

# **BasicNeeds** *BasicRights*

Mental health is a right not a privilege

## **Financing Mental Health Care in Seven Low-and Middle-Income Countries: A Case Study of Uganda**

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Acronyms**

MH Mental Health  
WHO World Health Organization  
TPO Transcultural Psychosocial Organization  
BNUU BasicNeeds UK in Uganda  
FY Financial Year  
PHC Primary Health Care  
SIDA Swedish International Development Agency  
LIC Low Income Country  
NGO Non Governmental Organization  
KII Key Informant Interview

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## **Executive Summary**

Many developing countries spend just one percent of their overburdened health budgets on mental health (Nightingale, 2008) and the World Health Organization Aims Report on Mental Health Systems in Uganda (2006) affirms this.

The study determined that one of the main sources of financing for healthcare in Uganda are private health insurance firms like African Air Rescue and International Air Ambulance, however these do not cover severe psychiatric and neurological disorders. Other sources included Non Governmental Organizations which supplement government efforts and external donors like the European Union and the African Development Bank. Despite these private sources, all the KIIs and literature review revealed that out of pocket expenses were the major source of financing mental health care. The actual proportion of this cannot be established because most payments are not always receipted. It is also important to note that clients and their carers opt to pay for a better packaged private service rather than attend at government health centers. Finally the study revealed that the Government, even with the inadequacy of its resources was the most sustainable source of financing for mental health.

Decisions for funding mental health care are made with the participation of stakeholders at various levels. According to KIIs the government liaises with the Ministry of Health to implement a series of participatory processes that ultimately lead to decisions implemented at Primary Health Care. However, the KIIs add that private health care firms are generally more restrictive when it comes to covering mental illness as opposed to other physical illnesses because they attach mental health care with high costs associated with long term psychotherapy and extended hospital stays (The Report of the Surgeon General 2007). Other decisions to fund mental health care may rely on contextual political, socio-economic and environmental factors and funds are sometimes based on predetermined donor priorities. It is important to note that more than 70% of Uganda's health budget is donor funded.

Finances allocated to mental health care are usually utilized to provide curative rather than preventative interventions. These include the purchase of psychotropic drugs and anti epileptic drugs, recruitment and payment of personnel, medical supplies, administration costs, outpatient and in patient services and policy development to include others. However, KIIs and the case study revealed that in as much as funds are allocated, sometimes they are not disbursed or even when disbursed they are not adequately accounted for.

Nonetheless, an analysis of annual budget allocations for the last five years indicates that government funding for mental health care has been increasing steadily. Also the finalization of a Mental Health Policy will ensure that this continues to happen.

Although these positive changes are taking place, the impact of the current level of funding for mental health care was found to be more negative than positive. This is

worrying in a country where a 2006 household survey indicated that 4% of households had at least one member with a mental disability and Sebunya et al. (2009) affirms that one third of the population has been said to have some form of mental disorder.

It is only when policy makers at all levels acknowledge of the existence of a nationwide treatment gap in mental health service delivery and the need to bridge that meaningful allocation of funds to finance mental health care in Uganda will be made.

## Chapter 1

### 1 Background

It is well known that mental health services have been under funded for many years; not only for crisis community teams but the whole public mental health system (Hermann, 2007). Many developing countries spend just one per cent of their overburdened health budgets on mental health which is used to fund services, treatment and research. (Nightingale, (2008): Africa: Mental Health Research-Falling Through the Gaps)

Also worth noting is that the Trade Related Aspects of Intellectual Property Rights International Agreement (2005) dictates that governments may exempt drugs from patent protection if they are used to treat diseases that are life threatening or that emerge during national emergencies. As mental disorders are not eligible for exemption under these criteria, drugs to treat them are not exempt. This means that when newer and more effective drugs with better side effects are patented, they will remain prohibitively expensive for most people in developed countries. (Loke and Patel, 2007)

Mwenda and Platas (2009) report that stakeholders seem to think that there is not enough money to provide quality health care in Uganda. They add that funds allocated to Uganda's health sector are difficult to ascertain because most come from donors but some back of the envelope calculations show that over shs. 1 trillion is flowing into the health sector this year, and less than 30% of it (around 370 billion) is provided by Government, which is more money than any other sector in Uganda receives. Whereas this heavy reliance may severely distort domestic health priorities, not all the blame must be heaped on donors. Government itself must be held accountable for rampant wastage and inefficiencies in the health sector, wastage that has been valued at around 90 billion Uganda shillings per year, due to health worker absenteeism, grant leakages drug expiry among other things.

According to the 2006 National Household Survey, while around three quarters of all health facilities in the country are owned or managed by Government, only 35% of the Ugandan population sought treatment at these facilities. Nearly a half of all Ugandans, (46%), sought health care in private facilities, despite the fact that they are much fewer in number, comprising only about a quarter of the country's health facilities. Mwenda (2009), reports that those who can afford to pay for health care will opt to exit the government run health system and those who cannot pay will be at the mercy of the public sector. For those who have little to no money, receiving any sort of service may be received as a gift with gratitude rather than a right that one can demand for or have expectations of. While the bulk of financing for mental health is left to out of pocket expenses within East Africa, Uganda has the highest level of income poverty with an annual income per capita of \$300 as compared to \$350 and \$580 for Tanzania and Kenya respectively. This therefore puts more financial strain on its predominantly poor citizens. More still, three powerful forces, that is, material deprivation, the stigma of mental illness and the poverty that interacts with the lives of people living with mental illness keep them in this pitiful state. People with mental illness are not only among the poorest in society, but they remain poor for long periods of time, and from generation to generation. (Ssebunya et al, 2009).

The 2006 household survey by the Uganda Bureau of Statistics also indicated that 4% of the households in Uganda had at least one member with a mental disability and the New Vision newspaper of Sunday 31 August 2008 cited a study that reported that the prevalence of mental illness in Northern Uganda tops worldwide. The same article also quoted the then Acting Director of Butabika Hospital, Dr. James Walugembe as saying that the number of mental health cases treated at the hospital rose from 4,274 in 2005/2006 to 5,604 in 2006/2007. Ssebunya et al (2009) adds that although there is little data on the prevalence of mental illness in Uganda, one third of the Ugandan population has been said to have some form of mental disorder.

