

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN UGANDA**



**MINISTRY OF HEALTH
REPUBLIC OF UGANDA**

WHO-AIMS REPORT ON THE

MENTAL HEALTH SYSTEM

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A report of the assessment of the mental health system in Uganda using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS)

Kampala, Uganda

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**Ministry of Health
Uganda**

WHO, Country office - Uganda
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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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Foreword

This study was carried out by Fred Kigozi, Sheila Ndyabangi, Joshua Ssebunnya and Dorothy Kizza as part of the activities of the Mental Health and Poverty Research Project (Butabika National Hospital/Makerere University) funded by the British Department for International Development (DFID).

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Data was collected mainly from the Ministry of Health headquarters, Butabika National Mental Hospital, Makerere University Medical School (Department of Psychiatry), Uganda Nurses and Midwives Council, Mental Health Uganda, Basic Needs U.K in Uganda and Kamwokya Christian Caring Community.

Data collection was, by self-administered questionnaire, designed out of the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) document, version 2.2. The instrument comes along with Excel data entry programme, for data entry and analysis.

Data was collected in 2006 and is based on the calendar year 2005.

Introduction

Uganda is located in East Africa with a geographical area of approximately 236,040 square kilometers. At the time of this assessment, the country had a population of 27.4 million, and a population growth rate of 3.3% (State of Uganda Population report, UNFPA, 2006). The main languages used in the country are English and Luganda. Religious groups include Roman Catholics, Protestants, Muslims and evangelical churches.

As of the year 2006, the proportion of the population under the age of 15 years was 49.3%, while those above the age of 60 years were 4.5%. About 88% of the population was in the rural areas. The life expectancy at birth for males was 50.7 and 52.7 for females. The literacy rate for men was 76% and 61% for women.

The country is a low-income group country based on World Bank 2005 criteria. The proportion of the health budget to GDP was 3.5. The per capita total expenditure on health was \$ 36, and the per capita government expenditure on health was \$ 8. Government expenditure on health was 10.3% of the total government expenditure.

There were 65.3 hospital beds per 100,000 population in public sector and 10.6 general practitioners per 100,000 population. In terms of primary care, there were 350 physician-based primary health care facilities in the country (232 in the public sector and 118 in the private) and 1,443 non-physician based primary health care clinics (1,050 in the public sector and 393 in the private sector).

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Uganda. The goal of collecting this information was to improve the mental health system and to provide a baseline for monitoring the change. This is expected to enable Uganda develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing health policy reforms, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Uganda has a draft mental health policy and an out-dated mental health law, but no separate comprehensive Mental Health Strategic Plan. At the time of this assessment, a very small proportion of health financing directly went towards mental health. Mental health financing was mainly oriented towards the National Mental Hospital and Regional Referral Hospitals with mental health units. There were no social insurance schemes covering mental health. The majority of the population had free access to psychotropic medication. No human rights review body existed for the regular or institutionalized review of human rights issues in the mental health facilities. The mental health workers had not received specific training in human rights.

The mental health authority was part of the office of the Principal Medical Officer in charge of mental health at the ministry of health headquarters. There was one National Mental Hospital, 27 Community based psychiatric inpatient units, 1 day treatment facility, and no community residential facilities. The day treatment facility treated 0.64 per 100,000 general population. There were 1.4 beds per 100,000 general population in the community based psychiatric inpatient units and 1.83 per 100,000 beds in the mental hospital; and all the above had an occupancy rate of 100%. Uganda had seen an increase in the number of mental hospital beds in the previous 5 years from 450 to 500. All forensic beds were in the mental hospital. While 62.4% percent of the psychiatry beds in the country were located in or near the largest city, majority of the patients admitted had a diagnosis of mood disorders followed by epilepsy and substance related problems.

Primary health care staff received minimal training in mental health, and interaction with mental health services was rare where there were no Mental Health Professionals.

It was found that there were 1.13 human resources working in mental health per 100,000 of the population. Rates were particularly low for clinical psychologists, social workers and occupational therapists. Most psychiatrists worked for both government administered and private facilities. There was an uneven distribution of human resources in favour of the National Mental Hospital and the urban areas, particularly in the main city. User associations were present in the country, though not receiving financial support from Government. Some of these associations had been involved in developing and implementing policies.

Public education and awareness campaigns were overseen by the mental health division, with experts from the National Mental Hospital. There were links with other relevant sectors, but no legislative or financial support for people with mental disorders.

Data was collected through the HMIS and compiled by facilities to a variable extent. The collected data is produced by the government health department in an annual performance report. There had been some research on mental health published in indexed journals.

MAJOR FINDINGS

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Uganda's mental health policy was developed in 2000; and was still in draft form (in 2006). The policy included the following components: (1) developing community mental health services, (2) downsizing large mental hospitals, (3) developing a mental health component in primary health care, (4) human resources, (5) involvement of *users* and their families, (6) advocacy and promotion, (7) human rights protection of users, (8) equity of access to mental health services across different groups, (9) Monitoring system. Financing and quality improvement are not addressed as these are assumed to be integrated into general health services. In addition, a list of essential medicines was present. These medicines included all categories of psychotropic drugs (i.e. antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs).

