Pioneering work in mental health outreaches in rural, southwestern Uganda

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In Uganda, the rates of mental illness are high due to poverty, high prevalence of HIV/AIDS and long-term exposure to civil wars and armed rebellion. The cost of mental health services in urban hospitals remains prohibitive for the rural poor who resort to traditional healers, and many mental health workers prefer working in urban areas. In response, a community outreach program has been developed in rural, southwestern Uganda to deliver effective mental health care. The programme was aimed at improving access to psychiatric care by taking services to communities where the majority of the rural population live, yet where services were non-existent. Baseline information on the training needs was collected by interviewing health workers in rural health units, and the need for a mental health service was assessed by interviewing members of the community and local leaders. Records of local health units were also reviewed. The result of the programme has shown that marginalized and neglected people with mental disorders have been able to access mental health care. Through increasing knowledge and access to psychiatric services in the community, mental health problems and psychological problems can be managed effectively with little need for referral to larger hospitals.

Keywords: Mental health outreaches, mental illness, primary health care, community mental health care, conflict, Uganda

Background

Uganda has a population of approximately 26 million people (2002 census), 89% reside in rural areas. The country has emerged from a period of political and bloody civil strife lasting over 40 years. Most regions in Uganda have experienced armed conflict since 1972, i.e. the killings of civilians during Idi Amin's rule, the liberation war of 1979, the Luwero war of 1981 – 1986, and the prolonged war that has been raging in the northern part of the country during the past 22 years.

The Mbarara District, one of the 56 districts of Uganda, is located in the southwestern part of the country about 260 kilometres from the capital city Kampala. The district has a land area of approximately 10 500 square kilometres and a population of about 1.4 million people. The main economic activity in the district is agriculture, consisting primarily of cattle rearing and subsistence farming. About 45% of the population is below the age of 15 years.

During the liberation war of 1979, the Mbarara district was particularly affected by widespread destruction of property and lives. Subsequently, Mbarara became the temporary home of internally displaced people from Luwero, who are now living in Kanyaryeru. Mbarara is also the site of two refugee camps, Oruchinga and Nakivale, serving refugees from Rwanda, Burundi,

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Democratic Republic of Congo (DRC), Ethiopia and Somalia. The population has been exposed to torture, maiming and killing, various forms of sexual and gender-based harassment and violence, forced marriages, physical injuries from bullet wounds, land mines, robbery and destruction of property, erosion of moral and social values, massive abductions of the youth, and the displacement of entire communities into camps.

The HIV/AIDS epidemic has also contributed to extensive personal loss, family fragmentation, and the increased burden of caring for ill relatives and orphaned children. Substance abuse is also common. Many of these problems are inter-related, with for example, HIV/AIDS having adverse psychological effects on infected individuals as well as their partners and children. In Uganda, the rate of HIV/AIDS is 5.3% in males, and 7.3% in females, with a national average of 6.5%, (The Uganda Ministry of Health (MOH), 2005).

Mental health problems in Uganda

In Uganda, most people are unaware of where they can get medical help for mental health disorders. Because of widespread cultural beliefs that mental illness is caused by witchcraft, patients are often taken to traditional healers, or left untreated. Patients with mental illness are regarded as an embarrassment to the family, and may be restrained with shackles, chains or ropes, or subjected to stoning and expulsion from the community.

Patients with epilepsy face many problems similar to those of the mentally ill. Although epilepsy is a neurological condition, in Uganda mental healthcare workers usually treat it. Other health workers perceive it as a *'disease of the head'*. In this article therefore, for practical reasons, people with epilepsy are regarded as part of the larger category of patients with neuropsychiatric disorders and mental health issues.

Mental illness in most parts of rural Uganda is often surrounded by stigma. The majority of patients with mental illness and epilepsy in rural areas remain untreated due to lack of knowledge and limited access to services, Those who do seek treatment in health care services have often been suffering for a long period, and if not *'cured'*, may be abandoned.

