

# Mental Health in Uganda and Canada: A Descriptive Case Study of the Issue and Recommendations for Improved Mental Health

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## Abstract

Mental health is a crucial part of overall wellbeing. Canada's mental health system has progressed over the last decade but still has room for improvement. In comparison, developing countries, such as Uganda, have not shown the same progression with their mental health systems. The embedded experience, together with expert consultations in the field, were conducted over several months at a human immunodeficiency virus (HIV) specialized hospital, the Joint Clinical Research Center (JCRC) in Kampala, Uganda on the topic of mental health systems. The observations and consultations were thematically analyzed into four main themes: cultural attitudes towards mental illness, the interconnectedness of childhood HIV and mental health, a gap in education for mental health professionals to become certified, and barriers to addressment of mental health issues at the JCRC. The main barriers for Ugandans seeking professional treatment were also identified, which included the accessibility and availability of professional treatment. Local solutions are outlined, as well as recommendations for improvements and future research.

**Keywords:** mental health, Uganda, Canada, case study, global health

## Introduction

The mental health of an individual contributes to their overall wellbeing. Many scales have been developed to quantify that contribution (e.g., Prilleltensky et al., 2015; Linton et al., 2016); but, as wellbeing is a complicated construct, no firm proportion has been decided. Mental health is influenced by a number of factors. These include

environmental and life-stage stressors; socio-demographic status; and genetic, environmental, cultural and political factors, with a variety of importance ascribed to each over different life stages (Elovainio et al., 2000; Snachex-Lopez et al., 2008; Muntaner et al., 2015). Mental health in turn can affect financial status, physical health, relationships, job security and other life stresses, which can affect larger systems such as the economy by limiting individuals from

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making a stable income or contributing to community and national growth.

There are *connections* between an individual's mental health, their ability to contribute in a meaningful way to their local, regional and national economy, and the impact that economic development has on the environment (Majeed & Mumtaz, 2017). When communities are forced to rely on economies that are based in unsustainable resource extraction, community happiness plummets (*ibid*). This in turn impacts those in extractive and non-extractive jobs (Chen & Nakagawa, 2018). Thus, it is important to consider the barriers to individual health and wellbeing that may be impacting the larger community.

Here, we study the mental health issues in Uganda. This study was grounded in a phenomenological approach. Phenomenology involves examining a phenomenon through the lens of those experiencing the phenomenon and how they describe the experience (Dermot, 2000). In this study, the phenomenon is mental health care at a population scale as treated in networked health care centers focused on HIV. Mental health is examined through a combination of methods, including literature review and an embedded experience that enabled expert consultations and observations of local individuals. We connect observations of how developing nations are not yet positioned to respond to mental health crises nor develop a citizenry that has the capacity to pivot to new systems that are aligned with eliminating barriers to mental health services and education. Specifically, we (1) provide evidence from our observations of patients and practitioners about the barriers to improved mental health in Uganda; and (2) compare mental health contexts of developing (Uganda) and developed (Canada) nations to illustrate areas of divergence where developed countries could assist developing ones.

## Mental Health: A Literature Review

Mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2019). Mental health is a crucial aspect of overall human wellbeing as it is heavily correlated with physical health (Breland et al., 2013). For example, Okeke and Wagner (2014) conducted a study in Uganda specifically around human immunodeficiency virus (HIV) treatment and mental health. The researchers found that the prevalence of major and minor depression in a treatment group 12 months after starting antiretroviral therapy (ART) for HIV treatment had decreased 15 and 27 percent, respectively, in comparison to a group of patients who were HIV positive but had not started ART.

Taking care of one's mental health applies not only to those struggling with a mental illness but also to all

individuals. The number and types of mental illness are extensive, and the symptoms are diverse. Just like physical illness, the earlier the recognition of a problem, diagnosis and start of treatment, the more likely a positive outcome (Shonkoff & Phillips, 2000). Due to the relationship between physical health and mental health, it is important to support both areas when dealing with any type of illness.

Past research has found that physical activity is effective in preventing and treating depression (Conn, 2010; Rethorst et al., 2009). Chronic illnesses often need changes to lifestyles, and life-long mental and emotional support along with medical support, to be transformative. Mental illness, such as depression, is comorbid among chronic illnesses, such as heart disease and chronic obstructive pulmonary disease (COPD). It is found in adolescents with HIV, but commonly goes undiagnosed or not properly treated (Brown et al., 2007; Kemigisha, 2018; Putman-Casdorph & McCrone, 2009; Rutledge et al., 2006). Changes in local environments brought on by climate change can lead to challenges in maintaining both physical and mental health.