While funding and allocation of resources for mental health care faces challenges like insufficiency, poor distribution, inappropriateness, inflexibility, poor coordination and timing of disbursement, identifying whether these barriers are applicable to individual countries or regions is a first step in improving the use of these scarce resources. Left unchecked, these barriers could worsen the problems of inequity in access to services and also increase allocative and productive inefficiencies, making it harder for services to respond to the preferences of service users. (Knapp et al. 2004),

### **Literature Review**

Four broad predetermined themes were used to review literature. These were main sources of funds, decision making process for allocation of funds for mental health, the use or spending and impact on mental health care.

### **Main sources of funds**

McDaid et al. (2005), observed that although the level of resources available for mental health vary considerably, financing mechanisms for mental health care do not differ much from those for health care in general. All countries rely largely on some form of income or sales related taxation and/ or social insurance. However, for some countries in the former Soviet Union in particular, the transition to social health insurance systems has not always been effective, increasing the significant proportion of out of pocket payments and private insurance. This similar to Uganda where the proposed social health insurance scheme failed to take off because of inadequacies in financing to develop an adequate system to support the health insurance scheme. <sup>1</sup> For example in Armenia and Georgia only 41% and 38% of the funding to mental health is from public sources. The inadequacy of evidence suggests that private expenditure on mental health is limited, owing in part to the association of mental health problems with poverty.

However, health insurance, whether funded through private or public sources, is one of the most important factors that influence access to health and mental health services according to a mental health report compiled by the Surgeon General (2007). In Uganda this is provided by private health service providers like African Air Rescue and International Air Ambulance and facilitated by employers or out of pocket expenses of an individual. Where this happens the service is usually accessed by middle or upper

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<sup>1</sup> Author's note

class citizens. However the health insurance providers do not include coverage for severe psychiatric and neurological disorders in their service contracts.

Another major source for financing mental health care is Non Governmental Organizations who in most cases supplement government efforts or work outside the system since mental health is a low priority area and sometimes, local governments are not interested in these partnerships. For example, in Kenya the majority of mental health programmes are funded by non governmental organizations. (The Daily Nation, Saturday 27 June 2009).

In Uganda health care is also financed by external donors as reported by Kates et al. (2008). This report states that donor governments, including the United States and European nations, provide almost all external health funding to low-and middle-income countries through both bilateral and multilateral channels. The WHO Aims Report on Mental Health Systems in Uganda (2006) showed that while the government spent 1% of its expenditure on health care, on mental health in primary care, other aspects of mental health are funded within the general health budget as part of the integrated health service delivery. The report continues to state the budget was supplemented by funding from African Development Bank with nearly 45% of the support going to mental thus raising expenditure on mental health to approximately 4% in that year.

In summary, the sources of mental health finance in Uganda take various forms and usually are tailored to programmes like community mental health, research or livelihoods. The government is being lobbied by various stakeholders to increase allocations with some response, however trivial. For example during the last FY, the Ministry of Health for the first time allocated 40 million Uganda shillings exclusively for the purchase of mental health drugs through the credit line.

### **Decision making for allocation of funding to mental health**

Decisions for the allocation of funding for mental health are made at different levels as presented in the discussion below.

The acknowledgement of the existence of a nation wide gap for mental health service delivery and the need to bridge it seems to form the basis of the decision to increase allocation of funds in Uganda. Uganda's mental health policy, although still in draft doesn't not adequately cover the important part of how to finance the proposed interventions which could pose a major hindrance in their financing. A policy brief titled Developing Effective Mental health Policies and Plans in Africa by the Mental Health and Poverty Project (2007) suggests that the existence of a mental health policy goes a long way in influencing financing for mental health care. In addition, realism should be upheld in the detail of what can be achieved and how. The policy brief continues to add that analysis of policies in Africa revealed that they had all been written in an over ambitious way and high expectations for mental health care are set, describing many objectives broadly without any clear information about how they will be achieved within available resources. While it is of crucial importance to indicate how policy formulation will be financed, whether additional resources will be allocated to mental health and if so

what is going to be the source of additional funds, none of the policies had such information. Furthermore, though finances are mentioned in the policies of South Africa, Ghana and Zambia, no specific mention is made for of the source or allocation of funds. In the Uganda policy, financing is not addressed at all.

Furthermore the mental health report of the Surgeon General (2007) found that private health insurance is generally more restrictive when it comes to providing insurance covers for mental illness as opposed to other somatic illness. It adds that insurers feared that the covering mental health services would result in high costs associated with long term psychotherapy and extended hospital stays and yet that they were reluctant to pay for these services. It goes on to say that while the majority of individuals who use mental health services incur comparatively small expenses, some who have a severe illness will face financial ruin without the protection afforded by insurance. This has been found to be the case in Uganda.

Mental health financing may also rely heavily on contextual political, socio-economic and environmental factors in the country. This maybe the case in Uganda where over 70% of the health budget is donor funded and funds are spent on pre determined thematic or priority areas like the health sector strategic plan as opposed to being matched to existing needs. McDaid et al. (2004) in a study on resource allocation methods for mental health funding in 17 western European countries found that with few exceptions (where local budgets are provided) these were based on historical precedents or political judgments rather than objective measures of population health needs. Another observation was that the methods used are unlikely to target resources to areas where they are most likely to be effective; they may also allow inequalities to persist.

### **Use or Spending of funds allocated to mental health care**

A review of evidence for the efficacy of well documented treatments, suggested that mental health services on which funds were used included hospital and other 24 hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psycho social rehabilitative services and other intensive outreach approaches to the care of individuals with severe disorders. (Frank et al., 1996) In Uganda's case, interventions in mental health are usually curative other than preventive.

