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An evaluation of the Mental Health Facilitator programme in rural Uganda: Successes and recommendations for future implementation

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This study evaluated the impact of a Mental Health Facilitator training protocol conducted with individuals from a local community in rural Uganda. The training programme is designed to facilitate the development and delivery of basic mental health services in under-served communities globally. This article aims to communicate the best practices and limitations of the training programme in the affected area. Using semi-structured interviews, the investigators interviewed 19 Ugandans who participated in the Mental Health Facilitator training programme. Participants' occupations included head teachers and headmasters (n = 7), hospitality industry employees (n = 5), comprehensive health nurses (n = 3), religious leaders (n = 2), a vocational school director (n = 1), and a community chairperson (n = 1). Following transcription, the data were analysed for recurring patterns and themes. Results suggest that the participants achieved a better understanding of local mental health referral from the curriculum as well as knowledge of strategies to improve service delivery and access to services. Limitations to the mental health facilitator role included resource barriers, setting expectations with community members, and stigmas related to mental health. The best practices in a developing country setting should seek input from local community members.

Keywords: mental health facilitator, Uganda, rural community development, Global Livingston Institute

Introduction

Mental disorders in Africa represent a significant public health concern, yet mental health issues and treatment remain a low priority throughout Africa (Bird, Omar, Doku, Lund, Nsereko, Mwazna & the MHaPP Research Consortium, 2011). The extreme need for mental health services is constant across Africa and globally, with estimates ranging as high as 90 per cent for persons who need treatment but do not have access (Basic Needs, 2015). Many African countries are characterised by low incomes, low life expectancies and a high prevalence of communicable diseases and malnutrition, resulting in mental health services receiving low priority in public health agenda settings (Okasha, 2002; Jenkins et al., 2010). Similarly, although mortality is largely the result of infectious disease and malnutrition in African countries, morbidity and mortality due to mental illness represent a notable public health concern, yet receive little attention or funding from the government (Gureje & Alem, 2000; Jenkins et al., 2010).

While mental disorders represent 13% of the global burden of disease, 79% of African countries spend less than 1% of their health budgets on mental health, revealing a striking disconnect between disease burden and mental health financing (Raja, Wood, de Menil & Mannarath, 2010; Basic Needs, 2015). Perhaps some of this disconnect can be explained in part by the fact that many communities in Africa are using most of their resources to meet fundamental needs of food, water, shelter, and safety, and are simply unable to address mental health issues (World Health Organization & Ministry of Health, 2006; Kigozi, Ssebunnya, Kizza, Cooper & Ndyanabangi, 2010). When mental health services and resources are available, they are often insufficient, fragmented, and inaccessible, particularly in low-income countries where resources are highly centralised around more urban populaces.

Mental health in rural Uganda

It is estimated that nearly 35% of Ugandans—about 11.5 million people—suffer from some kind of mental illness, with mood disorders and depression being some of the most commonly reported illnesses (Kavuma, 2013). However, less than half of those needing psychiatric and mental health assistance actually seek medical attention for reasons including inaccessibility of treatment, cost of travel or of medication, religious and cultural ideologies, and social stigma (World Health Organization & The Republic of Uganda Ministry of Health, 2006; Kavuma, 2013). Access to mental health services in Uganda are largely underfunded and inaccessible with 'widespread inequality between urban and rural areas in the resources available for mental health care, including staffing and inpatient beds' (Kigozi et al., 2010, p. 7). The last known legislative revision of the Mental Health Plan for Uganda was in 1964 (World Health Organization & Ministry of Health, 2006). The World Health Organization (WHO) and Ministry of Health (MoH) assessment of the mental health system in Uganda found one national mental hospital, 27 community-based psychiatric inpatient units, one day-treatment facility, and no known community residential facilities (WHO & MoH, 2006). The Ugandan public healthcare delivery system is comprised of national and

regional hospitals, as well as a tiered system of health centres that provide a range of services (Ministry of Health, Health Systems 20/20, and Makerere University School of Public Health, 2012). At the highest level are regional referral hospitals, and below are general hospitals and sub-district health centres, levels I–IV. A health centre I facility provides basic community-based preventive care, while a health centre II facility serves a few thousand people and runs an outpatient clinic, treating common diseases like malaria and providing antenatal care. A health centre IV facility serves approximately 100 000 people and offers out-patient treatment services, maternity care, in-patient services and laboratory and surgery services. In a country of an estimated 35 million people, there are 30 known psychiatrists—less than one per million people in Uganda. In terms of practising mental health workers, this number is estimated to be 310, or 1.13 per 100 000 people with 62.4 per cent of the psychiatric beds located in or around Kampala, the country's capital city (Kigozi et al., 2010). The assessment conducted by WHO and MoH (2006) also found that Uganda only spends approximately one per cent of its primary health care dollars on mental health services.