Recent epidemiological surveys on rates of mental disorder in Uganda do not exist, but high rates of mental illness would be expected due to the impact of poverty, decades of internal military conflicts, and the HIV/AIDS epidemic. An early prevalence study carried out in two villages in Uganda showed rates of mental disorder of 23.3% (Orley & Wing, 1979), while a more recent community based study in western Uganda estimated prevalence rates of mental disorder at 30.7% in adults (Kasoro, Sebudde, Kabagambe-Rugamba, Ovuga & Boardman, 2002).

Mental illness is therefore considered common in the sub-Saharan Africa, but only those with severe behavioural disturbances are identified. Many forms of mental disorders are likely to remain unrecognized, even though many people with mental health issues present themselves to the health care services, with surprisingly large numbers attending general outpatient services. A longitudinal study by the World Health Organization (WHO), conducted in 14 developing countries, found that almost one-third of all patients presenting at primary health care services showed discernible evidence of mental health problems (Sartorius, Ustun, Costa de Silva, Goldberg, Lecrubier, Ormel, Von Korff & Wittchen, 1993). For example, a study in Zimbabwe found that 26% of patients attending

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primary health care sites had mental health disorders (Reeler, Williams & Todd, 1993). Recent research in Nigeria showed that around 20% of child attendees at primary care facilities were suffering from psychological or psychiatric conditions, including depression, anxiety and conduct disorders (Gureje, Omigbodun, Gater, Acha, Ikuesan & Morris, 1994). The inadequate knowledge of general health workers in mental health also contributes to this lack of recognition as mental health professionals are primarily located in urban areas and far too few in number.

Mental health is an underdeveloped aspect of health care in Uganda. Uganda has approximately 18 psychiatrists in total, with the majority practicing in the capital city of Kampala. In addition, there are about 40 psychiatric clinical officers, with half of them practicing in regional hospitals in rural areas.

Decentralization of mental health services, with increasing emphasis on outreaches and community based programmes therefore, represents an obvious strategy for accessing mental health care service for the majority of the population. WHO advocates inclusion of mental health care as a part of primary health care worldwide (World Health Organization, 1978). The need to train primary health care workers and other personnel to provide basic mental health care is increasingly recognized (Acorn, 1993; Brooker, Tarrier, Barrowclough, Butterworth & Goldberg, 1992), and may be particularly indicated in conflict affected countries (Eisenman, Weine, Green, De Jong, Rayburn, Ventevogel, Keller & Agani, 2006).

Health services in Mbarara

A referral hospital attached to the medical school of Mbarara University of Science and Technology (MUST) is located in the district capital. It has a capacity of 336 beds and serves three districts in southwestern Uganda, i.e. Mbarara, Bushenyi, and Ntungamo districts (with a population of approximately 3.2 million people). Within the hospital is a psychiatric unit with 20 beds. The staffing level of the psychiatric unit consists of, at present, one psychiatric clinical officer, eight psychiatric nurses, two occupational therapists, a counsellor, and a recently posted psychiatrist. Although the staffing level for the psychiatric unit is adequate for in patient care, there is a need for more staff to provide better quality for out patient services, both in the hospital and in the community. On average, the hospital receives about 200 out patients each week. Hospital staff participation is needed in the community outreaches, which creates a burden for the few staff remaining at the hospital. The average waiting time at the hospital is between 2-6 hours.

The average distance to Mbarara regional hospital from other places in the district is about 60 kilometres. Therefore, most patients must travel long distances to access the mental health services in the regional hospital. In some places, public transport is quite difficult and the quality of the infrastructure is poor. Some have to walk long distances in order to get to a road where they may be able to board a vehicle. This is a difficult venture, especially if a patient is severely disturbed or rather resistive and cannot walk.

Additionally, such a journey costs approximately 8000 Ugandan shillings (approximately 4 US $). In Uganda, the average daily income for a person is less than 1$. Although it is government policy to offer free treatment, hospital supplies of psychotropic medication are inadequate and erratic, patients are often prescribed drugs that must be purchased from pharmacies in urban

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areas and often cannot afford it. As a result, many remain in villages untreated.