There was no comprehensive Mental Health Plan, although there was a health sector strategic plan, of which mental health was a key component. There was no emergency/disaster preparedness plan for mental health. However, one of the core interventions in the Health Sector Strategic Plan was addressing mental health although problems in conflict situations.

The last revision of the mental health legislation was in 1964. The legislation basically focused on custodial care of the mentally ill persons, and is an antiquated kind of law that has been overtaken by events. Most of the contemporary issues that would be expected in the legislation were not included. Mention is only made of the voluntary and involuntary treatment as well as law enforcement and some other judicial issues for the mentally ill persons. There were no procedures and standardized documentation for any of the components of the legislation.

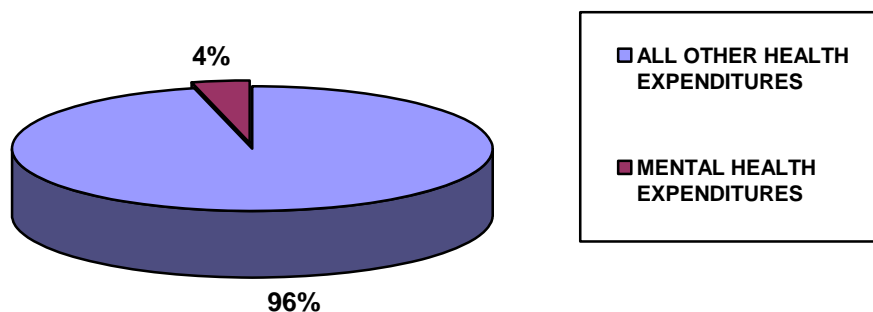
Financing of mental health services

One percent (1%) of health care expenditures by the government health department was specifically directed towards mental health in primary care. However, as part of the integrated health service delivery, other aspects of mental health are funded within the general health budget as well. Furthermore, under donor support to the government, the health sector's financing was supplemented by funding from African Development Bank (ADB), with nearly 45% of the support going to mental health. This raised the expenditure on mental health to approximately 4%.

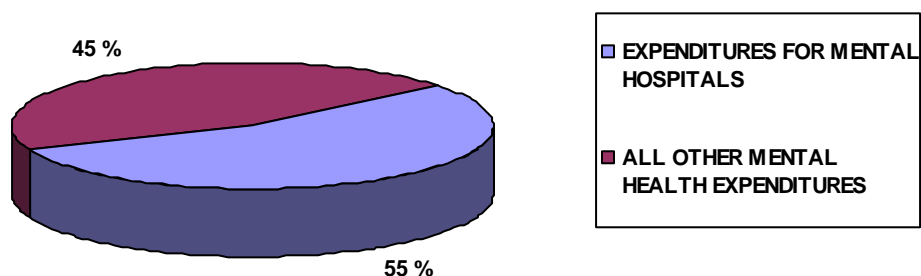
Of the overall expenditure on mental health, 55% was directed towards the National Mental Hospital. The whole population (100%) had free access (of at least 80%) to essential psychotropic medicines. This is based on the fact that medication is provided at no cost in all public health facilities. For those who pay out of pocket, 37% of the daily minimum wage was needed to pay for one day antipsychotic

medication, while 7% of daily wage was needed to pay for one day dose of antidepressant medication. Mental disorders were not covered in the current social insurance schemes.

GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Human rights policies

The country had no National or Regional Human Rights Review Body for assessing the human rights protection of users in mental health services. Neither the mental hospital nor the community based psychiatric units or community residential facilities had received at least one review/inspection of human rights protection of patients in the year of assessment. Similarly, the staff in the mental hospital and community based inpatient psychiatric units had not had any specific training, meeting or any other type of working sessions on human rights protection of patients. Some of the health workers however had received general training on human rights.

Domain 2: Mental Health Services

Organization of mental health services

An office for coordination of mental health services exists at the Ministry of Health headquarters, occupied by an official at a level of Principal Medical Officer. The main roles for the office are basically policy development, resource mobilisation planning, and coordination, plus monitoring and quality assessment of the mental health services at regional and district levels. Mental health services to communities are organized in terms of catchment/service areas at Regional and District levels. There was only one mental hospital; and it organizationally offers integrated general health services at the outpatient's facility to the nearby population.

Mental health outpatient facilities

There were 28 mixed outpatient mental health facilities available in the country, with no special clinics for children and adolescents only. The number of users per 100,000 general population treated by these facilities could not be established. However, these facilities had treated a total of approximately 13,710 new users in the previous year. Of all the new users treated, 40% were females and 16% were children and adolescents.

The users treated in outpatient facilities were said to be primarily diagnosed with mood disorders and epilepsy [reliable data on the diagnoses per disorder was not available]. The average number of contacts per user could not be established. Fifty four percent (54%) of outpatient facilities provided follow-up care in the community and conducted outreach clinics whenever they had funds, but these were not regular. In terms of available interventions, 1-20% of users had received one or more psychosocial interventions in the previous year. Fifty seven percent (57%) of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytics, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day treatment facilities

There was only one day treatment facility available in the country. This facility treated 0.64 users per 100,000 general population. Of all users treated in the day treatment facilities, 49% were females and 36% were children or adolescents only. The average number of days users spent in day treatment facility could not be established. There were no day treatment facilities for children and adolescents only.