Although mental illness accounts for a significant disease burden in Uganda, estimates suggest that only 5 to 10 per cent of persons suffering from a diagnosable mental disorder have access to mental health services (Kavuma, 2010; Baluku, 2014). Mental health service utilisation remains extremely low throughout Uganda, and in many areas, especially the rural communities, these mental health services are simply unavailable (WHO & MoH, 2006; Kigozi, 2010; Baluku, 2014). For example, in the region we conducted the following Mental Health Facilitator (MHF) programme evaluation, located in the Bufundi Subcounty of the Kabale District, five government health units exist with mental health service referral capability to the Kabale Regional Hospital. Despite this availability, Baluku (2014) claims that mental health facilities in the Kabale District are widely under-utilised, and those with known mental illness throughout the district are not receiving or seeking mental health care. Although little is yet known about the specific factors associated with help-seeking behaviours for mental health problems in this district, help-seeking behaviour has previously been shown to be related to fear of mental illness, distrust of medical providers, perception of severity of the illness, and a belief that mental health problems are due to supernatural causes (Cooper, Ssebunnya, Kigozi, Lund, Flisher & The MHaPP Research Programme Consortium, 2010; Kavuma , 2013; Baluku, 2014). These religious and cultural beliefs that associate mental illness with witchcraft and other supernatural powers often result in stigmatisation of individuals with mental illness, and these mentally ill patients are either taken to traditional healers, or simply left untreated (Byaruhanga, Cantor-Traa, Maling & Kabakyenga, 2008; Cooper et al., 2010; Kavuma, 2013).

The disease burden of mental disorders in Uganda, combined with low mental health spending and insufficient and inaccessible mental health resources indicates a need for innovative, accessible, community-oriented approaches to mental health care, particularly in rural communities. The Mental Health Facilitator (MHF) programme is one such programme, designed to improve access to mental health care and increase community capacity by educating and training community members from diverse backgrounds how to address mental health concerns in their communities (Hinkle, 2012, 2014).

The Mental Health Facilitator programme

The Mental Health Facilitator programme 'combines globally consistent training with locally informed needs that may begin to further address the mental health care, mental health quality and mental health equity gaps as they exist both universally and uniquely' (Paredes, Schweiger, Hinkle, Kutcher & Chehill, 2008, p. 78). Initially developed in collaboration with the World Health Organization (WHO), the MHF training programme was created by NBCC International (NBCC-I), a division of the National Board for Certified Counselors, and was launched in 2008 (Hinkle, 2012, 2014). The MHF programme aims to further 'the development and delivery of community-based care consistent with WHO's recommendations for addressing global mental health needs' (Hinkle, 2014, p. 13). It is an internationally utilised programme introduced in 25 countries globally, and is based on a training programme that is trans-disciplinary and focused on mental health competencies that teach community members to respond to mental health concerns in a consistent way wherever they appear, or however they are interpreted (Hinkle, 2014).

According to Hinkle (2014), 'The MHF curriculum consists of information ranging from basic mental health knowledge to specific, local, culturally relevant, first-contact approaches to helping, including mental health advocacy, monitoring, and referral, all of which meet local population needs and respect human dignity' (Luke, Hinkle, Schweiger & Henderson, 2016, p. 5). The MHF programme is typically a three-tiered programme encompassing trainers and master trainers. Trainers have a bachelor's degree or its equivalent, and master trainers have a master's degree or its equivalent in a profession or field related to mental health (Hinkle, 2014; Luke et al., 2016). Both levels of trainers are also required to take part in additional instruction beyond the curriculum that includes feedback on a demonstration of teaching a part of the curriculum (Luke et al., 2016). To implement a MHF programme, NBCC-I works with local organisations that are interested in implementing a programme that increases the service capacity of a community (Hinkle, 2014).

The World Health Organization (2001) advocates for the need for research on factors that assist in utilising community mental health interventions within their cultural context. A recent qualitative study using an applied ethnographic research design was employed to explore outcomes of the MHF programme's implementation in Malawian schools through interviewing 40 stakeholders and participants in the programme (Luke et. al., 2016). Results indicated that the participants believed that the programme was valuable and study participants confirmed that the programme based in schools allowed community members to learn how to assist one another. The concepts learned allowed MHFs to use the information regularly, including learning how to help others find sources of

assistance. The participants drew parallels 'between the interconnectedness encouraged in the training and the strong interpersonal relationships within the local culture. Participants also recognised the adaptability of the curriculum and credited the MHF programme with dealing with *real issues*' (Luke et al., 2016, pp. 13–14, emphasis in original). One goal of the MHF programme involves culturally appropriate, grassroots efforts to address mental health concerns in resource-poor countries. Based on comments delivered by the participants, we have initial evidence of meeting that goal in Malawi.

GLI and Entusi Resort and Retreat Centre

The Global Livingston Institute (GLI) is a community-based research institute co-located in Denver, Colorado and Kabale, Uganda, developing strategic partnerships in both East Africa and the United States with a focus on education, job creation, and social impact. The mission of GLI is to educate students and community leaders on innovative approaches to international development. Modelled after the Aspen Institute, GLI develops strategic and innovative partnerships with local community leaders and institutions to execute community-development research initiatives, leadership summits and education forums, public health interventions, and economic development opportunities. The aim of the organisation is to promote an approach to international development that fosters listening and thinking before action.

The Entusi Resort and Retreat Centre was launched in August 2012 on Lake Bunyonyi in Kabale, southern Uganda as a space to cultivate this innovative community development work in rural Uganda. Employing 19 full-time Ugandans and led by Ugandans, the Entusi Resort and Retreat Centre acts as a forum for the growing dialogue in social and economic progress within the local and international community through research, exchange of ideas, and the sharing of knowledge (Global Livingston Institute Annual Report, 2015). The 2012 Mental Health Facilitator training took place at the Entusi Resort and Retreat Centre.

