

Scaling up of mental health and trauma support among war affected communities in northern Uganda: lessons learned

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In 2008, the local nongovernmental organisation TPO Uganda and the Uganda Ministry of Health began a project aimed of improving the availability of mental health services in three districts in Northern Uganda. The project consisted of: 1) training of general health workers in the primary health care system in mental health; 2) strengthening the capacity of the specialised mental health workers to deliver and supervise mental health outreach services; and 3) increasing the capacity of community members to respond effectively to mental health and psychosocial needs of people within their communities. The project provided assistance to 'patient support groups' that then provided support to patients with mental disorders. At the end of the 22 month project, the capacities of health workers and Village Health Teams to provide mental health services were strengthened. Major gaps, that still need to be addressed, were attrition of government health workers and a lack of drugs. Lessons learnt also include: the importance of coordination and joint planning between nongovernmental organisations and the government; the importance of support supervision; the important role of village health team members in community mobilisation and sensitisation; and the roles of patient support groups in complementing medical/clinical activities.

Keywords: evaluation, integration, mental health, northern Uganda, patient support groups, primary health care, village health teams

Introduction

Uganda is a low income East African country with an estimated population of 30.7 million (Uganda Bureau of Statistics, 2010a). 56% of the population is below 18 years old (Uganda Bureau of Statistics, 2010b). Over 80% of the population live in the rural areas, although the rate of rural to urban migration is high. The population growth rate is estimated at 3.2% per annum, and 31% of the population is estimated to be living below the poverty line. Uganda's gross national income per capita is US \$460, when using the Atlas conversion factor, and US \$ 1,190, when using Purchasing Power Parity method that calculates the purchasing power over a US dollar in the concerned country (World Bank, 2010). While health indicators have improved slightly since the 1990s, they are still poor as indicated by a maternal mortality ratio of 435 per 100,000 live births (Government of Uganda & UNFPA, 2010), an under five mortality rate of 137 per 1,000 live births, and an infant mortality rate of 75 per 1,000 live births (Government of Uganda, 2009). Communicable diseases contribute 50% of disability adjusted life years lost (DALYs) (Government of Uganda, 2010a).

Until 2006, northern Uganda had experienced two decades of a civil war perpetrated by the Lords Resistance Army (LRA). The

most affected victims of this conflict were the local civilians, in particular women and children. Communities were also affected in their entirety as their means of livelihoods were destroyed, social safety nets incapacitated and families forced to settle in internally displaced persons (IDP) camps. Several studies on the war note that the cult-like, indoctrinating ideology of the LRA, specifically targeting children, inflicted immense psychological torture and anguish on their victims. At the height of the conflict, 1.8 million people were living in IDP camps (Horn, 2009; Multi-Country Demobilisation and Reintegration Program (MDRP), 2007). As a result, 60% of the population in northern Uganda is categorised as poor, compared to 16% in the central region (Higgins, 2009).

There is a scarcity of research published on the process of implementing mental health care into primary health care (Flisher et al., 2007; Knapp et al., 2006; WHO & Wonca, 2008). This article therefore describes an evaluation that was carried out, as a way to document successes and challenges of integrating mental health care into primary health care, in a post conflict situation. The challenge is not just the scarcity of evidence on the process of integration, but also notes that implementing that process are not always smooth (Petersen et al., 2011). For conflict affected countries, an additional challenge is that while efforts are being made to better document the effectiveness of mental health and psychosocial programmes, there is often a tension between rigorous quantitative methodology, and using more qualitative and participatory methods. There is a growing consensus that qualitative participatory evaluations are valuable, as they may be maybe more representative of the voices and perspectives of the target populations and other

stakeholders (de Graaf, Jansveld, & de Jager, 2008; Tol & Jordans, 2008). While some project evaluations aim to measure impact in a quantitative manner, others aim to assess success and challenges of the *processes* in order to improve programme implementation. This article is based on a qualitative evaluation that was meant as: *'a learning and management tool, a source of feedback to field workers and an opportunity for joint critical reflection on relevance of the programme with regard to the priority needs of the targeted populations'* (Kortmann, 2008).