Community-based psychiatric inpatient units

There were 27 community-based psychiatric inpatient units available in the country with a total of 1.4 beds per 100,000 population. (The facilities considered here are the psychiatric units in all hospitals other than the National Mental Hospital). Fifteen percent (15%) of these beds in community-based inpatient units were reserved for children and adolescents only. Aggregated information on admissions to these units and diagnoses was not available. About 1-20% of patients in community-based psychiatric inpatient units had received one or more psychosocial interventions in the previous year. Thirty seven percent (37%) of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community residential facilities

There were no community residential facilities available in the country.

Mental hospitals

There was one National Mental Hospital available in the country with a total of 1.83 beds per 100,000 population. The hospital also had mental health outpatient facilities. The number of beds had increased by 11% in the previous 5 years. No beds in mental hospitals were reserved specifically for children and adolescents. Of all the patients treated in the mental hospital, 41% were females and 16% were children and adolescents. The patients admitted to mental hospitals belonged primarily to the following two diagnostic groups: mood disorders (33%) and epilepsy (17%). Concrete and reliable data on the diagnostic groups was not available and what was given was a supposition from the available information. The available information was based on the number of contacts and not cases.

The average number of days spent in the mental hospital is (for all patients) was estimated to be 15 days. The hospital had an occupancy rate of 100%. Almost all patients spend less than a year in the hospital except for some few mentally-ill offenders who had spent more than a year in hospital. [However, the tendency of patients to escape from hospital was still common, making it hard to determine the accurate number of days patients spend in the mental hospital]. The number of patients physically restrained or secluded could not be established. About 21-50% of the patients in the mental hospital had received one or more psychosocial interventions in the previous year. The mental hospital had at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in the facility all year long.

Forensic and other residential facilities

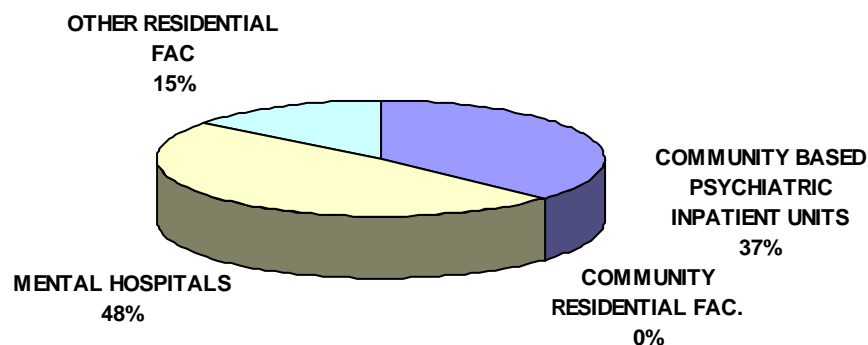
In addition to beds in mental health facilities, there were 0.42 beds per 100,000 general population for persons with mental disorders in forensic inpatient units (a bed capacity of 116). All these beds were within the mental hospital. However, only 10% of the beds in this unit were occupied by the mentally-ill offenders. This category is of long-stay patients, with some few spending more than 5 years in the unit.

There were 7 other non-public residential facilities, 4 of these being for children and adolescents with mental retardation while 3 were for people with alcohol and substance use problems. There was a total of 120 beds for youth aged 17 years and below with mental retardation and 30 beds for people with substance abuse problems.

Human rights and equity

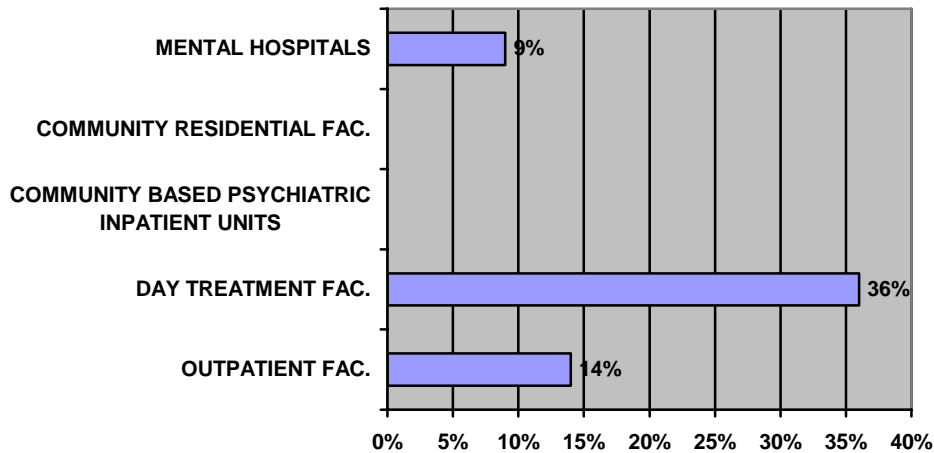
Most admissions to community-based inpatient psychiatric units were voluntary. The proportion of involuntary admissions to the mental hospital was unknown. The patients who were restrained or secluded at least once within the previous year in the community-based psychiatric inpatient units, as well as in mental hospitals could not be ascertained as there were no records to that effect. Sixty two percent (62.4%) of the psychiatry beds in the country were located in or near the largest city, a kind of distribution that prevents access for rural users. On average, there was a substantial difference between government-administered and private for-profit mental health care facilities in terms of the average number of minutes of an outpatient consultation with a psychiatrist and average number of beds per nurse in the facility. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) was not an issue in the country.