NBCC-I and GLI partnership

In 2012, NBCC-I and the Global Livingston Institute (GLI) formed a partnership to adapt and implement the MHF training programme in southern Uganda, and then later to conduct an evaluation of the training. The GLI had established a series of academic partnerships engaged in rural community development work that provided the ideal structural foundation, resources, and relationships necessary to conduct parallel training in another rural community in collaboration with NBCC-I. One of the strongest features of the MHF programme is its adaptability to the cultural contexts, norms, and traditions of the community in which it is being delivered (Luke et al., 2016). Yet this adaptability can also produce challenges in the facilitation of the programme and development of delivery of mental health services, as the customs of each community must be factored in. NBCC-I and the GLI formed this strategic collaboration to first address this challenge and opportunity to adapt the training programme to the cultural contexts of rural Uganda, and then evaluate the impact of the training in the community to inform future implementation. The Colorado School of Public Health at Colorado State University joined this partnership to assist in the data collection and evaluation of the programme by conducting interviews with MHF programme participants, analysing and coding transcription data, and identifying successes and challenges of the programme in the community, as well as recommendations for future training.

This research evaluation examines the effectiveness of MHF training in the Kabale District to determine the best practices and limitations related to the training that can be taken into account if additional training is scheduled. While this study will inform best practices for future Mental Health Facilitator training in Uganda, more importantly this study advances the field and provides additional insights for international mental health practitioners on key issues to take into consideration when designing and implementing mental health training in rural communities. The content of this paper is timely and relevant as mental health initiatives and interventions are taking a more community development approach (Jenkins et al., 2010).

Methods

Participants and setting

Nineteen out of the twenty participants in the MHF training were involved in this evaluation. Table 1 reports participant's occupations. Other demographic data regarding the participants is not reported in this paper in order to protect the anonymity of the participants.

Procedure

Institutional Review Board approval was granted by the Colorado State University Research Integrity and Compliance Office. The participants consented to the study individually. Participants were recruited via telephone by the Entusi Resort and Retreat Centre staff. Two researchers for this project evaluation travelled to the participants' locations to conduct semi-structured interviews. Each interview began with one of the researchers asking the following general question: 'Please describe one example of a time when you used the skills or information you learned in the MHF training?' After this question, researchers followed up with additional, open, general questions, including: 'How has the training been helpful to you, your family and/or the community?' and 'What

Table 1: Participant demographics

Occupation	*n*	Per cent
Hospitality industry staff (waiter, attendant, receptionist)	4	21%
Primary school teacher	3	16%
Primary school headmaster/deputy headmaster	3	16%
Comprehensive health nurse	3	16%
Religious leader (reverend, priest)	2	11%
Resort manager	1	5%
Community chairperson	1	5%
Secondary school headmaster	1	5%
Vocational school director	1	5%

have been the challenges to using what you learned?' Another example of a question later in the interview was the following: 'Is there something that should be done differently in the MHF training the next time the training is taught?' Researchers ended the interview with an opportunity for participants to address anything not discussed in the interview with the following question: 'Is there anything else you would like to tell us that we have not already talked about?'

Interviews were conducted over the course of five days in various locations, including participants' homes, community members' homes, churches, schools, and health centres. Staff from the Entusi Resort and Retreat Centre provided English interpreting from the local language, Rukiga, as necessary. Six out of nineteen (32%) participants interviewed required some interpreting support; two (11%) needed complete interpreting. Participants received a copy of informed consent to read, and all participants received verbal communication of the informed consent. The purpose of the research, risks and benefits to participants, confidentiality and the right to refuse or withdraw from the research were specifically communicated, and participants were informed that their information would not be shared outside of the research team. To further ensure confidentiality, all consent documentation and participant interview responses were stored in a secure location and destroyed after transcription was complete. Interpreting support was necessary for many participants to ensure all aspects of the research and consent were understood before participant signatures were collected.

Data analysis

The research team pre-identified three themes for the data analysis: *MHF training skills and takeaways*, *challenges to implementing MHF training*, and *recommendations from participants*. Within these categories, common themes were defined when identified by three or more participants. The themes were informed by the thematic methods described by Baluku (2014) and his work in the region. Once categories and themes were identified, interviews were analysed and responses were recorded according to each category (*skills and takeaways; challenges to implementing training; recommendations from participants)* and identified theme. For trustworthiness of data coding and interpretation, two primary investigators from the research team then re-analysed transcription data collaboratively to ensure responses were coded in the appropriate category. Differences of opinion, though uncommon, were mediated by extensive discussion and referral back to transcript data to reach consensus. Transcription data were also used to identify prominent mental health problems in the region, and reported causes of these problems as participants viewed them. These problems and reported causes were only included when identified by three or more participants.

Results and discussion

In general, all 19 participants in this research evaluation agreed that the MHF training was valuable and provided individual as well as community benefits. Additionally, no participants reported any negative side effects from the training within their communities. The interviews and subsequent data analysis revealed important information regarding mental health problems experienced in the region, as well as their reported causes. Table 2 contains a list of the noted problems and reported causes of mental health issues in the region.