### **Impact on Mental Health Care**

An article on schizophrenia.com (September 2006) reports that the extremely low funding of mental health services in New Mexico has resulted in a bad situation for the mentally ill as well as all other citizens. This came to light after some street shootings were blamed on people with mental illnesses. Based on figures compiled in 2003, New Mexico came in last on per capita spending on mental health services, at only \$28.80 per capita compared to a national average of \$91.88. Consequently, the Senator agreed that a mandatory outpatient treatment law must be tied to increase funding. As such while mental health funding has increased over the years, the percentages are nothing

in comparison to the magnitude of the problem and thus the entire population is affected in one way or the other.

Worse still is the article on Mulago Hospital, the National Referral Hospital that exposed that services at the hospital had deteriorated to the point that society has become so disenchanted with public health care in Uganda that mediocrity is the highest level of care aspired to. Patients are unaware that they are entitled to be seen by a doctor or a nurse or even about what treatment they should be receiving. (Mwenda & Platas 2009). Mulago Hospital also provides specialized mental health services.

Loke and Patel (2007) argue that because of limited resources the distribution of services in the community is uneven, with few people in rural areas able to access them. On top of this primary care centers are scarce, and a fifth of all countries cannot offer even a basic set of drugs such as an antidepressant and an anti psychotic. In addition, in most countries basic psychological therapies are not provided and the many social and physical health needs that patients with mental disorder have are routinely ignored. They go on to say that the overwhelming majority of people, even with severe mental disorders, in poor countries do not receive evidence based care. This is despite the evidence for the effectiveness of relatively cheap drugs and psychosocial treatments.

### **1.1 Problem Statement**

According to the World Health Organization (2003), financing is a critical factor in the realization of a viable mental health system and mental health financing is a powerful tool with which policy makers can develop and shape quality mental health systems. Without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions. In fact a significant proportion of persons with mental illness (76-85 per cent) in developing countries are not receiving the treatment they need, not because the treatments don't exist but because financial issues, stigma and often sheer logistical problems prevent it. (Nightingale, (2008): Africa: Mental Health Research-Falling Through the Gaps)

In addition to drugs and logistics, poor financing also affects the quality and number of qualified mental health staff in the system. Hermann (2007) argues that no one would argue that it is absurd to suggest that surgery should be performed by anyone other than a surgeon. Yet in mental health this is increasingly common to see. Complex patient treatments are provided at the hands of inadequately trained staff.

Tackling barriers of resources for mental health can be done by improving mental health literacy and building the case for increased investment in health. Decisions for resource allocation are notoriously difficult to defend because decision makers generally look for evidence on consequences of or alternative courses of action for cost effectiveness and, strengthening the information base. They will only earmark or protect funds that will make a positive impact on mental health care. It may also be achieved through coordinating funding across sectors and making direct payments to service users.

This study is intended to explore the trend of mental health financing in Uganda for the last 6 years to date (June 2009) so as to establish emerging gaps and make appropriate recommendations as to how it may be improved. This will in turn impact positively on the impact of mental health care.

## **1.2 Justification**

Limited or unequally distributed mental health resources pose impediments to increasing access to mental health treatment. Previous studies indicate that in the poorest countries, the smallest percentage of overall health budgets goes to mental health care (Saxena et al., 2007). Even allocations from WHO for mental health are not scaled in accordance with the estimated global disease burden of mental disorders (Stuckler et al., 2008). Furthermore, available resources for mental health resources in LAMICs are unequally distributed at the national, regional and community levels (Saxena et al., 2007). A lack of transparency about the sources and allocations of funds for mental health, along with limited information on options for cost-effective mental health care contribute to the financial barriers plaguing mental health care in LAMICs (Knapp et al., 2006).

BasicNeeds aims to improve access to mental health care for poor people in low- and middle-income countries (LAMICs). Through studies conducted in countries where BasicNeeds works, we have found that the availability of psychiatric medicines, human resources, and infrastructure for community mental health services (CMH) are heavily subject to funding decisions (Raja et al., 2007; Appiah-Kubi et al., 2007). Existing resources from government for CMH are inadequate in each of these countries, requiring BasicNeeds to supplement the essential components for CMH delivery such as medicines (Raja et al., 2009). The proposed financing study will provide BasicNeeds with information on how funding for mental health is sourced, allocated and utilized in seven LAMICs—Sri Lanka, Lao PDR, Tanzania, Ghana, Uganda, Kenya and India. The findings of the study will be used to influence mental health policy and decisions for financing mental health care in these nations. The findings will also form a basis for more in-depth studies on financing or costing future community based psychiatric interventions. The findings will also be used to set a framework for tracking finances for mental health services in districts.

### **1.2.1 Objectives**

#### **1.2.2 General Objective**

To determine the trends in mental health financing and from FY 2004/2005-2008/2009 and how this has impacted or impacts on mental health care in Uganda.

#### **1.2.3 Specific Objectives**

- a) To determine the main sources of financing for mental health in Uganda
- b) Establish the decision making process for allocation of finances for mental health.
- c) To find out what the allocated funds are used for.

- d) To determine the impact of financing on the status of mental health care in Uganda.

### 1.3 Study Questions

- 1.3.1 What are the main sources of funding for mental health care in Uganda?  
1.3.2 How are the funds for mental health care allocated?  
1.3.3 How is the funding used?  
1.3.4 How does the current funding situation (including sources, allocations and sustainability) impact on mental health care?

## Chapter Two

### 2 Methodology

This study explored financing for mental health care in Uganda; a Low Income Country using a variety of qualitative and quantitative methods. The case study was conducted at Buliisa Health Centre IV in Buliisa district.

#### **Sampling:**

Study areas were purposively selected on the basis of BasicNeeds' operational areas to economize on shared resources across programmes and departments and their role in the planning and disbursement of finances for mental health services. Buliisa Health Center IV was selected as a case study.

All key informants were selected because of their familiarity with mental health service administration in Uganda. At national level these were:

1. The Principle Medical Officer in Charge of Mental Health at the Ministry of Health
2. The Acting Assistant Commissioner for Infrastructure and Social Services in the Ministry of Finance, Planning and Economic Development.
3. The Principle Economist, Infrastructure and Social Services Development in the Ministry of Finance, Planning and Economic Development.