Background

Mental health, psychosocial issues and conflicts

Mental disorders and psychosocial problems are the frequent consequences of armed conflicts (Baingana, Bannon, & Thomas, 2004; de Jong et al., 2001; Steel et al., 2009). Other common mental health consequences of armed conflict include: depression, posttraumatic stress disorder (PTSD) and other anxiety disorders, as well as alcohol and substance abuse. Psychosocial consequences of armed conflict can include increased levels of interpersonal violence (against spouses and children), early sexual activity, promiscuous sexual behaviour, increased teen-age pregnancies, petty crimes, and vandalism, among others (Boothby, Strang, & Wessells, 2006; de Jong, 2002).

An epidemiological survey carried out in 15 districts of Uganda in 2004 found rates of up to 50% for depression in one of the most conflict affected districts, compared to 8% for districts not affected (Kinyanda, 2004). A more recent qualitative study, also carried out in northern Uganda, found locally defined syndromes that correspond to depression/dysthymia, anxiety and behavioural problems (Betancourt et al., 2009). Other studies have found high rates of

PTSD, depression and anxiety disorders (Ovuga, Oyok, & Moro, 2008; Pham, Vinck, & Stover, 2009; Roberts et al., 2008).

The need to provide interventions for mental health and psychosocial problems associated with conflicts is recognised, not just to alleviate the pain and suffering, but also because mental health and psychosocial problems are disabling, therefore making any attempts at reconstruction futile (Baingana et al., 2004; Cardozo et al., 2004; Mollica et al., 1999; Mollica et al., 2001). Mental disorders have also been found to negatively impact efforts for reconciliation (Bayer, Klasen, & Adam, 2007; Pham, Weinstein, & Longman, 2004).

Presently, in northern Uganda, the environment of return from the IDP camps is still difficult, and poses several challenges to families, ranging from inadequate livelihood support, access to psychosocial support and mental health care. Consequently, the government is encouraging public/private partnerships, especially with nongovernmental organisations (NGOs), to deliver specialist interventions to improve quality of life, such as mental health care, psychosocial support and child protection. TPO Uganda has, over the past three years, supported the local district health services to scale up services that provide psychosocial support, increase access to mental health care and support families to overcome emotional distress.

TPO Uganda is a Ugandan NGO. It began operations in Uganda in 1994, with the aim of providing psychosocial support and mental health care to communities, families and individuals in conflict and post conflict settings. Services are delivered through a community and family oriented intervention model, which mainly focuses on identifying existing community support structures, traditional circles of support and systematically building their capacity

to identify and participate in supporting psychosocial and mental health needs. This support is focussed on: children in need of protection; survivors of gender based violence; children and families infected and affected by HIV & AIDS; and families whose socio-economic wellbeing has been incapacitated by conflict and/or any other disasters.

Organisation of health services in Uganda

Uganda's health care system is organised along the principles of primary health care (Figures 1 and 2). A Health Centre I (HC I) is the first contact point for patients, which is also called an Aid Post. There is frequently no physical structure, but relies on outreach activities regularly held under a tree, or in a community building. The next level of care, Health Centre II (HC II) has a small outpatient structure, however, no admissions take place. Health Centre III has one ward for females and another for male patients, as well as a maternity unit. The bed capacity is eight. Health Centre IV (HC IV) is often attached to a Health Sub District, found at every sub County, which is an important administrative unit. The bed capacity of 25 is larger than for HC III, as well as having a larger, more diverse and more specialised staff. This level has an operating theatre and should be able to perform Caesarean sections and surgeries, such as repair of hernias and fractures. The District Hospital is the next level of care. There are both medical and surgical wards with both male and female wings, as well as a children's ward. There is also a maternity unit and a theatre. The bed capacity at the District Hospital can be up to 100. The Regional Referral Hospital has a bed capacity of about 250 beds. There are 12 Regional Referral Hospitals in Uganda.