MHF training skills and takeaways

Several themes emerged from the data related to training skills, benefits and takeaways from the training. These themes are presented in Table 3.

Guidance/communication skills

All of the participants reported gaining guidance and communication skills related to mental health from the MHF training. Specifically, participants consistently reported gaining the skills needed to speak with groups or individuals regarding mental health in their communities, as well as communication skills that allowed them to better communicate with individuals suffering from mental illness. In many countries where the MHF has been implemented the term and definition of counselling differ. With this in mind, the reader is encouraged to consider cultural and linguistic differences when reviewing qualitative comments in the article. Therefore, it should be noted in this theme and some subsequent themes that when participants mention gaining or using 'counselling' skills, they are specifically referring to communication and guidance skills, and are not claiming to have learned professional counselling skills.

Skills/education on causes of mental health problems

Most participants (78.9%) reported receiving education that contributed to greater understanding of the causes of mental health problems and how to prevent or avoid them. Participants commonly mentioned alcohol abuse, malnutrition, poverty, lack of money management skills, violence and abuse as particular contributors of mental health problems and mental illness in this region. Participants also reported receiving skills that allowed them to articulate this knowledge to their communities.

Raising awareness of mental health in communities

Participants commonly mentioned (78.9%) 'sensitisation' of mental health and mental illness within their communities after receiving the training. Sensitisation was understood as raising awareness of mental health concerns within their communities.

Referral skills

Sixty-eight per cent of MHF training participants mentioned obtaining the knowledge and skills required to refer individuals to appropriate professional resources, including the Kabale Regional Referral Hospital. Participants reported an increased ability to recognise mental health issues and mental illness, and reported gaining knowledge and skills on how to help others find sources of assistance.

Table 2: Reported regional mental health problems and reported causes*

Reported regional mental health problems	Quotation
Stress	*'The common one in the community is always stress, because once you have stress there is other problems.'* – Participant 4, primary school teacher *'At times you see somebody quiet and cannot talk, probably thinking he's doing his or her own thing, when mentally he's stressed or he has a problem.'* – Participant 5, primary school headmaster
Anxiety	*'Like for example, anxiety, he's quiet, not communicating with others, not sharing.'* – Participant 5, primary school headmaster *'But other mental disorders like the mania, the anxiety…we have to refer.'* – Participant 3, health centre II nurse
Depression (episodic and chronic)	*'She was having—we call it depression; I don't know whether you know it. Then we referred her to Kabale regional hospital and after one week she recovered.'* – Participant 1, hospitality staff *'Mental problems – they always you have in strains. We have these simple stresses, depression.'* – Participant 16, comprehensive health nurse
Suicide	*'…and sometimes they commit suicide…after doing the referral they had no money to go to town and then they committed suicide.'* – Participant 19, hospitality staff
Addiction (gambling, alcohol, drugs)	*'I met some challenges because some of them do not know they are addicted to drinking alcohol and when you tell them not to drink too much…they don't change completely.'* – Participant 10, primary school headmaster *'When we had a fellow around and he was almost losing his senses because of drug abuse…We had to take time and we [helped] him so that he should stop the habit.'* – Participant 11, deputy headmaster *'Alcohol. Here it is…worse, and more use. People are drunk. They end up in gambling and…they end up smoking, drinking alcohol.'* – Participant 16, comprehensive health nurse
Sleep disturbances/difficulties	*'Like if a patient came with sleepless nights, lacks concentration, I'm checking for diseases like malaria…Or someone is hearing funny voices, seeing funny things. Then we see this one is a mental case.'* – Participant 17, comprehensive health nurse
Mental illness	*'People around have a lot of problems and the problem[s] of mental health are many.'* – Participant 10, primary school headmaster *'The knowledge which I got there I use it in the community because in the community we've got many cases…of mental illness.'* – Participant 3, health centre II head nurse
Poverty/lack of basic resources	*'Like even here at school. When some students lack school fees because they are poor and the parents are not able to give them school fees in time and you find a child is crying.'* – Participant 14, vocational school director *'How can somebody get stress?…If somebody was a business man, then afterward he ran out of money [and] then from there he gets that stress. Then another thing, somebody can get stress [when] he comes from a poor family.'* – Participant 19, hospitality staff
Drugs/alcohol	*'Especially these young boys when they fail to go to school they resort to taking some drugs and these drugs enter into their brains and at the end of the day their brain is changed…They just depend on drinking this liquor and their minds have changed completely.'* – Participant 13, secondary school headmaster *'Yes, mental health [problems] in the community is on the increase…because if you check the causes alcohol is there and it very cheap...Because of poverty people are taking drugs in order to get sleep, and they end up becoming mental cases.'* – Participant 16, comprehensive health nurse
Malnutrition	*'Because there [are] some students who come without food. They don't pack meals, so they stay here without meals during their lunch time. So we try to counsel them that they should have…meals...If we don't eat, mentally we are losing much.'* – Participant 5, primary school headmaster
Disease	*'Causes of mental retardation? We have diseases, we have illness, poor feeding, which is malnutrition. It can be caused by diseases, by accidents.'* – Participant 12, primary school teacher *'We had…disease...In environment you have diseases, like meningitis.'* – Participant 17, comprehensive health nurse

Table 2: Reported regional mental health problems and reported causes* (cont.)