Key informants at decentralized health care levels these were:

1. District health personnel from Kampala in central Uganda, Hoima and Buliisa in western Uganda and Amuria in eastern Uganda.
2. Regional/ referral hospitals Hoima and Buliisa in western Uganda and Amuria in eastern Uganda.
3. At PHC levels from Hoima and Buliisa in western Uganda and Amuria in eastern Uganda.

All interviews and discussions were conducted in English.

### **Key informant interviews**

These were conducted by the Research Assistant. Verbal consent was obtained before data collection began. An interview guide was used to facilitate discussions. The interview was documented at the time it was conducted. The interview guides are attached to the report as Appendices.

### **Secondary document review**

This was conducted by the Research Assistant and the choice of documents was determined by discussions at the IRMT meeting, study objectives and during the course of interviews. The documents included annual National Budget speech Documents for the relevant years, funding allocation documents from the Social Services and Infrastructure Department of Ministry of Finance, Planning and Economic Development and District Transfers for Health Services.

For the case study the documents reviewed were the Financial Report for Buliisa district, Buliisa Health Sub District Budget and the Health Management Information System monthly reports for financial year 2008/2009. The latter included payroll information, mental health patient records and pharmacy records. These documents were reviewed after KIIs as a way of triangulating the information that we had received from them. A Document Review Matrix was used to facilitate data collection. The literature review was compiled using desk research. A full list of documents reviewed is provided in the reference section.

### **Data Analysis**

This was done by the Research Assistant and Operations Manager of BNUU in Kampala. . The Research Assistant directed the coding and analysis of qualitative data using broad pre-established themes from the study objectives. Cross tabulations was done for data organized in tables. The use of direct quotations was maintained wherever possible. .

A diagram depicting the flow of mental health funding from sources to the recipients is included in the report. Quantitative information collected in the Matrix has been analyzed using tables, graphs and summary statistical sampling to illuminate trends.

## Chapter Three

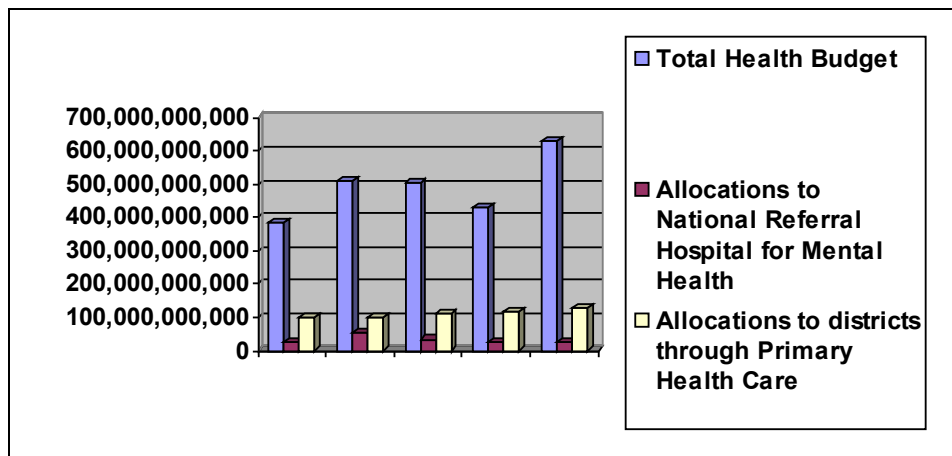
### Findings and Analysis

The findings of the study were analyzed and reported under four broad predetermined themes. These were main sources of funds, decision making process for allocation of funds for mental health, the use or spending and impact on mental health care. Emerging gaps were henceforth identified.

#### 3.1 Main sources of funding

According to key informant interviews, the Government through the Ministry of Finance and Economic Development was reported to be most sustainable source funds for mental health services in Uganda. The Ministry of Finance and Economic Development makes allocations against an annual budget to the Ministry of Health, districts and National Referral Hospitals. The main sources of funds for the Government were found to be taxation, multilateral and bilateral organizations. This is similar to the situation in Europe where all countries rely on some form of income or sales related taxation but contrary to Uganda's neighbour, Kenya where the bulk of mental health financing is said to come from NGOs.

#### Government of funding to the Total Health Sector for the Financial Years 2004/2005-2008/2009

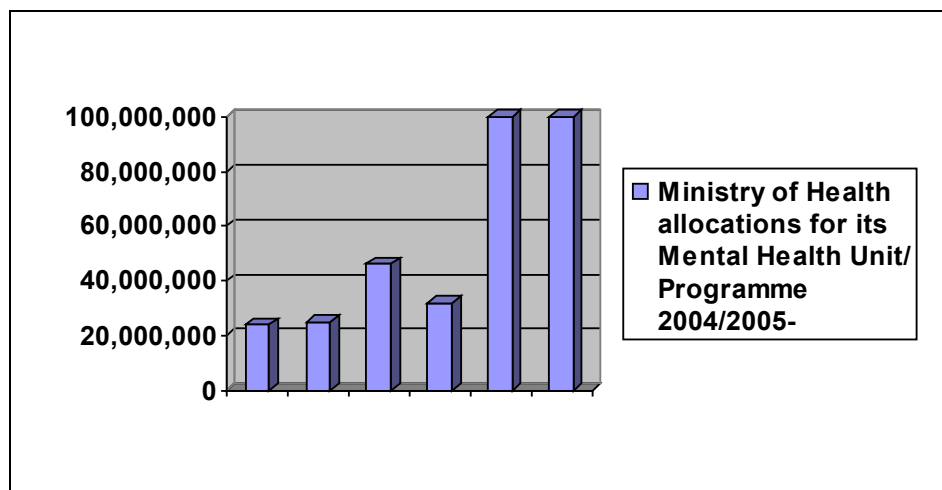


While the total health budget and allocations to National Referral hospitals have gradually increased, funds allocated to mental health remain low.

The Ministry of Health receives a bulk allocation from the annual national budget and it allocates money to its Mental Health Section in the context of its priorities. The Principle Medical Officer in charge of mental health said in an interview:

*'I lobbied and have thus been getting money for mental health activities since 2000. The amount allocated has now risen from a paltry 12 million in FY 2000/2001 to 100 million in FY2008/2009.'*

## Ministry of Health Allocations to its Mental Health Unit/ Programme, 2003/2004-2008/2009



The graph shows that the Ministry of Health has gradually increased funds allocated to its mental health section over these years.