Health Unit	Beds	Location	Population	Existing
HC I	0	Village	1,000	2000
HC II	0	Parish	5,000	746
HC III	8	Sub-County	20,000	679
HC IV	25	County	100,000	127
Gen. Hosp.	100	District	100,000-1M	87
Reg. Ref. Hosp	250	Region (3-5 Districts)	1M-2M	10
Nat. Ref. Hosp	450	National	over 20M	2

Figure 1: Levels of care: Uganda.

Gen. Hosp. = General hospitals; HC = Health centres; Nat. Ref. Hosp. = National referral hospitals; Reg. Ref. Hosp. = Regional referral hospitals.

There are two National Referral and Teaching Hospitals, with bed capacities of 450 each.

Districts are responsible for implementation of the National Health Policy, planning and management of district health services, and data management (Government of Uganda, 2000). District Hospitals, and all health units below this level, are the responsibility of the Districts. Regional Referral Hospitals and the National Referral Hospitals are the responsibility of the Ministry of Health. All district level staff, which include all district hospital staff and below, as well as staff under the District Health Office is recruited, deployed, and remunerated by the District Service Commissions. Health worker staffing norms used for district level staff are the Local Government Staffing norms. Regional Referral Hospitals, National Referral Hospitals, as well as Ministry of Health personnel, are recruited and deployed by the Health Service Commission (Government of Uganda, 2005). Any intervention provided at the District level requires the agreement of the District authorities, while

activities carried out at the Regional Referral Hospitals are the responsibility of the Ministry of Health. This creates a challenge, as both levels of care then have to be consulted and kept abreast of developments. While it may be easier to get the Districts to recruit mental health personnel, if the position falls within the Local Government Staffing norms, this is more difficult at the Regional Referral hospital level. The reason it is more difficult is that it involves recruitment through the Health Services Commission, which is a more centralised process. Additionally, other inputs like funds for outreach clinics or medication maybe available at the District level, but then the Regional Referral Hospital staff cannot use them. So while the Regional Referral level staff may appreciate their supervisory role, they have problems in actually implementing it due to the above constraints.

An important element in the health care system is the village health team, as they serve as an important link between the community and health providers. Such a team consists of community volunteers,