Reported regional mental health problems	Quotation
Violence (interpersonal, domestic, child abuse)	*'In the village you find the parents are abusing the children.'* – Participant 1, hospitality staff *'You find a man is fighting with a woman…Then if they are fighting you can advise them through according[ly].'* – Participant 18, hospitality staff *'He met the problem of…the youth, like the age of 20 and below…In the evening time they always like sit…they drink. They meet some people on the way and start punching them.'* – Participant 6, community chairperson
Traditional beliefs (e.g. men should drink, women should not attend school, etc.)	*'For us, traditional beliefs [are] that men should always drink. Drinking is a problem because it has caused stress in some individuals, especially family members. It has caused some family members to be poor. Children have not gone to school, because the money that has been obtained by someone has been spent on alcohol.'* – Participant 4, primary school teacher *'Most of the girls don't like education…Maybe they feel as if it's…for the boys.'* – Participant 15, hospitality staff
Genetics	*'Causes…are biological…like genetics, inheritance.'* – Participant 16, comprehensive health nurse
Accidents	*'…This is a lake, there are some people at times [who] tend to drown in the lake because of different problems.'* – Participant 15, hospitality staff

*Note: These are *reported* problems and there is not sufficient information to link reported problems to reported causes.

Table 3: MHF training programme skills and benefits

Skills and benefits	*n*	Per cent	Quotation
Guidance/communication skills	19	100%	*'The training was very beneficial in that when I guided those children the parents appreciated [it]...Now I have others, too, who I am trying to guide and counsel.'* – Participant 2, primary school teacher *'I acquired the skill of communicating with the people. At times you see somebody quiet and cannot talk, probably thinking he's doing his or her own thing, when mentally he's stressed or he has a problem. So from there I acquired the role of communicating and know what could be the problem.'* – Participant 5, primary school headmaster *'I can call it some good experience because…right now I can be able to know that this person is mentally disturbed. I've got all the skills for how I can counsel the person, himself or herself, and then the family which is affected.'* – Participant 17, comprehensive health nurse
Education/skills on mental health problems and causes	15	78.9%	*'I got much knowledge which I could use to manage my community and help it...so I can use that knowledge to help many people.'* – Participant 3, health centre II nurse *'We…educate [about] the dangers of alcohol and drugs...mainly prevention is the best way.'* – Participant 16, comprehensive health nurse *'…Mental health…in Uganda we are not taking it as serious as we can… But now we came to learn that it was a serious challenge.'* – Participant 14, vocational school director *'Yes, the community is benefitting. Because I can assess this one…[has]a mental problem. This one is another disease.'* – Participant 16, comprehensive health nurse
Raising awareness of mental health in communication/'sensitisation'	15	78.9%	*'Yeah, actually the training helped me because before that training my village wasn't good. They always had stress... But after the training we went back and taught them…Now they're okay. There's a big change in the village.'* – Participant 19, hospitality staff *'It has been going on for a long time, but we had not yet acquired the ability to sensitise the community to change…'* – Participant 11, deputy headmaster
Referral skills	13	68.4%	*'Those people were thinking that maybe they were bewitched, but when we …educated [them], they came to know their condition and we referred them to Makanga, to Kabale Hospital. They went there. They got treatment and now they have somehow improved.'* – Participant 3, health centre II nurse *'So we are doing it, we are conversing with people. We refer them for assistance with some experts of course.'* – Participant 5, primary school headmaster

Table 3: MHF training programme skills and benefits (cont.)

Skills and benefits	*n*	Per cent	Quotation
Personal benefits	8	42.1%	*'I used to beat my children…But now I have some words to tell him.'* – Participant 9, hospitality staff *'And it helps me. Because I have my relative who is mentally disturbed.'* – Participant 8, priest *'My children…used to go to the bars and came [home] during the night. When I told them what we learned, they changed.'* – Participant 10, primary school headmaster *'Even me personally, I realised in my day to day work I did not mind a lot about mentally sick patients...I would just deal…[with] the physical illness.'* – Participant 17, comprehensive health nurse
Reducing stigma and mistreatment of mentally ill	3	15.8%	*'I talk about it…to help them. Not to disturb or to beat them, not to kill them.'* – Participant 8, priest *'But now I normally tell people to stop that [beating a mentally ill person]. It is ill–advised. Please take the patient to the hospital.'* – Participant 9, hospitality staff *'Stigma is not much [now] because people were enlightened about the mental disorder conditions.'* – Participant 3, health centre II nurse

Personal benefits

Almost half of the participants (42.1%) reported personal benefits that they gained after attending the training. Some of these included the ability to better understand their own mental health concerns, as well as those of their families. Other benefits included obtaining knowledge and communication skills to avoid violence within their families and communities by using communication skills to resolve conflict.

Reducing stigma

Although stigma was not commonly mentioned, some participants (15.8%) reported gaining a better understanding of the causes of mental illness, which resulted in reduced violence and mistreatment of the mentally ill by community members.