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



Note: The biggest challenge in determining the number of users treated per facility, diagnoses and other information was that for the few facilities where information was available, the information was the number of attendances but not cases/patients.

GRAPH 2.2 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS

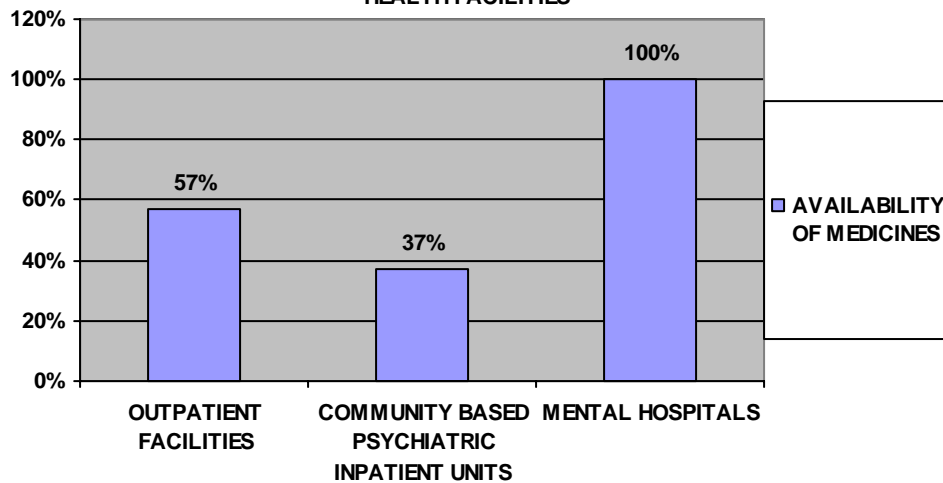


The percentage of users that are children and/or adolescents varied substantially from facility to facility. The proportion of children users was highest in the day treatment facility and lowest in the mental hospital.

Note:

- 1) There was no reliable data from other facilities.
- 2) It should be noted that some of the children and adolescents could have been treated in more than one facility. For example those who were initially treated in the day treatment facility might have been referred to the mental hospital for further treatment.

GRAPH 2.3 - AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



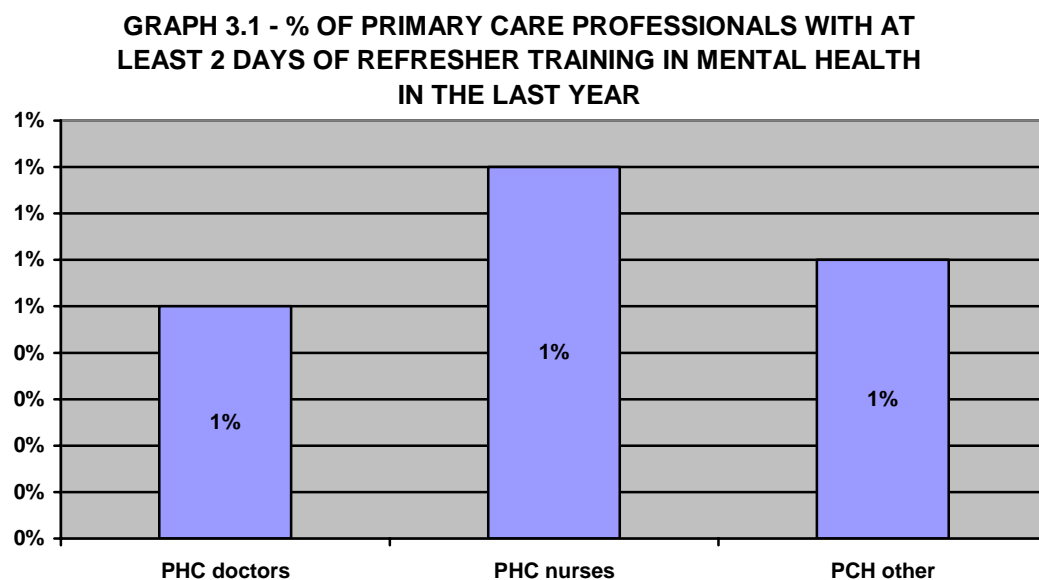
Psychotropic drugs were widely available in mental hospital, followed by outpatient mental health facilities, and then inpatient units.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

About ten percent (10%) of the training for medical doctors was devoted to mental health, in comparison to 3% for General Nurses. The percentage for non-doctor/non-nurse primary health care workers was unknown. In terms of refresher training, the proportion of primary health care staff with at least two days of refresher training in mental health was less than 1% for each category.