Disasters such as fires and floods lead to higher population rates of depression, anxiety, and post-traumatic stress disorder (Goldmann & Galea, 2014). Displaced people have a higher relative risk of grief and mental distress (Clayton et al., 2015). To confound this connection, those with existing mental health challenges are more susceptible to climate-related exposures (Shukla, 2013; Brandl et al., 2018). These findings suggest that planetary health may be important in forecasting mental health effects that a human population may face given anticipated climate change impacts. Next, we explore the context of this work and how environmental exposures in the study site lead to higher rates of mental illness.

## Uganda's Extraction-Based Economy

Uganda is a country in east-central Africa with a population of approximately 42 million people living in an area of 241 thousand square kilometres and a growing export trade economy with untapped reserves of oil and natural gas. The average life expectancy in Uganda is about 53 years, though high rates of infant mortality and disease outbreaks (Ebola, HIV) alongside previous wars, poverty and inconsistent foreign aid mean that fluctuations in the life expectancy occur (Ofcansky, 2018). More recently, the pressures of climate change in Uganda have meant that there is less available water overall (Kingston & Taylor 2010); for example, there is less water for cropping, and a resulting change in crops being grown (Okanya et al., 2013). An inability to continue farming at family, local, and regional scales, has resulted in an increase of climate migrants from rural areas to urban centers, and the urban poor facing higher rates of disease, including the human

immunodeficiency virus (HIV), tuberculosis, and malaria (McQuaid et al., 2018).

There are multiple life struggles in Uganda, one of which is HIV. HIV risks are heightened, particularly for rural populations and urban migrants (Chan, 2015). In the developing world, health care workers at a distributed network of hospitals supported by several World Health Organization (WHO) initiatives serve as frontline workers in treating HIV and implementing campaigns to reduce stigma against seeking HIV treatment. One such place is the Joint Clinical Research Centre (JCRC); a research institute and hospital in Kampala, Uganda that addresses HIV illness through testing, treatment, research, and clinical trials. All testing, treatment, and drugs are free for patients. The hospital supports all aspects of health relating to HIV and plays a crucial role in creating a healthier community and continuing to reduce adverse effects of the epidemic. The JCRC served as the primary site for the case study in this research.

Here, we address the issues that are faced when seeking professional treatment for mental illness and, as aforementioned, the importance of supporting mental health when treating chronic illnesses such as HIV. This case study focuses on service providers and patients at JCRC who are struggling with mental health.

## Mental Illness in Canada

As a comparison, we sought to discover more about mental health issues in Canada. Canada is a developed country with a population of about 38 million people ranked among the top in the world for quality of life (OECD Better Life Index, 2019). Canada is not without climate change issues; in 2018, millions of Canadians were affected by wildfires, power outages, tornadoes, floods and heatwaves (Vogel, 2019).

One in five Canadians experiences a mental health issue or illness in any given year (Canadian Mental Health Association [CMHA], 2020). Canada's mental health system may be seen as progressive in comparison to other countries; that is, throughout Canada, mental health aspects are incorporated and supported in hospitals, which have in- and outpatient psychiatric departments, as well as support for mental health offered in post-secondary education institutes in many forms (Goldner et al., 2016). For example, the University of Saskatchewan has the University of Saskatchewan Psychology Clinic (USPC), which offers professional counselling services from clinical psychology graduate students (supervised by registered psychologists). Canada has also attempted to reduce the stigma around mental illness (PHAC, 2016). Education is a key factor to decreasing stigma, and understanding what mental illness is and how it manifests. Psychology courses and degrees are offered at both the undergraduate and graduate levels at almost all Universities across Canada (Canadian

Psychological Association, n.d.). There are also multiple campaigns to help end the stigma and encourage people to reach out for help without feeling shame, guilt, or embarrassment. In summary, the mental health care and educational systems are perceived to be advanced in comparison to other national systems.