Challenges to implementing MHF training

Poverty, access to transportation, access to medication, expectations, stigmas, and community perceptions were all challenges identified for training implementation. Table 4 lists the challenges identified by the community members in eight categories related to the implementation of skills and knowledge gained in the training, and in order of frequency.

Poverty/lack of basic resources

Over half of the participants (52.6%) noted the challenge of poverty on community health as well as the ability to manage and meet mental health problems and needs. First, poverty is understood by MHFs to pose a significant mental strain on community members. Specifically, lack of food was often mentioned as a significant barrier to learning and a leading cause of stress. Many participants commented that community members are either unconcerned with mental health issues or do not take them seriously due to unmet basic needs.

Lack of transportation

Transportation in many areas of Uganda presents a significant challenge to people who are seeking treatment, and to expanding awareness of mental health knowledge. Even if a referral by a MHF has occurred, individuals requiring other sources of assistance are often unable to seek additional treatment due to lack of transportation. Participants (47.4%) discussed transportation as a challenge.

Medication unavailable

Health workers and individuals from other professions (42.1%) acknowledged lack of affordable and available medication for mental illness as a significant challenge.

Incentive expectations from community

Twenty-six per cent of MHFs noted a challenge going into communities due to community expectations. Many participants reported that community members expect them to offer not just facilitation or referral support, but also tangible resources like money, food, and clothing, and when they are unable to do so, community members are less likely to receive or seek their help.

Traditional beliefs/witchcraft

One-fifth (21%) of participants mentioned traditional beliefs in witchcraft as posing a significant barrier to treatment and support of mental health issues. This belief causes many individuals to seek treatment from church, prayer, and traditional healers instead of health professionals. Additionally, a belief that they are bewitched causes some individuals not to seek treatment at all for fear of being labelled, mistreated or stigmatised by others.

Difficulty implementing behaviour changes

One-fifth of the participants (21%) mentioned difficulty in working with community members, particularly men, to understand and change their behaviour to support their mental health or avoid mental illness.

Stigma/negative beliefs toward mentally ill

Sixteen per cent of participants mentioned that stigma itself posed a challenge with implementing the MHF training skills in their community. Stigma and negative beliefs

Table 4: Challenges to implementing MHF training programme

Challenge	*n*	Per cent	Quotation
Poverty/lack of basic resources	10	52.6%	*'The challenges…That sometimes when you go to those villages… [you] find that they have a problem or maybe they don't have food for children…when you try to talk with them, they say, "No– we are talking but yet we don't have something to eat."'* – Participant 1, hospitality staff
Lack of transport	9	47.4%	*'But some of them…complain at times when they tell them to go back for a refill, they say they don't have transport.'* – Participant 3, health centre II nurse *'…there is a problem of transport. You find that someone is dying because of [lack of] transport.'* – Participant 19, hospitality staff *'The means of transport – going to the hospital is also a problem.'* – Participant 2, primary school teacher
Medication unavailable	8	42.1%	*'You see here, as a health centre II, those medications we don't have. We have a few for the epileptic clients. But…mental disorders like the mania, the anxiety, those ones we don't have. We have to refer. So in referring some clients…they don't go in time. When they go, they don't finish their dose as per described.'* – Participant 3, health centre II nurse *'Because when you go to the hospital they don't have the medicine for the mental health problems; they don't have that medicine. So, also, we need to follow up because if you take a mad person to the hospital it may just be pain killers [because] they don't have the medicine.'* – Participant 9, hospitality staff
Incentive expectations from community	5	26.3%	*'We have a problem of asking me something…—to give them. We want a dress. We want money. We want something. That's the problem that we met. They want something. They were asking something from me and…I didn't have that.'* – Participant 8, priest *'And to visit…the families you need something to go with for motivation... so if you go there and they remember I am [employed],…and that maybe [he] has something for me which I don't have..'* – Participant 9, hospitality staff *'When you try to visit such families which have mental problems and you begin addressing such issues related to mental health…they think probably you will be financial help to them.'* – Participant 17, comprehensive health nurse
Traditional beliefs/witchcraft	4	21.1%	*'Some of them…they say "these are ghost attacks." They don't know this is a mental disorder.'* – Participant 3, health centre II nurse *'People are telling them, [and] they believe these mentally retarded people are bewitched…They still think and attribute mental illness to witchcraft. That is actually a challenge.'* – Participant 2, primary school teacher
Difficulty implementing behaviour changes	4	21.1%	*'Challenges are there. Certainly when you try to advise someone they don't easily adapt. Some stick in their beliefs. So that one is a challenge because when you look at something and you try to advise someone in order to avoid it, they don't easily adjust themselves.'* – Participant 4, primary school teacher
Stigma/negative beliefs toward mentally ill	3	15.8%	*'When you find a mad person you just beat them.'* – Participant 9, hospitality staff *'And more so the other challenge I see in the community is still having stigma. They stigmatise the mentally sick patients…[and] they are denied the chance to interact with people freely because they are taken to be mentally disturbed people.'* – Participant 17, comprehensive health nurse
Facilitators not seen as qualified	3	15.8%	*'Challenges are definitely there because the community needs more sensitisation…When you open up such a topic they ignore [it be]cause they always believe in the qualified doctors, but for us we apply the ability of counselling."* – Participant 11, deputy headmaster *'With the challenges, since we got some just a bit of the training, at times you are not all that qualified to speak to such people. So…when you try to talk to those people, they challenge [you]. They say, "You are not educated in that." At times they challenge you and say, "We've seen you everyday. You've not gone to school to learn that course." It's very hard to tell someone at least I got that little bit of training and they accept [it].'* – Participant 15, hospitality staff

toward the mentally ill included the belief that mentally ill persons were 'bewitched', the fear that mentally ill persons could spread their illness to others, and the thinking that mentally ill persons do not deserve the same treatment as other community members, often resulting in violence and mistreatment. Stigma and negative beliefs toward the mentally ill were reported to be the result of lack of knowledge and awareness regarding the mentally ill.