In addition to the referral hospital, there are over 130 rural health units located throughout Mbarara district. The basic structure of the primary health care system in Uganda consists of four levels of health care delivery that are outlined below.

Health Care Centre (HC) I – serves a village of approximately 1000 people. Services provided at this level include community based preventive measures and promotion of health services. No trained health staff are found at this level. The service is provided by a village health committee, a cadre of elected representatives, who have been given some basic instruction in health issues. In accordance with the Ministry of Health, units at this level are called "*health care centres*".

Health Centre II – serves a parish of approximately 5000 people. Services provided include preventive measures, promotion of health services and out patient curative health services, as well as outreach care, with staffing provided by general nurses.

Health Centre III – serves a sub-county of approximately 20 000 people. Services provided include preventive measures and promotion of health services, in and out patient curative services, maternity care, and laboratory services. Staffing is provided by a medical assistant (clinical officer), general nurses, and a laboratory assistant.

Health Centre IV – serves a county of approximately 100 000 people. Services provided include preventive measures, promotion of health services, in and out patient curative services, maternity care, emergency surgery, blood transfusion, and laboratory services. Medical doctors, clinical officers, nurses, a health educator, a health inspector, dental assistant, laboratory technician, laboratory assistant, anaesthetic officer and a dispenser provide staffing. It is worth noting that no mental health workers are included in the staff on any of these levels.

Rural health care is provided at primary health care units (i.e. HC II, III, and IV) located in the district. If proper training could be provided for primary health care workers, the location of these care units in community settings would make them ideally accessible to most patients with mental disorders.

Initiation of the mental health outreach service (planning phase)

In 2002, a programme was initiated to test the feasibility of providing mental health outreach services to populations in rural and remote areas in the Mbarara district. We chose 15 health units in the district and also in a rural community of Rubindi sub-county, where a community oriented sensitization program was to be implemented in order to increase awareness of mental health issues. Four of the health units were located at a distance of approximately 40 kilometres from Mbarara Regional hospital, while 11 were located at a distance of between 40 and 70 kilometres. All of these health units were rural in character. The sub-county of Rubindi was also chosen because there was no functional government health unit, as opposed to a nongovernmental unit, e.g. staffed by a nongovernmental organization (NGO). During the planning phase, we obtained baseline data regarding health workers' attitudes to mental illness, the level of care currently available, and the numbers of patients visiting the health unit. We developed a questionnaire (see Box 1) to assess the training needs of health workers, e.g. their knowledge of mental health, common mental disorders, services available, etc. The questionnaire was administered to all qualified health workers who agreed to

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Box 1: Primary Health Workers Needs Assessment Questionnaire

MBARARA HOSPITAL. Mental Health Program.
Name of Health unit ———————————————————
Date ———————————————————
Name of Health Worker ———————————————————
Qualification ———————————————————
1. Have you ever received any training in mental health? Yes/ No.
2. Do you receive/attend to patients with mental illness? Yes/ No.
3. On average how many patients with mental illness do you treat in a month?

4. What types of mental illness do you come across in the course of your work or do you know of?

If any, what drug do you use for each condition?

5. What are the common psychiatric drugs you stock in your health unit?

6. What are the common drugs used for the treatment of epilepsy?

7. Apart from the health unit, where else do patients with mental illness in this area seek help?

8. Do you think that more mentally ill people could be seen and helped in the existing health units?

9. What are the common attitudes and beliefs towards mental illness?

10. What suggestions do you have that could help to improve the situation of, or the care of, persons with mental illness?

Thank you

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participate and who were available at the health unit. A total of 34 health workers were interviewed. We also reviewed medical attendance records for the year before. Medical attendance records were available in all the health units. The health workers on duty recorded the information contained in the records. It is basic information and includes names of patients and their particulars, diagnosis and drugs prescribed, whether admitted, treated as an outpatient, or referred. As a result of inadequate training in mental health issues, the diagnosis commonly used was *'mental disorder'*, and not specified any further.