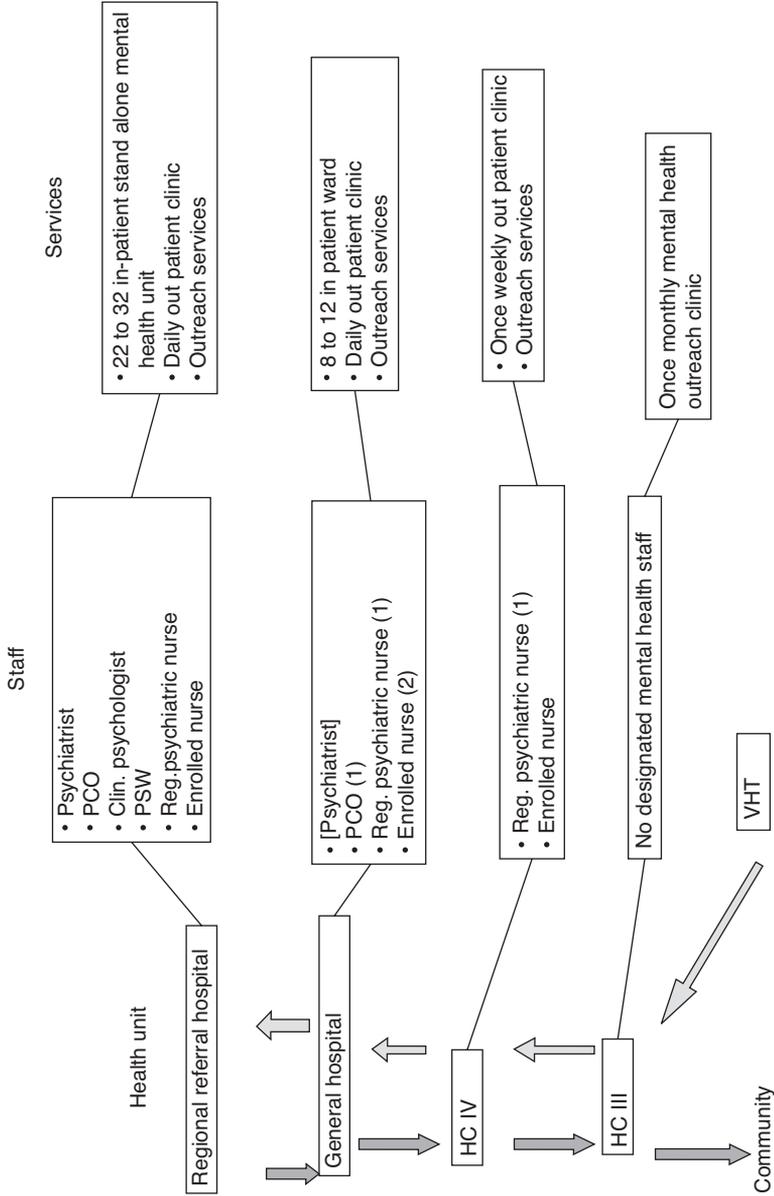


Figure 2: Organisation of the Mental Health Service: Uganda.

and has as responsibilities to identify the community's health needs and take appropriate measures. These can include: overseeing the activities of Community Health Workers, as well as maintaining a register of members of households and their health status (Government of Uganda, 2000). As of 2010, 75% of districts had formed village health teams, but only 31% of these districts had trained all village health team members in all villages. Village health team activities are also challenged by the very high attrition rate due to no, or poor, incentive/motivation systems (Government of Uganda, 2010b). Yet, village health teams play an important role in northern Uganda due to the severe shortage of trained health workers (Government of Uganda, 2007).

Mental health services in Uganda

In 1999, mental health care was included in the First Health Policy, as a component of the Uganda National Minimum Health Care Package (UNMHCP) (Government of Uganda, 1999). Mental health care is also included in specific sections included in the three Health Sector Strategic Plans (HSSP) (Government of Uganda, 2000, 2005, 2010b). The first HSSP had, as its main objective: *'to provide improved access to primary mental health services to the entire population, and to ensure ready access to quality mental health referral services at district, regional, and national level'* (Government of Uganda, 2000).

Every health worker has training in mental health provided in the basic, pre-service training. This means that, even at the peripheral levels of the health care system where there is no designated *'mental health'* worker, general health workers should be able to recognise and manage or refer common mental health problems. A manual for training village health teams in mental

health has also been developed (Government of Uganda, 2010c). Two specialised mental health workers are attached to an HC IV (Health Sub County), and more specialised mental health workers should be present at the District Hospital. A person with a mental disorder, who requires admission, can be admitted to either the male or the female wards at HC IV. The District Hospital is supposed to have a small unit for patients with mental disorders, with between 8 - 22 beds. HC IV is also supposed to run mental health clinics once a week, while District Hospitals should do this on daily basis.

Project description

The project was initiated in March 2008, and closed in December 2010. The project goal was stated as: *'mental health services are available to communities affected by conflicts and war trauma in Gulu, Kitgum and Pader districts in northern Uganda.'* The population of the district of Gulu is 374,700, that of Kitgum is 387,100 and the population of Pader is 481,800 (Uganda Bureau of Statistics, 2010b). Large percentages of these populations had been in IDP camps, but over the duration of the project, were slowly resettling back into their original communities. There is one Regional Referral Hospital in Gulu District. Kitgum has one Government District Hospital as well as a faith-based Hospital (St Joseph's Hospital). Pader District does not have a District Hospital, the highest level of care being the Pader Health Centre IV. In total, the facilities mentioned above, in the project areas, had nine qualified psychiatric nurses and eight psychiatric clinical officers (with training levels falling between that of a psychiatric nurse and a psychiatrist). There were no psychiatrists in any of these facilities. The project has three main objectives.