Graph 3.1: Percent of primary health care professionals with at least two days of refresher training in mental health in the last year

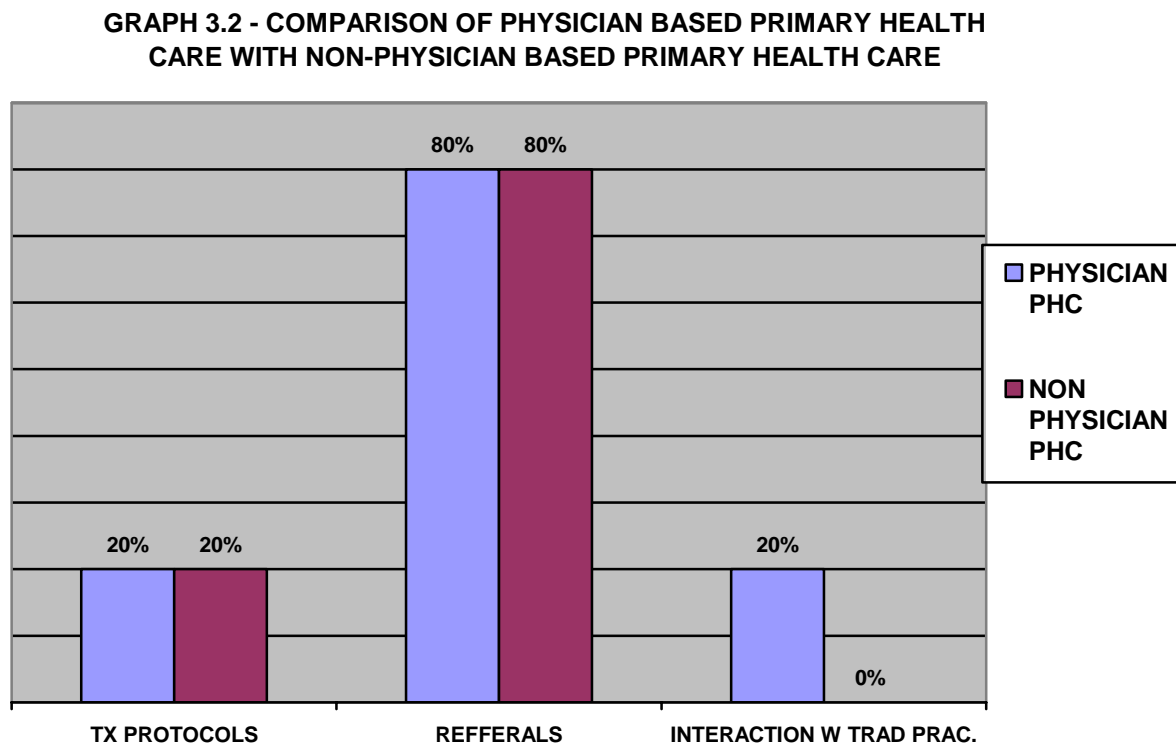


Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics were available in the country. In terms of physician-based primary health care clinics, 1-20% had assessment and treatment protocols for key mental health conditions available, just like the non-physician-based primary health care clinics. The majority (51-80%) of physician-based primary health care doctors made on average at least one referral per month to a mental health professional, and the same applied to the non-physician based primary health care clinics. In terms of professional interaction between PHC staff and other care providers, only a few of the PHC doctors (1-20%) had

interacted with a mental health professional at least once in the previous year. 1-20% of physician-based PHC facilities had had interaction with a complimentary/alternative/traditional practitioner, in comparison to none (0%) of the non-physician-based PHC clinics, and a few (1-20%) of the mental health facilities.

Graph 3.2: Comparison of physician-based primary health care with non-physician based primary health care



Prescription in primary health care

Non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications under any circumstances, whereas primary care nurses and clinical officers are allowed to prescribe and/or to continue prescription of psychotropic medicines with restrictions. For example they are not allowed to initiate but can continue a prescription, and they can initiate a prescription in emergencies. In contrast, psychiatrists, medical officers and psychiatric clinical officers are allowed to prescribe psychotropic medications without restrictions. As regards the availability of psychotropic medications, some of the physician based PHC clinics (21-50%) had at least one psychotropic medicine of each therapeutic category (anti-depressant, anti-psychotic, mood stabilizer, anxiolytic and anti-epileptic) available in comparison to a few (1-20%) of the non-physician based PHC clinics.

Domain 4: Human Resources

Number of human resources in mental health care

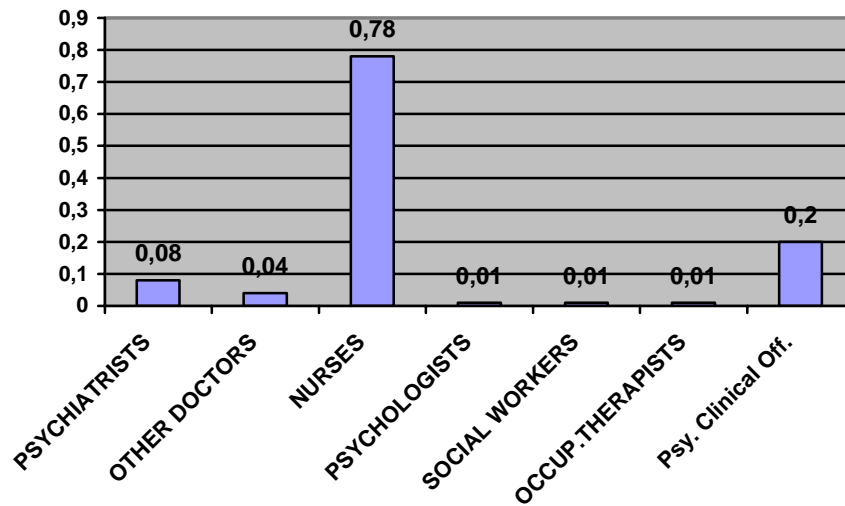
The total number of human resources working in mental health facilities or private practice per 100,000 population was 1.13. The breakdown according to profession was as follows: 0.08 psychiatrists; 0.04 other medical doctors; 0.78 nurses; 0.01 psychologists; 0.01 social workers; 0.01 occupational therapists; and 0.2 psychiatric clinical officers; other health care workers (auxiliary staff, non-doctor PHC workers, health assistants etc) exclusive. Five Percent (5%) of the psychiatrists worked for only government administered facilities, 5% for only NGOs/for profit mental health facilities/private practice; while 90% worked for both sectors. Accurate data on distribution of the other professionals was unavailable. All the professionals worked for both in and outpatient facilities. Fourteen (14) psychiatrists worked in community based psychiatric inpatient units and 8 in the mental hospital. Eight (8) other medical doctors, who are not specialized in psychiatry, worked in the mental hospital. As for the nurses, 62 worked in community based psychiatric inpatient units, while 153 worked in the mental hospital. Three (3) of the psychosocial staff worked in the community based psychiatric inpatient facilities and the other 3 in the mental hospital.