A focus group discussion was carried out in one community. The group consisted of nine members of the adult population (five females and four males), with each person given an opportunity to speak about issues concerning mental health in their community. The members were selected in order to collect as diverse views as possible. The group consisted of a religious leader, a local leader, a traditional birth attendant, two traditional healers, two elders/opinion leaders, a teacher, and a person with a disability.

Following the baseline data collection, a training of health workers was planned, consisting of three separate training sessions (one session each year), each lasting five days. The health workers trained included nurses and medical assistants (clinical officers). During the training we used and followed a training manual for operational health workers developed by the mental health section of the Ministry of Health. The skills taught included interviewing and diagnostic skills, so that staff workers could identify/recognize and refer difficult patients. The training covered the following clinical diagnoses: mania, depression, anxiety, somatization disorder, post traumatic stress disorder, substance abuse, schizophrenia, delirium, epilepsy and severe learning disabilities. The intent was to provide a course tailored to the needs of participants, rather than an encyclopaedic curriculum or area overview (Ventevogel & Kortmann, 2004). The content included: introduction/definition, etiology, symptomatology, and management (drug management and other forms e.g. counselling and patient communication skills). Information regarding drug treatment emphasized the most essential drugs, e.g. chlorpromazine, haloperidol, benzhexol (for side effects), imipramine or amitriptyline, and phenobarbitone. The medication list was purposefully restricted because we considered it more important for primary care workers to know a lot about a few drugs than to know a little about many drugs. The training methods included lectures, brainstorming, group discussions, plenary sessions, and role play. Pre and post training tests were conducted in order to assess the participants' level of knowledge. At the end of each training session, participants received attendance certificates issued by the District Director of Health Services.

The mental health outreach service

Following completion of the planning phase (2001), the mental health outreach service has been in operation since 2002. A mental health team at Mbarara regional hospital, consisting of a psychiatrist, psychiatric clinical officer, a nurse, and occupational therapist, conducts the outreach and clinical supervision. The outreach team goes out once a week, according to a preset program. Medical students from Mbarara also participate in these activities. Health care units (HC levels III, IV) are informed of the dates for the visits well in advance. This gives ample time for health workers to announce the date

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for the clinic in public places, e.g. churches, schools, markets, etc. Three health units are visited once every month because of the heavy patient load at these clinics. The other seven health units are visited once every three months. The community volunteers did an intensive mobilization and sensitization programme in these areas. Community volunteers encourage all identified patients to attend the clinic. Some patients are self-referred, while patients who have improved or benefited from the service encourage others. Functions of the mental health team in the outreach include: patient diagnosis and initiation of treatment, mental health education at the health unit, discussion/response to social concerns of patients and caretakers, on-the-job training of health workers, case conferences with patients, counselling to patients, and identifying and dealing with patients who need rehabilitation. Because of limited resources, only two members of the team accompany the outreach each time. However, a psychiatric clinical officer goes on every visit with other members of the team. Only 10 health units out of the original 15 health units are currently visited, due to financial limitations and the heavy workload of the mental health team at the regional hospital.

During the visits, clinics are held jointly with the primary health workers present at the health unit. At the clinic, the psychiatric clinical officer or a psychiatrist conducts the clinical interview, performs a mental state examination, and collects information on illness history with additional information provided by relatives who accompany the patient. The diagnosis is determined using DSM-IV criteria. Case notes are kept in the patients' notebooks, which the patient carries back and forth; as they form a good basis for follow up. Patients seen are recorded in a patient register book as part of the Health Management Information System (HMIS). The training in mental health provided to the primary health workers in these health units has resulted in an ongoing uptake of new patients, prescription renewals, and the referral of difficult cases to clinic days during which a psychiatric clinical officer or psychiatrist reviews the patient with the health worker at the health unit. During the training, the emphasis was on recognition of mental illness and the ability to categorize this as mania, depression, schizophrenia, epilepsy, etc. After the training, most health workers are able to give specific diagnoses, although adjustments may be needed during clinical supervision by the mental health team. For example, it has been fairly difficult for primary health workers to differentiate between depression, anxiety, and somatic problems, thus preferring combining all of these into one diagnostic category. The health worker's ability to make an accurate diagnosis is a bonus and most trained primary health workers have generally shown improvement in identifying major diagnostic categories.