The Mental Health Section at the Ministry of Health also receives direct funding from donors like WHO and SIDA. These are channeled through the Ministry of Health and the Principal Medical Officer in charge of Mental Health was concerned that WHO funding has reduced significantly and is now limited to funding national days and international meetings. She attributed this partly to the worldwide economic crunch. NGOs like BasicNeeds and TPO also contribute funding for this section.

According to annual District Health Transfers documents funds are received for the following services:<sup>2</sup>

:

1. Primary Health Care Wage
2. Primary Health Care Recurrent Non Wage
3. National Shared Services Programme
4. Essential Drugs-Credit Line
5. Government General Hospital Transfers Recurrent Non Wage
6. NGO Hospitals/PHC Transfers Recurrent Non Wage
7. NGO Wage Subvention
8. District Primary Health Care Transfers
9. Fiscal Decentralization Strategy

With the integration of mental health in Primary Health Care it is even more difficult to ascertain exactly what percentage of the budget is specifically for mental health and if this is financed through government or donors.

<sup>2</sup> Documents obtained during case study undertaking at Buliisa Health Center IV

The National Referral Hospitals receive direct allocations from the annual national budget. (Health sector) Butabika is the sole National Referral Hospital for Mental Health.<sup>3</sup>

KIIs with health workers revealed that out of pocket expenses was another source of financing mental health care. Patients and carers are compelled to buy drugs when they are unavailable at the health centers they attend. At some health centers the drugs may be sold drugs them which is contrary to the National Health Policy. Common assertions in some areas where drugs are sold to patients were:

*‘When we come to collect our monthly medicine and it’s not a BasicNeeds’ clinic day<sup>4</sup>, the health workers shout at us and chase us away!’*

*‘When it is not a BasicNeeds’ clinic we are made to buy drugs.’*

While this substantiates Mwenda& Platas’ findings on health finance sources, it is contrary to the national health policy where drugs are obtained from drug banks and it is illegal to sell drugs at a government health facility.

### **3.2 Decision making for the allocation of finances to mental health care allocation.**

Decision making follows a pre determined process that was outlined by the Programme Manager of the Mental Health Unit at the Ministry of Health. This is recounted below:

1. There is a national strategic planning process that takes the Health Sector Strategic Plan II into account.
2. Ministry of Health defines priorities for the Financial Year in a planning workshop that highlights key interventions under mental health. District Health Officers attend this workshop.
3. The results of this are integrated into the annual ministerial policy statement.
4. The Ministry of Health develops an annual workplan. Districts and lower health centers adopt this plan to develop individual annual work plans.
5. After this the government reviews the plans and communicates indicative figures for the financial year.
6. The Ministry of Health through the Budget Working Group makes allocations to programmes and districts which are then discussed by the relevant management teams. The ministry then communicates these allocations to districts through planning workshops based on planning guidelines.
7. Departmental plans and budgets are then issued to district councils and In Charges and the Councils then pass or approve them for that financial year.
8. The District Health Office may predetermine the allocation of some percentages of funds in the district budget, for example in Buliisa 50% of the current allocations went to purchasing of drugs.

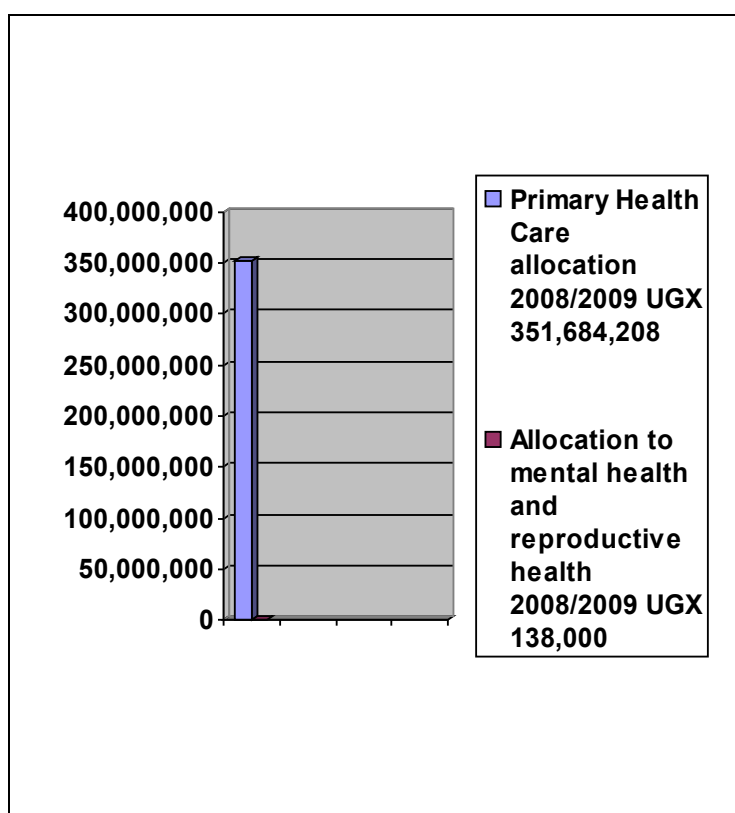
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<sup>3</sup> Documents obtained from the Department of Social and Infrastructural Development at the Ministry of Finance and Economic Development.