Facilitators not seen as qualified
Sixteen per cent of participants noted challenges in being received as someone qualified to address mental health concerns within their communities. Participants noted challenges from community members including insufficient education in mental health, the view that only doctors are qualified to work with mental health issues, and an unwillingness to take advice from a fellow community member.

Recommendations from participants
Table 5 lists the possible best practices provided by those interviewed in order of frequency. These include more training and follow-up, creating community awareness, ongoing meetings, training expansion, resource support, curriculum changes and women's engagement.

More training and follow-up for MHFs
The majority of participants (73.7%) reported wanting additional training and follow-up. Participants commented on not only wanting a review of the skills and knowledge from the previous training, but gaining additional knowledge on new topics.

Create more community awareness of mental health
Thirty-two per cent of participants recommended involving the community and creating awareness around mental health issues. Recommendations included community workshops, seminars, guest speakers and media and advertising campaigns.

Create ongoing meetings for MHFs
Almost one-third of participants (32%) expressed interest in collaborating more often with their fellow MHFs. Some called for regular meetings to collaborate and share experiences, successes and challenges in implementing the MHF training.

Expand MHF to more communities and community members
In addition to wanting more training themselves, 26.3% of the participants remarked on the need for training more people and reaching more communities. Many participants expressed interest in expanding the MHF training to more communities in the Lake Bunyonyi area, as well as the greater Kabale region.

Provide transport, lunch, and/or allowance for MHFs to reach communities
In discussing the challenges with reaching and educating communities, many participants indicated a lack of funding. One-quarter of participants (26.3%) recommended an allowance for them to incorporate expenses for transport and meals.

Curriculum changes
Twenty-one per cent of respondents indicated a need for curriculum or course changes. Some participants noted a need for greater clarification on topic issues relevant to their particular communities, such as grief and loss. Additionally, some participants commented on the need to provide the training in the local language, Rukiga, to increase understanding of subject material.

Provide badges/vests/uniforms for MHFs
A few participants (15.8%) recommended that they be provided with a way to designate and identify themselves within their communities.

Establish local counselling centre/mental health clinic
Some participants (15.8%) commented on the need for a local counselling or health centre that would assist in addressing mental health issues as well as related challenges such as poverty, lack of transportation and unavailable medications.

Involve youth and women
Sixteen per cent of respondents recommended that youth and women be more involved in both training and in community awareness and education.

The World Health Organization speaks to the dearth of mental health services in Uganda (WHO, 2001; WHO & MoH, 2006). These first-hand accounts and interviews provide insight into the successes and challenges of the MHF training implementation and expansion, but also begin to respond to the gaps in services through the MHF programme. The following summary of successes, areas of improvement, and recommendations for future MHF training are based on these interviews and speak to some of the gaps identified by the World Health Organization in Uganda's approach to mental health services (WHO & MoH, 2006).

Best practices
The MHF training appears to be successful in several areas. First, it is clear that those trained in the MHF programme gained greater knowledge about mental health and mental illness, including the causes of mental health problems, and identifying those who need to be referred (WHO, 2001). Additionally, the MHF training contributed to an increase in individual and community awareness of mental health issues, and a subsequent decrease in stigma of mental illness, addressing some of the issues raised by Baluku (2014) in his initial research in the region. This awareness and education was largely due to the communication and facilitation skills the MHFs acquired during the training. All participants reported at least some benefits from the programme and many reported significant changes in their community because of the training. Specifically, a participant employed in hospitality services in the region reported: 'Actually the training helped me because before that training my village wasn't good. They always had stress…but after the training we went back and taught