Awareness raising activities

Sensitization meetings with community members

In Rubindi sub-county, with a population of about 18 000 people, community sensitization meetings were carried out in seven parishes. Over the course of one year, each parish had five sensitization meetings, with 30 participants attending each session. Elders, religious leaders, teachers, local leaders, traditional healers, traditional birth attendants, and representatives of interest groups for women, youths and disabled persons attended meetings. Sensitization meetings focused on common mental illnesses, beliefs and attitudes towards mental

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illness, approach/handling/care of persons with mental health problems in the community, the community's role in promoting mental health, importance of early identification and early referral of patients for medical treatment, as well as the resettlement of patients.

Development and printing of posters and leaflets
Given the need for increased public awareness of mental disorder, we developed posters and leaflets containing important and basic health messages for use in educational campaigns, and pre tested them in schools, in adult community groups, with patients during health education talks, and with health workers. These materials were then further adapted for printing. The printed materials were distributed to patients, caregivers, schools, community leaders, and health workers. These materials served as useful stimulators of discussion during mental health education campaigns and community sensitization meetings.

Community volunteers (village health workers)

During community sensitizations in Rubindi sub-county, it became apparent that community volunteers were needed to motivate patients with regard to seeking treatment,compliance of treatment and to encourage caregivers to support patients in these efforts. Community members selected the volunteers to receive some basic training instruction in the area of mental health. Each parish has at least one volunteer. Community volunteers have the following responsibilities: identification and referral of patients for treatment; home visits (follow up of patients, assessment of home situation and treatment compliance); provision of basic information to the community concerning the care of mental health patients in the community; encouragement of community social support especially to patients and families; help in the resettlement of patients and their engagement in productive activities; and liaison work between the community and health unit. These volunteers are motivated young people who have basic literacy skills. They are also natives of the villages they serve, and live and work within their villages/parishes. Although they do not demand payment for their service, they are provided an incentive in the form of a lunch allowance and bicycles to facilitate movements within the villages.

Medication supply

Medication supply by the government health units/hospitals is inadequate and often unreliable. As mentioned, it is government policy to provide free medication to patients, although in most cases medications are lacking and patients do not get the prescribed treatment. Patients and care givers appreciate the importance of medication, and therefore the absence of medication in health units is a source of frustration and greatly contributes to poor compliance.
In the light of this problem, patients and caregivers resolved to contribute to the purchase of medications. During the discussions leading up to this decision, the following issues were considered: the distance travelled to a regional hospital, the waiting time, and the expenses involved in terms of transport and purchase of the prescribed medications from private pharmacies in the event medications at the hospital were not in stock. Support for the idea of contribution to medication purchasing was partly due to increased awareness of the dangers associated with lack of medication, e.g. that patients with epilepsy have more frequent attacks and that those with mental disorders

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experience symptom exacerbation. A patient pays 3000 Ugandan shillings (approximately US $1.50) flat rate at every visit to the mental health outreach unit.

The payment system works best in health units attached to churches. Those who are unable to pay are given treatment, but asked to make up the payment in subsequent visits. In cases where a chronic mentally ill patient has no money whatsoever, the committee managing the fund meets to discuss the issue, and may recommend that such a patient be exempt from payment. In a few cases, the community has helped patients who fail to pay.