Another aspect that reflects the advantages of Canada's mental health system is the movement towards technology for mental health support (Hatcher et al., 2014). This shift to e-mental health, for example, the mobile app BetterHelp, is helping those who cannot necessarily access in-person conventional support therapies, such as individuals who live in rural areas (Chiauszi & Newell, 2019). A challenge that remains is making more accessible and cost-effective support therapies that are culturally appropriate for the growing Indigenous and minority populations in Canada (Maar et al., 2009). In developing world countries, however, where poverty is high, many individuals may not have access to smartphones, computers, or the internet to gain access to these services. Where these services exist, accessing online mental health information is not a priority; that is, there are competing immediate needs that are prioritized ahead of mental health (Olok et al., 2015). This digital divide also applies in northern rural and remote communities in Canada (Jones et al., 2017; Hobson et al. 2019).

One of the concerns with the current mental health system in Canada, however, is access and cost. The wait lists are perceived as lengthy for initial access to mental health care providers and psychiatrists, and the costs of inpatient treatment are out of reach for many lower socioeconomic families with no benefits, which research shows is a population with higher reports of mental illness (Canadian Institute for Health Information, 2009). The costs of inpatient treatment may also be out of reach for families with and without benefits, as treatments may be required over a period of years, and benefits are typically short-term and limited in scope. There is also the issue of low access for rural communities who would need resources to travel to a city where there are psychologists and psychiatrists.

## Mental Illness in Uganda

Mental illness is commonly misunderstood in Uganda, and therefore it is frequently undiagnosed and untreated. Mental illness can manifest in physical symptoms with only these physical symptoms being treated as doctors may be unaware of underlying psychological issues (Okello & Neema, 2007). Mental illness is also overlooked due to the health care system's emphasis on physical diseases. HIV prevention methods do not commonly include mental health aspects. A study done by Lundberg et al. (2011), however, found that poor mental health is associated with risky sexual behaviours in lower-income African settings. Lundberg et al.

(2011) suggest that HIV preventative measures should consider including mental health components.

According to a practicing clinical psychologist at Mulago Hospital in Kampala, the most common mental illness treated is depression (JCRC 02, personal communication, 13/06/2019). Although the hospital treats many patients who have depression on its own, it is also comorbid with chronic illnesses such as HIV, cancer, or diabetes. Over one-third of the population in Uganda is affected by mental illness with depression being one of the most common; however, not even half of these individuals seek professional help (Bailey, 2014; Murray et al., 2015). This exemplifies Uganda's need to keep improving and emphasizing its mental health care system on a national scale. It also exemplifies a need to reduce other stresses such as water shortages, and the lack of rural employment opportunities, which lead to urban migration. Accessing treatment for mental illness in Uganda, however, is no easy task as there are multiple barriers citizens face when seeking help. Reported barriers include cultural beliefs, stigma, and the limited availability and accessibility of professional help (Kisa et al. 2016).

Thus, in this study, we sought to investigate the current state of mental health care provision in JCRC during a Queen Elizabeth Scholarship project in Uganda. We sought to find similarities between the Ugandan and Canadian systems for provision of mental health support and similarities. Next, we describe the approach and methods used to gather information for this work.

## Methodology and Methods

The project took place within a Queen Elizabeth Scholarship program, focused on planetary health, in Uganda with the fieldwork placement lasting 90 days in the summer of 2019. While working at the Joint Clinical Research Centre (JCRC), the first author observed and talked openly with local counselling students and staff. She also visited the mental health ward at Mulago Hospital in Kampala and met with a clinical psychologist for an expert consultation in the field to get a more specific view of the struggles facing Ugandans when seeking help for mental illness. The first author also ventured out of her area of expertise and completed lab safety training, shadowed in radiology, and attended education presentations on new HIV research, medication, and clinical trials. Because JCRC is an HIV-specialized hospital, she also focused on the link between mental and physical illnesses and how mental health support should be added to the treatment of chronic illnesses like HIV. She made recommendations for JCRC to consider to help improve the support of their patients' overall wellbeing.

## Methods

We conducted a descriptive case study method. A case study is defined as "an intensive study of a single unit for the purpose of understanding a larger class of (similar) units" (Gerring, 2004, p. 342). More specifically, a descriptive case study does not make any causal statements about relationships but rather "asserts that the unit under study (A) is like, or unlike, similar units (B and C)" (Gerring, 2004, p. 347). In the current study, the unit under study (A) is the mental health system in Uganda that will be compared to the similar unit (B) that is the mental health system in Canada. The observations of the mental health system in Uganda will be analyzed and then assessed for similarities and dissimilarities to the mental health system in Canada.