Only 1% of the medical doctors and 4% of the nurses were specialized in psychiatry.

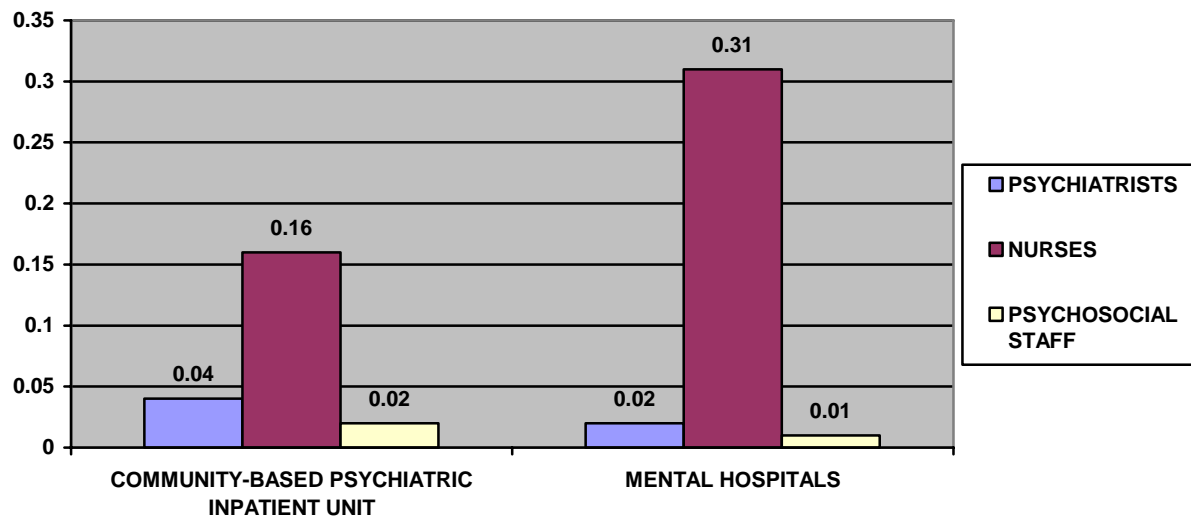
In terms of staffing in the mental health facilities, there were 0.04 psychiatrists per bed in community based psychiatric inpatient units in comparison to 0.02 psychiatrists per bed in mental hospitals. As for nurses, there were 0.16 nurses per bed in community based psychiatric inpatient units as compared to 0.31 nurses per bed in the mental hospital. Accurate data for other mental health staff is unavailable.

The distribution of human resources between the urban and rural areas was disproportionate. The density of psychiatrists in or around the largest city was 11 times greater than the density of psychiatrists in the entire country. The density of nurses was 13.4 times greater in the largest city than the entire country.

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



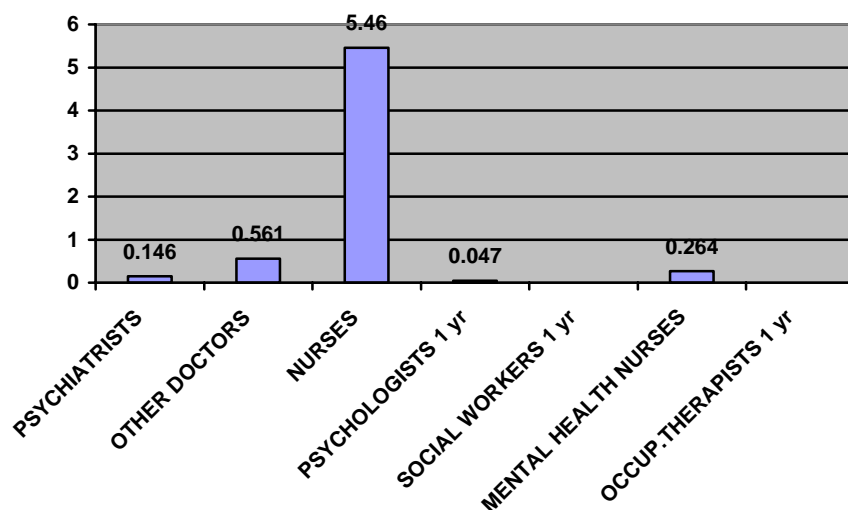
GRAPH 4.2 - AVERAGE NUMBER OF STAFF PER BED