1. Building the capacity of health workers to recognise, assess and manage mental illnesses.
2. Strengthening the capacity of dedicated mental health workers to supervise and implement mental health outreach services.
3. Helping communities to appropriately respond to the mental health and psychological needs of people within the community.

The project was fully implemented through government structures. TPO Uganda provided funds for the training of health workers so they were able to recognise and manage common mental health problems. The NGO and the District authorities identified which health centres were to be included for outreach clinic activities. Through an outreach schedule, the identified Health Centre III and IVs were visited at least once a month by the psychiatric clinical officers or psychiatric nurses, The NGO employed social workers, who provided support to the Village Health Team Members, as they in turn supported patient support groups.

Evaluation methodology

The evaluation was done by the first author. Methodology included a desk review of TPO Uganda documents at the offices in Kampala, Gulu, Pader and Kitgum. In each of the three districts, field visits were made, and these were discussed and agreed with the Project Coordinator in Gulu District and the two Project Officers in Pader and Kitgum Districts. The focus of the field visits was on qualitative aspects. Ten days were spent in the field, carrying out field visits. In each of the three districts, key informant interviews were held with the three District Health Officers, with

the people in charge of health units, and with senior technical staff and partners of the project such as CARE Uganda and the Peter Alderman Foundation.

In each district, focus group discussions were held with beneficiaries, including patients attending a clinic, patient support group members, and village health team members. Visits were made to the sites where the patient support groups held their activities, in all three districts. There was also direct observation of: clinics in progress, patient support group activities, and of the facilities where outreach clinics were held.

Findings

There were three purposes to the evaluation, and the findings are grouped around each. Purpose 1 had three objectives. In each purpose and objective, achievements and challenges are discussed.

Purpose 1

Objective 1: Evaluate the built capacity of health workers in the districts of Kigum, Pader and Gulu to recognise and assess, and manage mental illness

Successes included: patients with mental disorders successfully treated; health units providing space for the mental health clinics; district authorities recruited and deployed mental health staff to work alongside NGO staff; and mental health drugs were requisitioned. Village health teams, needed to work alongside TPO Uganda and government staff, were identified by the communities and participated in the mobilisation of patients and the running of mental health clinics. Mental health patients presented in large numbers, and were evidenced at each of the clinics that were visited. Health workers were trained in the management of common mental health problems. The data collected by the project was included in the

Ministry of Health (MoH) Health Management Information System.

Challenges included inconsistencies, such as workshops held, but no workshop reports were written. There was also an attrition of government health workers trained by the project. Transport was another challenge, with one vehicle for three districts proving inadequate. Lack of medication was yet another challenge. TPO Uganda had budgeted, over three years, to support drug provision at a reducing percentage: 100% for the first year, 75% for the second year, and 50% for the final year. The MoH/Districts were supposed to have increased drug supplies as the TPO Uganda support decreased. However, the government did not honour this agreement. Therefore, often, the NGO staff would have to provide emergency drugs to prevent shortages. The project could only cover some parts of some districts of Acholiland while the whole area was affected by the conflicts. Additionally, refresher training for the health workers was not carried out, leading to attrition of personnel, as well as knowledge and skills of those who remained in the project.

Objective 2: Evaluate the strengthening of capacity of Gulu Regional Referral Hospital (GRRH) and selected HCIVs to deliver and supervise mental health outreaches

Outreach visits from GRRH were carried out regularly, including support supervision. There was a drop in the numbers of hospital visits from patients from the areas where the outreach took place. The outreach activities had effectively diminished the need for patients to go to a regional referral hospital because services were available closer to home. Monthly mental health coordination meetings, of all stakeholders, took place regularly in each district.