## Information Collection

The information was collected using three different tools. Information was collected via online literature reviewing for background information on the mental health system in Uganda. Information was also collected by taking notes during expert consultations on-site at JCRC, off-site at Mulago Hospital, and through direct observations with the staff and student counsellors within JCRC.

## Information Analysis

Thematic coding was used to analyze the literature review information, observations, and field expert consultation notes gathered in Uganda to gain insight into the consistent key themes that surface regarding mental health in Uganda. Thematic analysis is used to identify, analyze, and report common themes within data (Braun & Clarke, 2006). Braun and Clarke (2006) outline six phases of thematic analysis; familiarizing yourself with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. We next report the results by theme with support from literature, expert consultations from the field, and observational data. The information gathered in Uganda was reviewed by the researcher team thoroughly and multiple times. Each information source was given a confidential code. The information was separated into categories regarding which information source it was from (i.e. observational or expert consultations in the field). The information was then further analyzed for observations and given information that held similar themes. The main themes were then defined, labelled, and structured into the tables that are presented in the results.

## Results

The primary results are presented in tabular format by theme preceded by results from literature reviewing in paragraph form. Tables provide paraphrased expert

consultation information, researcher notes from observation, and insights generated during thematic analyses. The sample included six main contributors, as well as the notes taken during fieldwork. Expert consultations in the field were done with one specialist (clinical psychologist), three counsellors, and one local student. One Canadian student from the Global Health Systems in Africa program at Western University also shared insights on her experiences over a longer period in the same hospital to triangulate the case study information. Approximately 250 hours were spent on-site (at JCRC) conducting observational studies and interacting with the six professional staff who are each described by an anonymous consultation code in the tables.

There were four main themes identified within the observations and three main barriers for individuals seeking treatment. The main themes were the interconnectedness of childhood HIV and mental health, a gap in education for mental health, cultural aspects of mental illness in Uganda, and addressment of mental health issues at JCRC. The three

main barrier subthemes for the last theme were cultural views and beliefs regarding mental illness, stigma, and accessibility and availability of professional treatment. This project was reviewed by the University of Saskatchewan and Western University behavioural ethics committees and the Government of Uganda research ethical committee and was given ethics exemption (USASK BEH ID 1218).

### Theme 1: The Interconnectedness of Childhood HIV Status and Mental Health

The research on childhood HIV status reported that children and youth with HIV experience higher than average rates of emotional and behavioural struggles, psychiatric disorders, and increased social stigmatization (Mellins & Malee, 2013). High rates of family violence, poor treatment adherence, and depression have been reported for populations in African nations (Denison et al., 2015; Kim et al., 2015; Johnson et al., 2015; Ramaiya et al., 2016). Expert

**Table 1:** Evidence of HIV status and mental health effects in children and adolescent.

Source of Information	Information Exemplars (followed by source acronym)
Expert Consultations in the Field	<p>Disclosure to children and partners [of HIV] is one of the biggest problems (JCRC-01)</p> <p>Parents don't want to tell their children they were born with HIV...this can cause major psychological trauma for the kids (JCRC-01)</p> <p>Counsellors report to the psychologist that it is easier for children to cope and adapt when they know at a younger age rather than later (JCRC-01)</p> <p>Psychologist reports that children who find out their status on their own suffer the most (suicide being common) (JCRC-01)</p> <p>Counsellors work with women to tell their children (JCRC-01)</p> <p>The psychological aspect of parents telling their children to keep their status a secret is instilled at a young age and is a huge issue (JCRC-01) which causes young adults not to disclose their status to their partners and thereby increases spread of HIV (JCRC-01)</p> <p>Mothers disclosing to their child is reported as the most difficult psychological aspect. Parents fear that the child will blame them (JCRC-01)</p>
Observations and field notes (with dates of notes).	<p>Observed interactions with a mother and adopted child who is HIV positive, now 12 years of age (8 is usually the age recommended to tell child). Child was suspecting/ asking about the drugs she takes. Observed multiple emotions in the child: betrayal because she felt her mom was lying, fear of what disease she was taking the drugs for, and difficulty trusting the counsellor (12/06/2019).</p> <p>Another child (12 years) knew her specific drugs by heart but didn't know her status. She suspected though, but didn't know how serious these drugs were for survival and therefore did not adhere to them properly (i.e. same time every day). This causes treatment resistance and the need to switch to secondary drugs. Child reported not knowing she was adopted (12/06/2019).</p> <p>Parents were observed telling their children they are taking drugs for another disease (cancer, heart disease) (12/06/2019).</p> <p>Parents also told their children not to tell anyone about the medication (12/06/2019)</p>

consultations in the field and immersive experiences confirm these findings in the study case site, as indicated in Table 1.