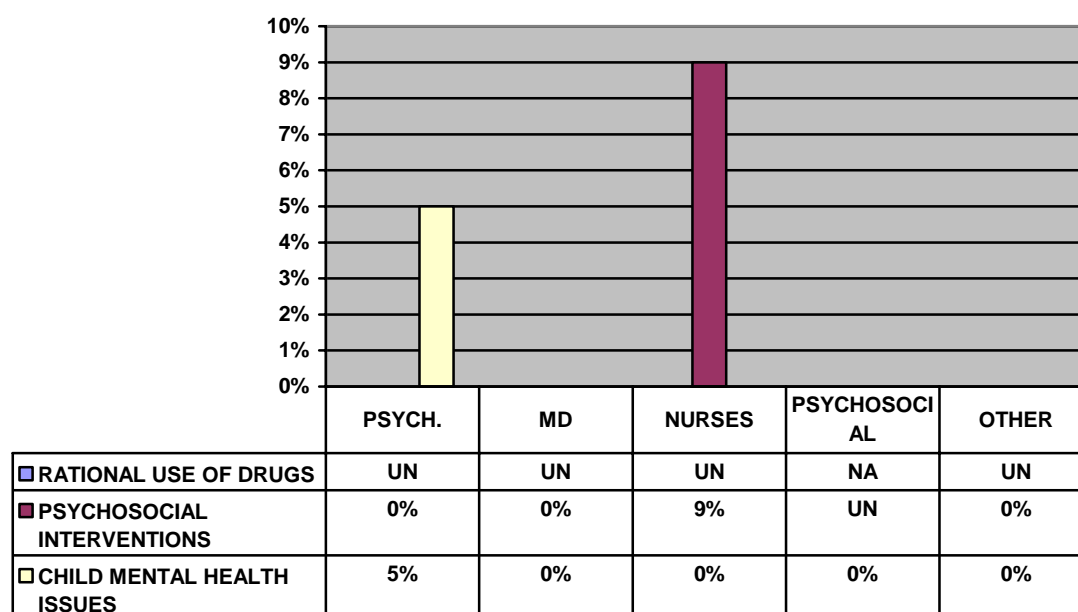
Training professionals in mental health

The number of professionals who had graduated the previous year in academic and educational institutions was as follows: 162 general medical doctors, 4 psychiatrists, 13 psychologists with at least 1 year training in mental health care, 10 occupational therapists with at least 1 year training in mental health care. The number of general nurses and that of social workers with at least 1 year training in mental health care could not be established. However, there were 1,491 nurses who registered with the nurses and midwives council that year. None of the psychiatrists emigrated to other countries within 5 years of completion of their training. The accurate number of mental health care staff with at least 2 days of refresher training in the rational use of drugs was unavailable. Nine percent (9%) of the nurses and 5% of the psychiatrists had received refresher training in psychosocial interventions, and child and adolescent issues respectively. The accurate number of other mental health staff who had received refresher training in psychosocial interventions and child and adolescent mental health issues was unavailable.

GRAPH 4.3 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



GRAPH 4.4 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



Psych = psychiatrists; MD =other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

Consumer and family associations

There were 2225 users/consumers who were members of user associations. However the numbers of families that were members of family associations was unknown. Government did not provide financial support to user associations for mental health initiatives. Consumer associations had been involved in formulation and implementation of the mental health policy and plan to some extent; but not the legislation. Only 4 of the NGOs were involved. A few mental health facilities interacted with consumer/user associations.

Domain 5: Public education and links with other sectors

Public education and awareness campaigns on mental health

The Principal Medical Officer in charge of mental health at the Ministry of Health oversees public education and awareness campaigns on mental health and mental disorders. Government agencies,

NGOs, professional associations and international agencies had promoted public education and awareness campaigns in the previous 5 years. The campaigns had targeted the following groups: the general population, children, adolescents, women, and trauma survivors. In addition, there had been public education and awareness campaigns targeting professional groups including: Health care providers (conventional, modern, allopathic, complementary/alternative/traditional sector, Teachers, Social services staff and Leaders and politicians and other professional groups linked to the health sector.

Legislative and financial provisions for persons with mental disorders

There were no legislative provisions to provide support for users in the following areas:

- I. A legal obligation for employers to hire a certain percentage of employees that are mentally disabled.
- II. Provisions concerning protection from discrimination at work (dismissal, lower wages etc) solely on account of mental disorder.
- III. Legislative or financial provision concerning priority in state housing and in subsidized housing schemes for people with severe mental disorder.
- IV. Financial provision concerning protection from discrimination in allocation of housing for people with severe mental disorder.

Links with other sectors

There were formal collaborations between the government department responsible for mental health and the departments/agencies responsible for primary health care/community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection and education. As regards support for child and adolescent mental health, information on the proportion of primary and secondary schools that had either a part-time or full time mental health professionals was not available as well. The number of primary and secondary schools with school based activities to promote mental health and prevent mental disorders was unknown. The percentage of prisoners with psychosis was greater than 15% while that with mental retardation was unknown. As for training, a few (1-20%) of the police officers, judges and lawyers had participated in educational activities on mental health in the previous 5 years.