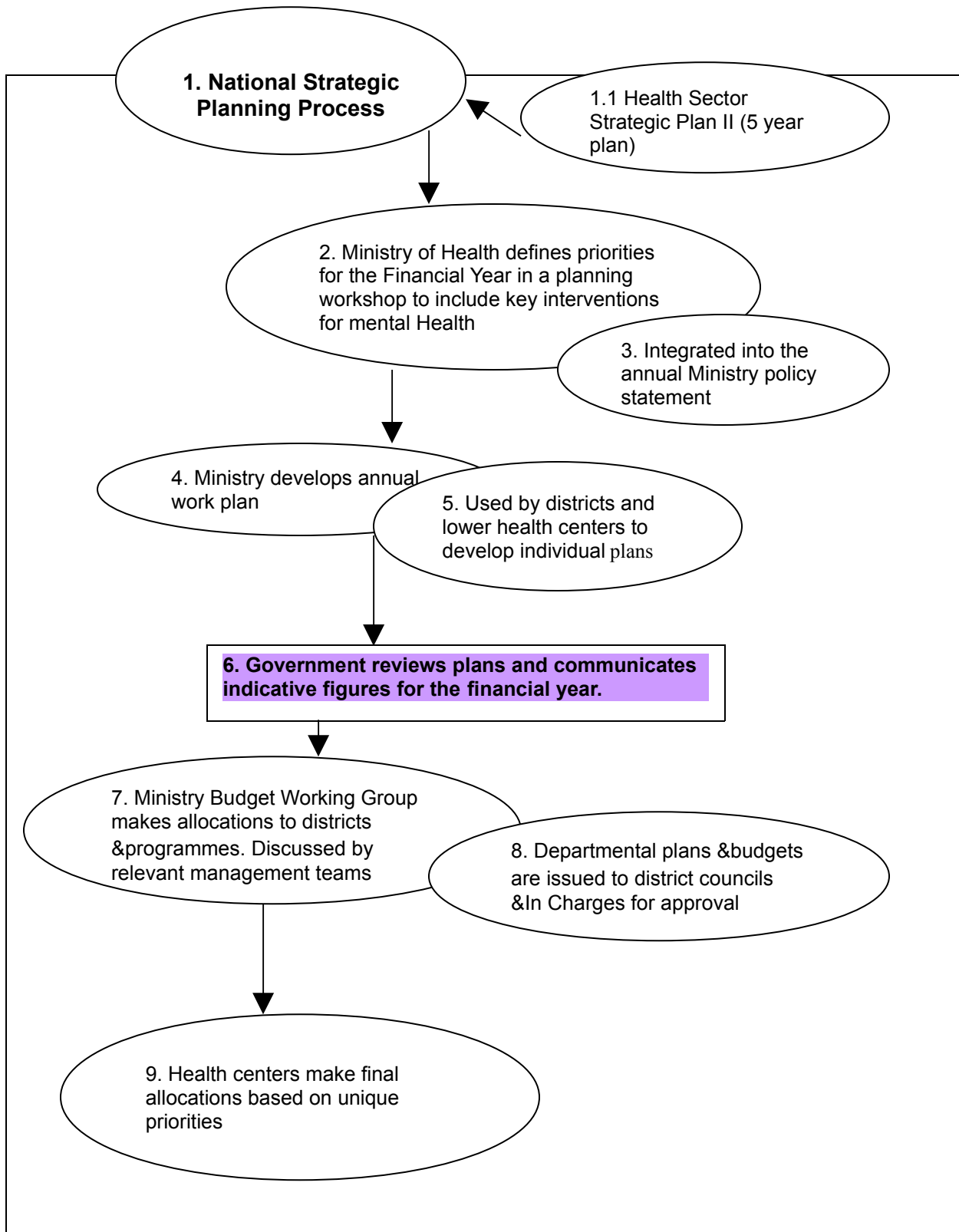
<sup>4</sup> A mental health clinic run at a local government health centre but facilitated by BasicNeeds

9. Health Centers then make final allocations based on their unique priorities. Usually priority is given to communicable diseases on the basis of resources received and demand or evidence of the magnitude of disease. A diagrammatic representation of processes 1-9 is provided on page 17.
10. Decisions made are also based on the Clinical Guidelines and the requirements of the Primary Health Care package and uniqueness of the geographical location.
11. The Health Service Commission recruits personnel for the health sector and the District Service Commission for districts. The Human Resource Policy may also determine funding allocations.

**Diagrammatic Representation of Case Study Primary Health Care Allocation and Allocation to Mental Health Activities**



## Diagrammatic Representation of Decision Making Process:



### **4.3 Use/ Spending of funds allocated to mental health care**

According to the national minimum health care package mental health services are integrated at all levels of health care (including PHC) but no special budget exists for this. It is estimated that a 1% allocation out of the Primary Health Care envelope is made to mental health. Examples of mental health activities that might be thus undertaken are:

1. Purchase of Psychotropic and anti epileptic drugs
2. Recruitment and payment of Personnel
3. Medical Supplies
4. Administration costs, for example, transport costs
5. Running Outreach clinics
6. Community sensitization
7. Health education
8. Development of Information, Education and Communication materials
9. Home visits
10. Policy development
11. Legislation development
12. Advocacy
13. Holistic mainstreaming and integration

Surprisingly, KIIs with health workers revealed that the actual activities undertaken in relation to mental health care are the purchase of psychotropic and anti epileptic drugs. One health worker from the first key informant interview had this to say:

*'I have never held a home visit or community outreach clinic for mental health for all the three years that I have been here yet fund allocations are always indicated in the budget. The funds never get disbursed'*

In a nutshell, funds allocated to mental health services are used to carry out the most basic community mental health i.e., diagnosis and treatment. Other routine services are offered at referral and regional hospitals and interventions by non governmental organizations. Most research activities like baselines to establish the magnitude of the problem and training and awareness creation activities for health professionals and the community alike are undertaken by the latter.

### **4.4 Impact of financing on Mental Health Care**

The analysis of findings from the study found the impact of the current levels of funding on mental health care to be negative rather than positive:

1. Minimal allocations are made to mental health care and yet these are not disbursed for use. For example, at Buliisa Health Sub-district, the 2008/2009 budget shows that while 351,684,208 Ugandan shillings was allocated to mental health, only 138,000 shillings was used for mental health and reproductive health activities. However there was no evidence on the receipt or expenditure of this money in the consolidated district financial report. However, observations made at BasicNeeds' clinics indicate that much more than this 138,000 shillings is spent on mental health

activities in terms of drugs and other accompanying medical supplies. It is also difficult to establish how much is spent on drugs since they are obtained through the credit line facility and a Primary Health Care funds. .