Working with traditional healers

In the course of our work, we realized that nearly all mental health patients first sought help from traditional healers. Therefore, we approached one prominent traditional healer who agreed to organize other healers for meetings, with the aim of establishing collaboration. We have been in contact with 20 traditional healers who agreed to work with us, especially in the areas of referral of patients, exchange visits and sharing of information. Thus far, traditional healers have visited the health units and interacted with the staff, and some health workers have had the opportunity to visit the shrines of the traditional healers. Some traditional healers have referred patients to the health units, and patients and relatives who have expressed an interest in consulting a traditional healer have not been discouraged. Our methods are similar to a community mental health intervention in Sierra Leone, where collaboration was established with traditional healers, who allowed reciprocal visits to their healing consultations and who attended outpatient sessions and training workshops (de Jong & Kleber, 2007).

Work in refugee camps

Services were extended to internally displaced people residing in the Kanyaryeru, Nakivale and Oruchinga refugee camps. Psychosocial problems are common among these internally displaced people and refugees. Many people presented with somatization, depression, anxiety disorders, post traumatic stress disorder (PTSD), substance abuse, helplessness and loneliness. In one meeting with the refugees, one male refugee said: '*here as refugees there is no man; Red Cross is the "man"*'. When asked to clarify, he said that as men, they have lost the power to take charge and provide for their families; all of them line up for handouts, a situation shared by all men in the meeting.

Support groups have been formed for traumatized persons. Women in Kanyaryeru with psychosocial problems benefited from the support groups and from praying together at least twice a week. In conflict-torn areas where existing health services are inadequate, traumatized persons may rely on religious coping mechanisms (Scholte, Olff, Ventevogel, de Vries, Jansveld, Cardozo & Crawford, 2004). Testimonies could be seen as contributing to create a bridge between the psychological and social processes of recovery. More important than the testimonies in this process, was the opportunity provided through bible study groups at the churches for members to create a new network which facilitates bonding and social cohesion (Tankink, 2007). Primary health care systems need to be aware of the silent suffering of traumatized persons to ensure the development of appropriate intervention strategies.

Results

Table 1 shows the distribution of patient attendance at health care units during the past three-year period. In total, 12 957 patients

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(2621 new patients, 10 336 re-attending patients) were seen at 10 outreaches (health care units). The total number of new patients seen by the mental health outreach programme increased approximately four-fold during the three year period. Patients with epilepsy (1563 new patients, 8101 re-attending patients) comprised by far the largest diagnostic group within the total patient sample (74.5%).

The majority of the patients presented with epilepsy, brief psychotic disorder, and depression. Very few patients present with alcohol problems at the health units possibly because in the community, alcohol is socially accepted. Drinking and getting drunk are considered normal behaviours. Some patients do, however, present with a dual diagnosis of alcohol problems with another diagnosis. Women have twice the number of depressive disorders than men, as seen in numerous epidemiological surveys in low and high income country settings (Rihmer & Augst, 2005). In Uganda, men do not easily express their depressive feelings, while women do and seek help. Finally, although the HIV/AIDS epidemic has had an impact on mental health in the population, the identification of mental disorders associated with HIV/AIDS has thus far not been emphasized in the outreaches.

Although for most diagnostic categories, the numbers of new patients seen tended to increase over the three years, the proportion of new patients within each of the main diagnostic categories remained approximately the same from year to year, with the exception of severe learning disabilities, where the number of new patients decreased slightly over the three years (see Table 2), partly because we did not offer specialized services to this category of patients. Due to the usual difficulties involved in record keeping at primary health centres, it has not been possible to further stratify (e.g. gender, age) the information provided in Tables 1 and 2.

The implementation of the project has resulted in improved mental health services in the rural and remote communities in the district. The integration of mental health care with primary health care services has provided better access to treatment for patients with mental disorders. Continuity

Table 1. Patients' attendance at health care units served by the mental health outreach during the years 2002–2004

Diagnosis by year	2002	2003	2004
Schizophrenia	95	128	174
Psychotic disorder	359	485	561
Depression/anxiety disorder	441	491	333
Bipolar affective disorder	39	50	78
Epilepsy	2330	3614	3720
Severe learning disabiltiy	37	16	16
Total attendance by year			
	New	Re-attendence	
2002	388	2913	
2003	684	4100	
2004	1549	3323	

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of care, with patients being managed at nearby health units and/or in their homes, has resulted in generally improved levels of functioning. Indeed, as indicated in Table 1, patient attendance has greatly increased. Patients that have been treated at Mbarara regional hospital when discharged can be followed up at the nearby health units, thus decongesting the hospital. The involvement of the community and the training of community volunteers has helped in the early identification and referral of patients to nearby health units, and also reduced the level of stigmatization of mental health patients and those suffering from epilepsy (reduced hostility, isolation, exclusion and discrimination of patients).