These observations are verified by government reports indicating approximately 25,000 new cases of HIV in children are diagnosed every year, with only 8% accessing treatment in the form of antiretroviral therapy (Ministry of Health, Uganda, 2010). Barriers to accessing care include parents and caretakers reporting that they opt not to tell the child their health status, or only tell them after an incident that requires that they do. Other barriers include caretakers not knowing where to access care, heeding advice of religious leaders to not access care because of stigma, and the overall cost of care needs (travel, food, medications) (Ministry of Health, Uganda, 2010; Bergmann et al. 2017).

### Theme 2: A Gap in Education on Mental Health Issues in Uganda

Murray et al. (2015) state that "In Uganda, mental illness is oftentimes understood in the context of Indigenous, religious, biomedical, and social explanatory models" (Quinn & Knifton, 2014, p. 555). "As such, discrimination occurs related to a lack of awareness and knowledge" (Murray et al., 2015, p. 1). There is a lack of education at the community level about mental illness to those affected, which means those who do not have a mental illness are also lacking the basic education to understand what it is and how it is treated (Cooper et al., 2010). Evidence from the immersive experience in Uganda provide support to these findings and can be found in Table 2.

The information shared above is verifiable against recent Ministry of Health documents indicating that while

the mission of the Ministry is to "To provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels" (Ministerial Policy statement, 2018/2019), the budget compliance records for the government indicate performing at only 51.2% compliance on health spending allocations, with key failures including the promotion of services for mental health and neurological diseases, as well as funding training institutions that focus on public health, community-based interventions, and psychological services (The National Planning Authority, 2020).

### Theme 3: Culture Aspects of Mental Illness within Uganda

Culture is a complex construct. Culture can be defined in numerous different ways, from a reductionist approach to broad definitions exploring patterns of behaviour across the globe. It can, and has been, described as a repeated cultivation of crops, to a group developing shared values, language, and knowledge systems (Kirmayer, 2018). The information collected in the field during the immersive experience exposed one aspect of culture specifically affecting treatment for mental illness, which aligned with published beliefs regarding mental illness in Uganda as well as other African countries. Murray et al. (2015) reviewed the cultural factors in Uganda that affect the treatment of mental illness, including the state of poverty as well as the infrastructure of mental health within the overall health system. One of which was the misunderstanding of

**Table 2:** Evidence of educational gaps of mental illness in Uganda

Source of Information	Information Exemplars (followed by source acronym)
Expert Consultations in the Field	<p>Social sciences were reported as being <u>not</u> as big a priority in education (JCRC-03)</p> <p>There is the perception that the president is not as strong a supporter of counselling and support services as post-secondary fields (JCRC-03)</p> <p>There is the belief that medical/natural sciences are higher priorities than social sciences and humanities because of perceived needed expertise and labourers in Uganda (JCRC-03)</p> <p>Professional counsellors struggle with traditional counsellors (i.e., there is no national accreditation body so anyone can 'counsel' in Uganda) which leads to a lack of evidence-based counseling in communities with no access to professional services (JCRC-02)</p> <p>A mental health professional mentioned that it is difficult for her to treat patients over the long-term due to being overworked with too many patients that need to be initially screened (JCRC-02)</p> <p>A gap in psychology in tertiary education contributes to the shortage of individuals going to school to become mental health professionals (JCRC-02)</p>
Observations and field notes (with dates of notes).	Professional counsellors do not report having, nor needing nearly as much training to do therapy as in Canada. (13/06/2019)