2. Secondly, minimal funding has led to poor supply of drugs, especially psychotropic drugs. The argument provided by most decision makers interviewed is that the drugs are too expensive in comparison to Artemisia Combination Therapy and antibiotics which are used routinely to manage communicable diseases. At lower health centre level requisitions for anti epileptic drugs are made under the mental health vote. The most common neuro-psychiatric drug is Phenytoin, with minimal stock for anti psychotics like chlorpromazine or anti depressants like amitriptyline and imipramine. As a result many patients suffer relapses due to such inconsistencies. Sometimes these relapses are fatal for example in Hoima district, depressed patients committee suicide.

3. As a result of low funding and a consequent inability to make mental health services more accessible, cheaper modes of treatment are sought by patients and carers. This includes traditional healers and religious leaders. KII respondents gave accounts of patients turning to religious leaders whose services were free and traditional doctors accept payments in kind (poultry and livestock) instead of money.

4. Health budgets rarely include logistical support required for support supervision. This includes fuel, stationary, day allowances for staff and specialized drugs. As a result the supervision structures is inadequate which in turn allow for practices such as absenteeism, theft of supplies and sale of drugs at some health centers. As noted some health centers visited had no In-Charges present at the time of the study as these were reported to be working in their private clinics where they make more money than the salaries offered by the government. In addition sometimes there are no drugs at the health centers or disbursements are late which reduces patient turn out at the clinics. Health workers get board and go home early or do not work at all.

5. Therefore communities remain set in destructive beliefs and practices with no sensitization in place because of no budget allocations. There is hardly any community awareness on mental health, especially in the rural communities aside from efforts by the Ministry of Health and NGOs. While interviews with health workers at district levels are willing to undertake the task, they lack facilitation in form of fuel for their motorcycles for example.

6. It should however be noted the gradual increase in funds for mental health from the various sources has had some positive impact. There is registration of increased attendance of mentally ill people at health units. While a large number of clinic attendants at the case study are epileptics, the number has increased over the months since July 2008 when 12 patients (all epileptics) were registered to 44 patients in February 2009. By June of this year, the clinic was serving 133 people with mental illnesses and epilepsy. This is as a result of BasicNeeds' activities in the district.

7. The inadequacy of the health budget can only allow for poor remunerations for personnel attached to health departments. Because of this and the fact that Buliisa is a remote district, inadequate human resources numbers arise. Prospective recruits anticipate minimum pay and other returns and where these are absent they

resort to turn down the job. The gross monthly pay for staff at a health center according to the government salary scale are:

<b>Title</b>	<b>Amount in Uganda shillings</b>	<b>Amount in British Pounds (ex rate 3400)</b>
Senior Clinical Officer	676,120	199
Clinical Officer	477,000	140
Nursing Officer	477,000	140
Enrolled Nurse	276,614	81
Enrolled Midwife	276,614	81
Nursing Assistant	149,720	44
Lab Assistant	276,614	81
Guards/ Askari	149,720	44
Records Assistant	220,217	65
Support Staff	149,720	44
Health Assistant	276,614	81
Driver	149,720	44

8. Funds provided for mental health are inadequate to provide a holistic service that contributes to exposure to other co morbidities, intensification of illness and unnecessary deaths. Other diseases afflicting a mentally ill person may be missed or ignored because of reasons ranging from a lack of motivation because of poor pay or a sincere lack of knowledge because of a lack of finances to undertake initial or refresher training.
9. Inadequate finances to provide a health center within 5km of settlements as is ideal translates to long distances to access mental health care and increases the burden of care especially for women. For example in Apapai sub county, Soroti district a mother waked for almost 6 hours to bring her mentally retarded to the health center, only to be told that the relevant services were unavailable.

### **Emerging Gaps**

1. There is no information or evidence on the cost effectiveness of currently funded services which means district planners and policy decision makers miss out on understanding sources of resource wastage and inefficiency of the service. The Principle Medical Officer in charge of Mental Health at the Ministry of Health gave an example:

*‘An ambulance and accompanying staff are financially facilitated to transport a patient from upcountry to Butabika Hospital to get a largactil injection when it would be much cheaper to make the drug more accessible.’*

## **Limitations**

While undertaking the study, the following limitations were encountered:

1. Records for the 2007/200 – 2007/2008 as the recommended year of study were unavailable; therefore the financial year 2008/2009 was adopted for the case study.
2. There were hardly any records on expenditure at the health centers visited for KIIIs. KIIIs reported that medical supplies are procured through requisitions to the district and the National Medical Stores. Therefore to reduce the impact of recall bias on the study, a decision was taken to review the financial year 2008/2009.
3. In many cases the Health Management Information System was not up to date because of a shortage of manpower.

## **Discussion**

Mental health is grossly under funded in Uganda as it is not a priority at neither centralized nor decentralized funding levels. This leaves the bulk of the financing to out of pocket expenses in a country where over 42% of the population is extremely poor and has led to the rise of funding from donors and NGOs to supplement the Government's efforts, which while commendable, are no match for the magnitude of the problem. The draft mental health policy attempts to outline possible avenues for finance mobilization but these are not exhaustive. However it may be that the mere existence of such a policy goes a long way in influencing financing for mental health care.

Inadequate financing of mental health care also contributes to the severe lack of specialized staff, especially in rural areas, which finally intensifies the magnitude of mental disorders. Furthermore, even where a structure for mental health care exists, it is not adequately financed to provide services.

It is also surprising that negative belief systems persist even among policy and decision makers with formal education and as a result widespread stigma remains a belittling factor in the advocacy for increased mental health care funding in Uganda. It also affects the magnitude and quality of mental health services offered by private health service providers even when medical insurance covers and out of pocket expenses are available as demonstrated in preceding arguments.

In as much as Government funding, though inadequate, is the most sustainable source of financing for healthcare in Uganda, in this context, priority is usually placed on communicable diseases like malaria and tuberculosis. Studies reveal that these areas are so well documented that it is impossible for them to be ignored which is in contrast to mental illness where limited and questionable data exists.

