation. It should be noted that integration of mental health into PHC is a national health policy requirement, with specific targets such as increasing community access to mental health services by at least 50%,[4] which calls for well-planned efforts and strategies.

This was found to be lacking at various levels, where it was nevertheless claimed that mental health is integrated into PHC. For example, even in the absence of any mental health activities, one health manager at district level maintained that mental health services were available, integrated into general health care indirectly. The study findings suggest an obvious need to educate healthcare managers and workers on what integration entails and the effective implementation strategies.

The findings further suggested that political will and commitment as well as good leadership are a pre-requisite for effective integration of mental health into PHC. It was, however, noted that the strong political will and commitment for mental health are mostly at the central level, and less at district level. This inadequate political support manifests in limited resource allocation as well as low priority for the recruitment of human resources for mental health at the lower centres.

It should be noted that although there is a system in place for training general health workers in mental health, the number of those who have received this training is quite small. Furthermore, most health workers trained before the inclusion of a mental health component in the curricula for health workers. Therefore, many health workers still lack knowledge in mental health. The situation is further complicated by the absence of regular supervisory visits from the centre as well as a lack of continuous professional development. Some of the health workers, including those who had received training in mental health care, confessed a lack of interest or a negative attitude that still prevails in relation to mental health. Training should therefore be tailored in such a way that it is not only designed to impart mental health knowledge, but also aims to change attitudes. Furthermore, training arrangements need to take account of loss of knowledge over time among health workers.

Inclusion of psychotropic drugs on the Essential Drug List and a ring-fenced budget for mental health drugs are positive aspects favouring improved mental health care. However, besides the frequent emptying of stocks, it is not clear to what extent the medicines are readily available at the lower health facilities. Given the strict restrictions on prescription of psychotropic drugs by general nurses, availability of medicines would not have a significant impact if they cannot be readily dispensed and used. This emphasises a need to ensure that the drugs are readily available and that health workers are able to dispense them.

In line with the above, participants identified poor help-seeking behaviour as one of the challenges. This implies a need for corrective measures for effective service delivery and utilisation.

Furthermore, it should be noted that under the decentralised system, authority lies with the management at district level to identify their priorities and allocate resources accordingly. While some participants believed that this system has also facilitated the integration process, others viewed the decentralisation system as one of the barriers. They argued that mental health is well prioritised at the macro level but not the district level, as evidenced by the lack of mental health professionals in some districts. A significant difference was evident in the mental health systems of the rural and urban districts, especially in relation to staffing for mental health; this is attributable to the difference in prioritisation by managers in rural and urban districts. This implies that although mental health is a priority area at policy level, the prioritisation has not moved down to district level.

In view of the above, there is a need for the Ministry of Health to closely monitor implementation of the various priority areas at the lower levels.

Overall, the study findings highlighted a number of effective current strategies for the integration of mental health into PHC in Uganda, similar to anecdotal individual experiences and perceptions on integration of mental health into PHC as reported in *Integrating Mental Health into Primary Care: a global perspective*.[6]

Conclusion

The study findings implied that this important policy requirement of integration has not yet been fully realised, as a result of a number of challenges within and outside the health sector. The fact that mental health is a component of the Minimum Health Care Package implies an obligation for all health managers to ensure that mental health services exist at various levels of care, which seems, however, not to be happening. This therefore calls for a deliberate strategy by the health departments concerned to scale up activities for effective integration of mental health into PHC, in order to ensure accessibility and equity in mental health service delivery.

ACKNOWLEDGEMENTS

This paper reports on the findings from the first phase of the Mental Health and Poverty Project (MHaPP). MHaPP is a Research Programme Consortium (RPC) funded by the UK Department for

International Development (DfID) (RPC HD6 2005-2010) for the benefit of developing countries. RPC members among others include Alan J Flisher (Director) and Crick Lund (Co-ordinator) (University of Cape Town, Republic of South Africa (RSA)); Therese Agossou, Natalie Drew, Edwige Faydi and Michelle Funk (World Health Organization); Arvin Bhana (Human Sciences Research Council, RSA); Victor Doku (Kintampo Health Research Centre, Ghana); Andrew Green and Mayeh Omar (University of Leeds, UK); Fred Kigozi (Butabika Hospital, Uganda); Martin Knapp (University of London, UK); John Mayeya (Ministry of Health, Zambia); Eva N Mulutsi (Department of Health, RSA); Sheila Zaramba Ndyanabangi (Ministry of Health, Uganda); Angela Ofori-Atta (University of Ghana); Akwasi Osei (Ghana Health Service); and Inge Petersen (University of KwaZulu-Natal, RSA).

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FUNDING

We thank the British Department for International Development (DfID) for funding this RPC.

CONFLICTS OF INTEREST

None.

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Accepted 13 July 2009