**Table 3:** Evidence of cultural factors regarding mental illness

Source of Information	Information Exemplars (followed by source acronym)
Expert Consultations in the Field.	<p>Bewitchment beliefs regarding mental illness and their popularity as theories of causes of mental illness abound in Uganda (JCRC-03). The psychologist reinforced those claims (JRCR-01).</p> <p>Very few students are enrolled in the university in Kampala for social work (JRCR-03). Those enrolled can only do so at the Masters level, which presents barriers to creating enough mental health practitioners (JRCR-03)</p> <p>Very few hospitals can provide needed internships so that students can obtain a Masters in Psychology (JCRC-03)</p> <p>It was common for families to abandon a family member with mental illness due to the fear of “catching” the illness or to get away from the bad spirits (JCRC-04)</p> <p>Traditionally, people in Uganda are taught to keep their problems to themselves and within their family (JCRC-03). The researcher observed that it is:</p> <ul style="list-style-type: none"> <li>• Not very accepted to talk to strangers or even friends/colleagues about issues they are having (JCRC-03)</li> <li>• A contact from the field hospital described how people from the researchers’ country [Canada] work too much and too hard compared to Uganda and usually burn out. They told the researcher to try and relax and not try to work 24/7 (JCRC-03). Overwork is described as a cause of mental illness.</li> </ul>
Observations and field notes (with dates of notes).	<p>A local counsellor was observed to tell a patient that depression is the devil pulling her down and to trust the Lord will fill the emptiness (JCRC-06).</p> <p>Mental illness is commonly described as witchcraft (13/06/2019)</p> <p>Researcher insight that even at case study site, harmful perceptions were not addressed adequately (14/06/2019)</p> <p>Counsellors indicated that cultural barriers are very hard to overcome. The mannerisms and the way they [patients] express different emotions outwardly are extremely different than in Canada. Facial expressions are different. (17/06/2019)</p> <p>People tend to laugh as a reaction/dealing with others personal/sensitive issues and downplay the seriousness of mental illness (27/06/2019). A colleague explained that it may be a culturally-bound sign of helplessness.</p> <p>People seem to be more patient with their own health struggles in Uganda which may contribute to lower anxiety rates than in Canada (19/06/2019)</p> <p>Due to the amount of money allocated to the mental health system [less than 1%], the environment of the mental health ward at Mulago hospital were not the same as Westernized standards with cleanliness, space, and overall conditions (02/07/2019)</p>

what causes mental illnesses, “Families are quick to relegate the ill to the realm of evil spirits, witchcraft, or ancestral spirits, rather than address the underlying medical condition” (Murray et al., 2015, p.1). These findings were confirmed via the expert consultations in the field and observational information in Table 3.

Cultural nuances in the perception of and treatment for mental health conditions are noted by Ministry of Health documents, for example, HIV communication strategies note that fear of stigma is a barrier to seeking treatment, and to parents and caretakers continuing treatment for children (Ministry of Health, 2010; WHO, 2015). It has also been noted by the Ugandan Ministry of Health that they are aware of drug fatigue and the perception that continuing treatment is not worth the effort since ultimately, HIV sufferers will die earlier (Ministry of Health, 2017).

#### Theme 4: Addressment of Mental Health Issues at JCRC

The theme of how mental health and mental illness is addressed at JCRC suggests how the larger systematic issues in the mental health system affect patients’ mental health support at hospitals. Because JCRC is specialized towards HIV, there was very little direct mental health support for the patients. Evidence for this lack of support is outlined in Table 4.

#### Barriers to Treatment of Mental Illness in Uganda

Three main barriers that individuals face when seeking treatment for mental illness included: cultural views/beliefs regarding mental illness, stigma, and the lack

**Table 4:** Evidence of how mental health is addressed at JCRC

Source of Information	Information Exemplars (followed by source acronym)
Expert Consultations in the Field.	<p>Initiation of a curriculum in mental illness was started in 2019 in JCRC aiming to address stigma and increase knowledge around mental illness (JCRC-05)</p> <p>Experts have reported that there are many complex mental health issues, but they do not track if or how they are being addressed at the hospital, which is frustrating for the experts (JCRC-01, JCRC-03, JCRC-04)</p>
Observations and field notes (with dates of notes).	<p>Counselling sessions with patients had the aim of checking in to make sure patients are adhering to drugs, not checking in on personal and mental wellbeing or the development of coping strategies (14/06/2019)</p> <p>Some practitioners discussed mental illness/mental health but only some patients and cases respond positively to that discussion (14/06/2019)</p> <ul style="list-style-type: none"> <li>• Patient advice still focuses on drug adherence not mental health, if mental health is mentioned at all.</li> </ul> <p>There were life challenges that patients faced that meant they could lose access to care, for example, a patient returned to JCRC who defaulted on her medication routine because her son was imprisoned near the South Sudan border. She went there to help him and forgot her drugs for the three weeks she was there (14/06/2019)</p> <ul style="list-style-type: none"> <li>• The counsellor reminded her to take her drugs, what time, and the importance of it but did not address the family issues and the impact of that on the patient's mental wellbeing</li> </ul> <p>It was noticed that health issues from HIV are addressed primarily, but very little focus on other mental health concerns are discussed (17/06/2019)</p> <p>The counsellors focus on present challenges, not addressing the past or future unless there is an obvious problem such as drug shortages (19/06/2019)</p> <p>Insight: maybe the issue [regarding little addressment of mental health issues] is that they do not have the tools and foundational education for counselling on mental illness/mental health issues (17/06/2019)</p> <p>Insight: perhaps there is a discomfort or cultural barrier with discussing social issues [in counselling sessions] that affect their mental health (14/06/2019)</p>