## **Recommendations**

On the whole it is important that clear accountability processes surrounding the allocation and disbursement of funds are outlined for effective and efficient utilization, however specific recommendations are outlined below:

### **Districts**

1. During the annual planning meetings, districts should advocate for fund allocation for the recruitment of specialized mental health personnel. They should also hire of specialized mental health staff and contract them where funds are available. For example the hire of a Psychiatric Officer in Buliisa district has been on hold the whole year because of bureaucratic processes available yet the funds are available.
2. Putting measures to ensure the monthly update of the Health Management Information System for evidence generation. This will provide the necessary evidence required for decision makers in the budget formulation and allocation process to devote more funds to mental health.
3. During the annual planning process they should ensure that funds are adequate to support the content of the Health Sector Strategic Plan.

### **Ministry of Health**

1. Increase in the allocation of financial resources to the mental health sector.
2. Lobby government for ring fenced funds for drugs and other complimentary services for community mental health.
3. The annual planning process should consider a requirement for funds for logistical support required for the provision of mental health services.
4. Create awareness among key decision makers and policymakers, for example one health officer interviewed said in disbelief:

*'You mean these mentally ill people can also sit and hold a focus group discussion?!'*

This kind of attitude undermines objective decision making and he may decline to increase fund allocations for mental health.

5. Carry out an analysis of the service to determine its cost effectiveness for the improvement of effectiveness and efficiency and thus determine best practice.

### **Government**

1. Increase the annual budget allocation to the health sector, which may consequently positively impact on mental health care allocations.
2. Allocate special funding for community mental health activities in the same way that allocations are made for priority health issues.

### **Conclusion**

It becomes imperative that further research is undertaken to reveal the cost effectiveness of current mental health services which would also indicate the cost of treating a person with a mental disorder at different levels of mental health service provision, how to improve accountability for allocated funds and to discover the percentages of out of pocket expenses. Besides this, invaluable information could be

found in documentation for mental health funding sources, allocations and utilizations for previous years, if they exist.

## References

Appiah-Kubi K, Raja S, Boyce W. Mental health: access to treatment and macroeconomics in Ghana. Unpub.

Associated Press (2006): Low Funding of Mental Health Services in New Mexico Harms all Citizens. <http://www.schizophrenia.com/sznews/archives/003862.html> Last accessed 17/07/2009

Atwoli, Lukoye (2009): Mental Health Needs a Vote in Ministry's Budget. <http://www.nation.co.ke/oped/Opinion/-/440808/616200/-/view/printVersion/-/15ud3ib/-/index.html> Last accessed 16/07/2009

Baingana, Florence (2008): Mental Health Programming for Low Income Countries. <http://www.dcp2.org/file/237/baingaina%20mental%20health%20programming.pdf> Last accessed 16/07/2009

Businge, Conan (2008): Mental Illness-Northern Uganda tops Worldwide, <http://www.newvision.co.ug/D/9/34/647347> Last accessed 17/07/2009

Hermann, Larry (2007): Mental Health System in Crisis. <http://www.theage.com.au/news/opinion/mental-health-system-in-crisis/2007/11/20/1195321779520.html> Last accessed 16/07/2009

Knapp M, Funk M, Curran C, Prince M, Grigg M, McDaid D. Economic barriers to better mental health practice and policy. Health Policy and Planning 2006 ; 21(3):157.

Loke and Patel (2007): Mental Health in Developing Countries <http://archive.student.bmj.com/issues/07/10/editorials/344.php> Last accessed 17/07/2009

[http://www.kff.org/hiv/aids/upload/7679\\_02.pdf](http://www.kff.org/hiv/aids/upload/7679_02.pdf) Last accessed 17/07/2009

McDaid et al. (2005): Policy Brief: Mental Health III Funding Mental Health in Europe. <http://www.euro.who.int/Document/E85489.pdf> Last accessed 17/07/2009

Nightingale, Katherine (2008): Africa: Mental Health Research-Falling Through the Gaps. <http://allafrica.com/stories/200801250553.html> Last accessed 17/07/2009

Platas& Mwenda (2009): Mulago Reflects a Sick Health Sector. <http://www.independent.co.ug/index.php/reports/special-report/71-special-report/887-mulago-reflects-a-sick-health-sector> Last accessed 17/07/2009

Raja S, Kippen S, Reich MR. Access to psychiatric medicines in Africa. Forthcoming In: Akyeampong E, Hill A, Kleinman A, eds. Culture, mental illness and psychiatric practice in Africa. Bloomington (IN): Indiana University Press; 2009.

Raja S, Clarke K, Kippen S, Mannarath S, Oginga A, Antwi Bekoe T, Morakoth M, Higini K, Mujune V, Senarathna T. Practice of community mental health: identifying essential features for scaling up. Manuscript in preparation.

Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet* 2007 Sep; 370(9590): 878-889.

Stuckler D, King L, Robinson H, McKee M. WHO's budgetary allocations and burden of disease: a comparative analysis. *Lancet* 2008 Nov; 372(9649): 1563-9.

Surgeon General (2007): Financing and Managing Mental Health Care; History of Financing and the Roots of Inequality.

<http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec3.html> Last accessed 16/07/2009

W.H.O. (2003): Mental Health Financing.

[http://www.who.int/mental\\_health/resources/en/Financing.pdf](http://www.who.int/mental_health/resources/en/Financing.pdf) Last accessed 16/07/2009

W.H.O (2007): Mental Health Policy and Service Provision

<http://www.who.int/whr/2001/chapter4/en/index.html> Last accessed 16/07/2009

W.H.O. & Republic of Uganda (2006): W.H.O. Aims Report on Mental Health System in Uganda. [http://www.who.int/mental\\_health/uganda\\_who\\_aims\\_report.pdf](http://www.who.int/mental_health/uganda_who_aims_report.pdf) Last accessed 23/07/2009

[http://www.research4development.info/PDF/Outputs/MentalHealth\\_RPC/MHPB8.pdf](http://www.research4development.info/PDF/Outputs/MentalHealth_RPC/MHPB8.pdf)

Last accessed 17/07/2009

## **Appendices**

Appendix 1. Document matrix