In terms of financial support for users, there was no mental health facility where users have access to programs that provide outside employment. There were no people receiving social welfare benefits for a mental disability.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities existed. The extent of data collection was variable among the mental health facilities. However, many of the facilities were not collecting the expected data. Of the data that the mental hospital collected and compiled, only data on number of beds was reliable. Both the mental hospital

and the community based psychiatric inpatient units made attempts to collect and compile data, but this had a lot of gaps. Mental health data is published by the government health department in an annual performance report. All the mental health facilities reported and transmitted data to the government health department, with lower facilities doing this hierarchically through the higher health facilities.

In terms of research, almost all psychiatrists, psychologists and social workers; and a few of the nurses (1-20%) had been involved in research. About 2 - 4% of all the health publications in the country in the previous 5 years were on mental health. The research focused on: a) Epidemiological studies in community samples; b) Epidemiological studies in clinical samples; c) Non-epidemiological clinical/questionnaires assessments of mental disorders; d) Services research and e) Psychosocial interventions/psychotherapeutic interventions.

Strengths and weaknesses

Analysis of strengths and weaknesses revealed the following:

Strengths

The mental health system has the following strengths:

- Existence of a mental health coordination office.
- Increasing investment in mental health infrastructure at community level, human resource and research.
- There is training of Mental Health specialists in the country i.e. Psychiatrists, Psychologists, Social Workers, Psychiatric Clinical Officers, Occupational Therapists and Psychiatric Nurses
- There is a fair balance between the mental hospital and community based psychiatric inpatient units.
- There is a Draft Policy yet to be finalized, and an integrated strategic plan
- There are community based mental health services which can be strengthened.
- Most health workers get some exposure to mental health during pre-service training, which can be improved.
- Public education being carried out.

Weaknesses

The following are weaknesses within the mental health system that need quick action:

- The mental health policy has remained in draft form for quite long.
- Records management is still poor, with a lot of gaps in HMIS.
- Inadequate financing for mental health.
- The mental health legislation is obsolete and requires urgent revision.
- Inadequate provision of free psychotropic medicines, and yet they are very expensive on open market.
- Interaction of mental health service providers with primary health care staff is poor.
- Inadequate collaboration between the mental health department and some other government sectors.
- Interaction of mental health services with family's and consumer's associations is still poor.
- Insufficient training of PHC staff in mental health, and little interaction between mental health professionals and primary health care providers.
- Inadequate psychosocial interventions.
- Absence of a comprehensive Mental Health Strategic Plan.
- Inadequate refresher training mental health professionals.

RECOMMENDATIONS FOR STRENGTHENING MENTAL HEALTH SYSTEMS

Considering the WHO-AIMS data and the context given by the situations mentioned above, possible areas of action are:

- Finalization of the mental health policy and development of the Mental Health Strategic plan.
- Improvement of training on mental health issues and interaction with mental health services for primary health care workers.
- Strengthen community based mental health services by training Primary Health Workers to promote integration of mental health into Primary Health Care.
- Strengthen multi-sectoral collaboration
- Develop training on mental health and human rights
- Review of mental health legislation to bring it up to date with current International Standards.
- A primary health care training program on mental health, spread in all regions in the country.

The following institutions/people should receive a copy of this report owing to their involvement in mental health services, programs, budgeting and finance:

In the ministry of health, key policy makers such as:

- ◆ Minister of health (Primary health care)
- ◆ Director general of health services
- ◆ Director, planning and development
- ◆ Director Clinical and community services
- ◆ Commissioner Health Services, Clinical Services
- ◆ Commissioner Health Services, Planning
- ◆ Assistant Commissioner Health Services, Human Resource Development

Others:

- ◆ District Health Managers
- ◆ Department of psychiatry, Makerere University
- ◆ Department of mental health and community psychology, Makerere University
- ◆ Key stakeholder NGOs involved in mental health service provision.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Uganda. This was part of a situational analysis of the mental health system in Uganda, and the goal of collecting this information was to provide a baseline for monitoring change towards improvement of the mental health system. This will enable Uganda to develop information-based mental health plans with clear baseline information and targets.

Uganda has a draft mental health policy and an out-dated mental health law, but no separate Mental Health Strategic Plan. The small proportion of health financing which goes directly towards mental health is oriented towards the National Mental Hospital and Regional Referral Hospitals with mental health units; while mental health also benefits indirectly from the general PHC funding to a limited extent. There is no mental health social insurance scheme although the majority of the population has free access to psychotropic medication. No human rights review body exists to review human rights issues in the mental health facilities and mental health workers have not received specific training in this area.

Approximately 1.13 human resources work in mental health per 100,000 population. Rates are particularly low for clinical psychologists, social workers and occupational therapists. User associations exist in Uganda but do not receive financial support from Government. Some of these associations have been involved in developing and implementing policies.

In terms of the network of mental health facilities, there is one National Mental Hospital (with 1.83 beds per 100,000 population), 27 community based psychiatric inpatient units (with 1.4 beds per 100,000 population), 1 day treatment facility (with 0.64 user per 100,000 population), and no community residential facilities.

Public education and awareness campaigns are overseen by the mental health division. There are links with other relevant sectors, but no legislative or financial support for people with mental disorders. Finally, primary health care staff receive minimal training in mental health.

It is clear that there is a need to finalize the mental health policy, develop a strategic plan for mental health and to direct more efforts towards strengthening the integration of mental health into Primary Health Care.

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