Table 5: Recommendations for MHF training programme

Recommendation	*n*	Per cent	Quotation
More training and follow-up for MHFs	14	73.7%	*'The only thing I would just wish to get to is to continue having…refresher courses and training...It's kind of not worthwhile to have the information and [no] dissemination because you are limited.'* – Participant 14, vocational school director *'But on the other hand what I feel that should be done is the follow–up. Like we went there, we moved out of the workshop, so there should be follow–up. So the experts should continue doing some supervision and guiding.'* – Participant 5, primary school headmaster
Create more community awareness	6	31.6%	*'The best way to address the stigma is like any other medical condition... the way we've always addressed them, maybe in media, churches, schools...I think if it is done that way,… putting that information in media [and]also in newspapers, I think probably it would help fight stigma.'* – Participant 17, comprehensive health nurse
Create on-going meetings for MHFs	6	31.6%	*'Like if in a month they could all meet together and share the knowledge… Because you can share what you have covered in a month, what you are going to cover in a month, and bring in changes…innovations.'* – Participant 19, hospitality staff
Expand MHF to more communities/community members	5	26.3%	*'And when a new person comes in they say, "A new person has come and they are also telling us the same story." They can have some change. What can change is hav[ing] different people coming in to talk to these parents.'* – Participant 13, secondary school headmaster *'We train one, then they go and then they train another...We can select communities. They come and…after training those communities, we bring other communities so we can spread [it] everywhere.'* – Participant 9, hospitality staff
Provide transport, lunch, and/or allowance for MHFs to reach communities	5	26.3%	*'They always meet people…after the training [and] they could give them some…allowance…They go in the community, and they move around,…call the people,…meet them and teach them.'* – Participant 19, hospitality staff *'How can we finance the meetings, finance the workshops? But otherwise it is working. Even the transport costs...sometimes when you call a meeting, they need some allowance.'* – Participant 14, vocational school director
Curriculum/course changes	4	21.1%	*'Sometimes at the training there are some things you don't discuss all the time. When you are in the field, there are [other problems that happen]."* – Participant 13, secondary school headmaster *'Most of the people here don't understand English. We want some of the facilitators to speak in our local language so that we understand it more.'* – Participant 7, reverend
Provide badges/vests/uniforms for MHFs	3	15.8%	*'Uniform or let me say badge...to know that they are coming from the training....people from the congregation …need to see you [as] different.'* – Participant 8, priest *'If we are trained and have the vests, that would be the best way.'* – Participant 14, vocational school director
Establish local counselling centre/mental health clinic	3	15.8%	*'Because now I mobilise these people. We make like a community clinic. Then they come and we normally train them maybe weekly or monthly.'* – Participant 9, hospitality staff *'So if we could have some clinics around the lake, I think whenever somebody is stressed – has a problem [that person can] go to that clinic and be given some treatment.'* – Participant 10, primary school headmaster
Involve youth and women	3	15.8%	*'The other issue…is that some men don't take it as seriously as women and youth.'* – Participant 14, vocational school director *'We should also go in schools...we should sensitise the school children.'* – Participant 3, health centre II nurse *'The youth, the women representative, and another person. I think…three people, that would be good…Because you know with peer groups, when, like me I am talking to the young generation, they tend not to listen…But when they have their peer group, the concept goes very well.'* – Participant 5, primary school headmaster

them…now they're okay. There's a big change in the village.' Additionally, the skills and knowledge attained at the MHF training seem to be translating into action within the communities: 'What we learned we are putting in to practice,' commented one primary school headmaster. These skills and knowledge are a first step in changing perceptions of mental health in Uganda, although there is much more work to be done (Kavuma, 2010).

Recommendations for future training

It is essential that follow-up and additional training occur. Based on input from MHFs, it is recommended that some small allowance for MHFs be considered for implementation. To facilitate follow-up, it is recommended that the GLI and NBCC-I work with the community to install an MHF council. This council would create an environment of collaboration and continue the momentum established during training. This council should meet at least quarterly, if not monthly, so that those trained can exchange ideas and discuss successes and challenges. This forum could also facilitate the goals of NBCC-I to contribute towards developing community-based mental health services in under-served communities.

As a result of language barriers, it is recommended that all of the interview materials be translated into the local language for subsequent training and training evaluation. Furthermore, the MHF curriculum should be further examined for local cultural relevancy. The following areas could be further addressed in a more locally contextualised curriculum: addiction (drugs, alcohol, gambling), accidents/death and violence. These appear to be common themes related to the development of stress, anxiety, depression and grief that have clear negative impacts not only on individuals, but also on families and communities.

Finally, careful thought should be put into the composition of the trainees to ensure a diverse pool of participants that reflect the composition of the community. The majority of MHFs trained during the 2012 training were male. While key community stakeholders are usually male in this region due to cultural norms and traditional beliefs, it is imperative to intentionally engage women and youth in the discussion of mental health education, management and support so that the whole community benefits (WHO, 2001; Patel, Flisher, Hetrick & McGorry, 2007).

Limitations and future research

This study is based on a small group of MHF participants and warrants further research—both qualitative and quantitative—with other community members and mental health professionals in the region to better understand the impact of this mental health training programme. In addition, the interviews were conducted in English, and six of the participants required some interpreting support with two needing complete interpreting support. Training the interpreters for future research and transcribing all of the research questions for the semi-structured interviews into the local language would create some additional consistencies in the methodologies.

Although outside the scope of this evaluation, future projects may examine potential partnerships between health centres in isolated villages of Uganda and regional referral hospitals in effective ways of serving the mental health needs of the local community. This would potentially alleviate a number of concerns observed surrounding the care and treatment of community members with mental health issues.

Conclusion

With limited access to and availability of appropriate and adequate mental health care services, strategic community-based training can successfully provide community members with appropriate mental health communication skills, inform misperceptions of mental illness, and ultimately facilitate delivery and access to existing services. The aim of this study was to assess the Mental Health Facilitator training programme created by NBCC-I and delivered by the GLI in rural Uganda for best practices and limitations to inform future trainings. Through a series of semi-structured interviews, this evaluation provides important information about benefits, challenges, and recommendations for the MHF programme to inform future training in developing country settings.

Authors' notes

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