Thus far, commitment to the outreach program is high among staff members at the local clinics. However, some health workers have complained of extra work. Some improvement may be needed in the data collection process in the future, in order to alleviate this problem. The increasing numbers of patients with mental health disorders being seen and treated in the outreach clinic certainly bears a risk of increasing the burden for primary health workers. However, perhaps this will encourage the Ministry of Health to develop appropriate strategies in order to respond to the mental health needs of the population. Fortunately, the Ministry of Health is currently advocating for the integration of mental health into the existing general health services at all levels. We believe this gives the best guarantees for sustainability.

The lack of psychiatric and anti-epileptic drugs and supplies creates a danger for patients who seek treatment, but who must return home without having received adequate medication. Such patients may lose confidence in the services and cease to seek medical help at the health unit in the future. Therefore, continuity of medication supply and associated care inputs must be assured if the service is to be meaningful to patients and their families. Furthermore, it is often dangerous to abruptly discontinue an essential psychotropic medication or anticonvulsant. Additionally, patients with severe mental disorders without supportive families may be especially prone to treatment non-compliance, because no one encourages them to stay on the medication. While a large number of patients with epilepsy respond well to treatment, some continue to get seizures despite the medication administered, which causes considerable frustration for patients and family members. Many communities that have been mobilized and sensitized have then actively participated in helping patients to access treatment. However, the importance of continuous pharmacological treatment has still not been recognized in the more remote areas, and therefore some patients remain in villages locked up/or held in chains without medical help, thereby increasing the risk of the development of chronic illness and long term social disability (social rejection, work handicap).

Discussion

In the context of community mental health, both the United States and the United Kingdom have been reducing psychiatric inpatient facilities over the last four decades, favouring instead non-institutional alternatives (Raftery, 1992). In developed countries such as the UK, mental health services are well developed with good resources and adequate staffing levels, and care is provided within a standardized health care delivery system. Low income countries have never had the opportunity to establish *'decentralized'* institutional mental health care. Thus, moving in the direction of an outreach

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Table 2 Proportion of new patients seen by mental health outreach, by diagnostic group

Year	Schizophrenia	Psychotic disorder	Depression/ anxiety	Bipolar disorder	Epilepsy	Severe learning disability	Total
	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)
2002	4.6% (18)	9.8% (38)	21.1% (82)	1.6% (6)	57.2% (222)	5.7% (22)	100.0% (388)
2003	6.1% (42)	13.7% (94)	19.3% (132)	2.5% (17)	56.6% (387)	1.8% (12)	100.0% (684)
2004	3.1% (48)	13.4% (208)	19.1% (296)	2.4% (37)	61.1% (954)	0.4% (6)	100.0% (1549)

Note: Schizophrenia (commonly seen types include disorganized, catatonic schizophrenia).
Psychotic disorders include Brief psychotic disorders, Schizophreniform disorder, Psychotic disorder (N.O.S).

service is both a necessary step due to the geographical remoteness of some regions, lack of trained mental health professionals, and the limited number of institutional facilities. It is also a development that is well in line with current conceptualizations regarding the negative effects of institutionalization. Traditional life styles that stress social support constitute an advantage for the integration of mental health with primary health care systems, where the involvement of family may be seen as an essential component of mental health care (Murthy, 1998).