Objective 3: Evaluate community capacity to appropriately respond to the mental health and psychosocial needs of persons affected by conflict, especially those affected by war trauma

Achievements included 18 village health team members identified to provide support to the project. They played a key role in mobilising patients for the Outreach Clinics, providing support to the patients' support group, following up patients in the homes to make sure they were taking their drugs and that they were doing well mentally. Village health team members were trained how to mobilise communities, how to sensitise communities to mental health issues, and how to identify and refer patients with mental disorders. Patient support groups were formed and held regular meetings. Some of these groups successfully carried out income generating activities. One of the visited groups had successfully mobilised members to plant groundnuts, which had then been harvested. They were planning to divide some of the harvest among themselves for consumption, and the rest was to be sold so the group could purchase an ox and a plough, which they would then hire out, as well as for use in their own group gardens.

Challenges

While each village health team was made up of 12 members, only one was trained. This was not adequate to either cover activities. There was no documentation of training of the village health teams, nor the patient support groups. None of the activities specifically targeted children, including those in school, and yet this is the largest segment of the population in Uganda.

Purpose 2) Study and establish the efficacy of the service delivery strategies and the model adopted by TPO Uganda

Achievements

The main achievement was accessing mental health services available to the

population in the north. Community mobilisation and sensitisation was effectively carried out, so numbers of patients at the outreach and static clinics far exceeded the targets. Average targets per clinic were 120 patients, but actual numbers often exceeded 200. This project demonstrates that with the addition of minimal resources to support coordination, transportation, scheduling, drug supply, and motivation for health workers and village health team members, integration of mental health care into primary health care can be successfully implemented.

Challenges

Many of the TPO Uganda outreach clinics were linked to the IDP camps. As the populations return to their original villages, access to services is going to become a challenge.

Purpose 3) Formulate lessons learned in a manner that will improve and strengthen the design for the next phase highlighting areas of emphasis

The following lessons were learnt:

1. TPO Uganda had only eight full time staff allocated to the project, but they were able to facilitate district health workers to establish and run mental health clinics, including support supervision, community mobilisation and sensitisation, coordination meetings and support to patients support group. In this way, a small number of project staff could have a significant impact.
2. Quarterly coordination and joint planning, between TPO Uganda and the government ensured smooth operation of all activities. A common mistake NGOs make is to plan and implement alone, without involving the government. This is especially true when the NGO has the resources, and the government may not be seen as making a significant contribution. However, if capacity is to be built within the governmental sector, and if such programmes as this one are to be sustainable, then regular planning and coordination meetings are a must.
3. Support supervision is critical to successful integration of mental health care into primary health care. Support supervision is a frequently mentioned challenge to integration of mental health into primary health care, and yet it is one of the critical pillars. In Uganda, a recent survey found that support supervision is one of the two weakest elements in integration of mental health care into primary health care (Makerere University School of Public Health, 2010).
4. Involvement of village health teams is crucial to the success of community mobilisation and sensitisation. Barriers to mental health care can include knowledge of the causes of mental disorders, as well as availability of mental health services (Nsereko et al., 2011). In Uganda, while mental health services have been strengthened since 2001 through two African Development Bank projects, a huge gap still exists between projections of patients with mental disorders and attendance at health units (Government of Uganda, 2010a). The concept of the village health team was introduced in the first Health Sector Strategic Plan and reinforced in the second HSSP (Government of Uganda, 2000, 2005). This project demonstrates that village health teams are crucial to mobilisation of patients, for community sensitisation, as well as for the support provided to the patients support group. This is especially true, as Uganda does not have a strong social support system. Village health teams

have demonstrated, through this project, that they can take on some of the social work roles required.