Much of the success of the mental health outreach is due to the activities of the community volunteers. Their involvement in linking the community to health services, early identification, referral of patients for treatment and follow up of patients in homes has been of major importance for improving the quality of life of the mentally ill. This compares well with the work done by family welfare educators of Botswana. Family welfare educators help in preventive aspects of health care, and encourage all identified patients to attend outreach clinics (Ben-Tovim, 1983). The results of our mental health outreach show that with the help of special training, primary health care workers can improve their knowledge and skills regarding mental illness. Consequently, the majority of patients with mental health disorders may be managed at the lower health care units.

Community based health care for mental illness has several advantages. Patients may be more motivated for treatment when treatment is delivered in a familiar and supportive environment, without disruption of family, social and community networks. Community based treatment in rural areas also eliminates the need for costly travel and thus improves patient compliance and treatment follow up. Patients are able to walk

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to the treatment units, where they are seen quickly by health workers who are familiar to them and who have a receptive attitude towards patients. Community mental health services are thus more *'user'* friendly than distant regional hospitals.

Refugees, especially men, find themselves in a situation where they have no power or authority over their families since agencies take over control and provide the basic necessities. Years of refugee life seems to have promoted a *'learned helplessness'* where people feel little power to control or influence their own lives (Seligman, 1975). War results in extreme suffering of the civilian population, especially women and children. There is little question that emotional distress and psychosocial problems can be directly related to being a survivor of violence and displacement (Marsella, Bornemann, Ekblad & Orley, 1994). Psychological intervention is therefore important in emergency situations, as well as in long term rehabilitation, by providing psychological support and prevention of complications. Moreover, the HIV/AIDS pandemic that has caused severe loss of life, increased caring of ill relatives and orphaned children, family fragmentation, domestic violence and other common forms of abuse, has undoubtedly also had adverse psychological effects on the majority of the population. Therefore, it is important to educate the general population that most forms of suffering may cause psychological problems and/or mental health problems, and that they are treatable.

While dealing with communities, it is also important to determine which coping methods may be most appropriate in that particular cultural setting, such as the traumatized women in Kanyaryeru who responded well to prayers. In developing appropriate materials, it is important to identify the range of expected individual and community reactions to severe stressors (e.g. rape) and to recognize culturally relevant ways of coping, e.g. prayers or rituals at times of difficulty (Inter-Agency Standing Committee (IASC), 2007). Prayers give social support and relaxation, help to diminish trauma, and provide a form of emotional ventilation through testimonies. This type of interpersonal sharing may have considerable therapeutic benefits.

The long term impact of conflict on mental health necessitates the establishment of a comprehensive mental health care service that can competently address the psychological problems experienced by the community. The government of Uganda through the Ministry of Health recognizes this need. The Health Sector strategic Plan II (MOH, 2005) provides a framework for special approaches for delivery of health services in conflict areas, especially in the north. The Ministry of Health is increasing its support to the training of health workers and mental health outreaches and psychiatrists receive financial support from the government to do clinical supervision in upcountry hospitals.

Challenges

Despite considerable service improvement, a number of ongoing challenges warrant further attention. These include the inadequate supply of drugs, the stigma associated with mental illness, the tendency among some health care workers to view mental illness as less important than other illnesses, and the difficulties associated with the management of mental illness, especially schizophrenia, where treatment compliance is poor. There are still many people with psychosocial problems who do not seek help. Finally and most seriously, the long term sustainability of the outreach program remains uncertain.

Recommendations

Based on our accumulated experience, we suggest that mental health services be easily

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accessible, especially to the rural poor, and that basic drugs should be made available without unnecessary interruption. The IASC guidelines on mental health and psychosocial support should be made available to primary health care workers. Nongovernmental organizations should be encouraged to enter the area of mental health, and efforts should be made to promote public awareness of mental health issues.

Conclusion

By increasing knowledge and access to treatment within the community, mental disorders and psychological problems can be managed very effectively, rarely requiring referral to larger hospitals. Such decentralization need not be costly. Through the support of continued training of primary health care workers, community volunteers, and increased community awareness, many more patients could receive quality treatment closer to their homes. While improving the health and productivity of the rural population, it also encourages patients to seek treatment earlier, reducing the burden of advanced cases at the regional hospital.

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