5. Combining medical/clinical activities with social activities leads to better outcomes for patients. Formation and support of the patients' support group, who then provide peer-to-peer support to the patients and their carers, provide incomes to the patients and families of those with mental disorders, as well as providing some rehabilitation activities for patients contribute to better outcomes for both the patients and their carers.

Recommendations

- One major gap observed was that of children's mental health services. There is a need to strengthen activities that access services to school aged children.
- It is important to develop guidelines for training of village health teams, including how to form patients support groups, how to provide support to the livelihood activities, and how sensitisation and mobilisation is carried out. Manuals should be provided to the village health team members in a language they understand.
- Manuals should be developed that outline roles and purpose of the patients support groups, especially in relation to peer-to-peer support of the carers and the patients. Groups have to be properly constituted within a legal framework in order to benefit from government and NGO initiatives.
- Support supervision guidelines should be provided for both the clinical, as well as the social support, aspects.
- Training of more than one health worker per clinic, in order to deal with the problem of staff attrition. It is also important to have refresher training for the health workers, at least once every year.

- Future programmes need to train more than one village health team per village.
- MoH needs to revise the Essential Drug Kit to include mental health drugs at the lower level of care. It may also be important to initiate a system to reward health units that have all drugs on the Essential Drug Kit available.

Conclusion

Overall, the project achieved the aims and objectives that it had set out. Mental health was successfully integrated into primary health care, health workers and village health teams were trained and they supported the provision of mental health services. Village health teams were instrumental in community mobilisation and sensitisation. Patient attendance was observed to be high, and patients reported satisfaction with the services provided. The project was also successful in the social support provided to patients through the patient support groups. The activities of the patient support groups provided income to households with people with mental disorders, and have the potential to provide peer-to-peer support for both patients, as well as, the carers of patients.

Major challenges encountered include inconsistent agreement by the government health service providers, so drug supply was not always consistent, and mental health workers to run the clinics were not always available. The project was also challenged by a weak support supervision system, which could have potentially negatively impacted the quality of the mental health services provided, and the quality of the patients' support group activities.

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Announcement

New Psychological First Aid Guide for Field Workers

Humanitarian emergencies, such as earthquakes, extreme drought and war, can be just as devastating to people's psychological and social wellbeing as to their physical health. This year, on World Humanitarian Day, the World Health Organization (WHO), War Trauma Foundation (WTF) and World Vision International (WVI) announced the release of the *Psychological First Aid Guide for Field Workers* as a resource to provide immediate psychosocial support that meets international standards of best practice.

Psychological first aid covers both social and psychological support, and involves the provision of humane, supportive and practical help to people suffering from serious crisis events. For staff and volunteers called upon to help in emergencies, the guide offers information on the most supportive things to say and do for people in distress, how to approach a new situation safely, and how to support people in ways that respect their dignity, culture and abilities.

The *Psychological First Aid Guide* can be taught to humanitarian workers within one day for immediate use. It orients humanitarian workers and others in how to give basic psychological support; to listen without pressuring the person to talk; to assess a person's needs and concerns; to help ensure that basic physical needs are met; to provide and mobilise social support; and to protect people from further harm. It emphasises support and protection for people who may need special attention in crises, including separated children and adolescents, people with disabilities, and people at risk of discrimination or violence.

The guide was developed in order to have widely agreed upon psychological first aid materials for use in low and middle income countries. Endorsed by 24 international humanitarian agencies, it reflects the emerging science and international consensus on how to provide basic support to people in the immediate aftermath of extremely stressful events. The *Psychological First Aid Guide* will enable humanitarian and emergency workers from all over the world to provide basic, but vital, psychosocial support to people in acute distress, including helping distressed relief workers themselves.

The guide is freely available in PDF format on this link: <http://www.who.int/mental.health/emergencies/en/>

Click this link to order the guide in print format from the WHO Bookshop:

<http://apps.who.int/bookorders/anglais/detartl.jsp?sesslan=1&codlan=1&codcol=15&codcch=819>