of availability and accessibility of professional treatment. These barriers are in line with the main themes from the literature and the Ministry guidelines about cultural factors in Uganda regarding mental illness, which contribute to inadequate treatment. The gap in education around mental illness contributes to the limited accessibility and availability of treatment. These barriers will be discussed further in the discussion.

### Mental Health Provision at the JCRC

The JCRC provides medical counselling for their patients, in which they receive pre- and post-testing counselling, are given the results of their test, and informed on how to properly adhere to the medication. If the patient displays emotional distress, they are allowed four appointments to manage this distress. The JCRC has limited

resources for treatment of mental illness; however, two innovations help offset the problem associated with limited resources: the use of *peer supporters* and *expert patients* to provide emotional support for patients who are HIV positive. The peer supporters are young patients who were born with HIV and work in the pediatric clinic to help kids and adolescents who are in the same situation. These volunteers are courageous to share their stories despite the stigma, and help others feel that they are not alone. Expert patients are older than the peer supporters and volunteer in the adult clinic. These are individuals who have had long, difficult journeys with HIV and provide the same support for adults as the peer supporters provide for other kids. The expert patients give health presentations and openly share their stories with patients who may feel isolated, alone, and



scared. Many of the expert patients have extraordinary stories that are truly inspiring.

The thematic analysis identified four main findings; the interconnectedness of childhood HIV and mental health, a gap in education for mental health, cultural aspects of mental illness, and appropriate focus on needs of those suffering from mental illness at JCRC. Two of these themes – a *gap in education* for mental health and the *cultural aspects* of mental illness – exemplify larger-scale issues within the mental health system in Uganda. The other two themes – *HIV and child mental health* and *addressment of mental health issues* within adult counselling at JCRC – suggest how those larger systematic issues directly affect the mental health care of patients at hospitals, such as JCRC.

## Discussion

This case study focused on examining barriers to mental health treatment in Uganda and a look at similarities to mental health services in Canada and Uganda. Mental health care systems in Canada have progressed but still have many areas that need improvement (Goldner et al., 2016; Kilbourne et al., 2018). Although Canada still has gaps in its mental health system, it continues to make small advancements. In comparison, developing countries such as Uganda still face acute resourcing and cultural barriers when it comes to individuals getting appropriate mental health care. Stigma about mental health still exists in Canada but not to such a sweeping degree. This has been noted as being driven by a more systematic campaign from government and leadership (as defined as a movement to solidify shared beliefs, meanings, and ways of thinking around mental illness) (Bartram, 2017). Global communication and aid in proper information dissemination within Uganda could bring the stigma levels in Canada and Uganda to a comparable level in the future.

Existing research on mental health in Canada was compared to observations and literature on mental health in Uganda. The comparisons suggest that similarities exist between the countries and include under-resourcing, stigma, and inadequate trained mental health providers for the number of patients. The differences included the availability and accessibility of treatment (i.e., emergency treatment is available in Canada but not Uganda) and the amount/type and the magnitude and extent of stigma. These differences are notable, but could bring the countries together, and that is where the importance of global communication comes in. Enabling countries to help each other promote mental health cross-culturally could help create healthier communities that are better prepared to address larger issues at a global scale. Planetary health practitioners and researchers could help identify how leaders and policymakers can re-imagine causative factors of mental illness and help policy makers prioritize mental health

provision. For example, the theme of children and HIV mental health issues is relevant for those assigned with duties related to environmental management, as risk of HIV increases with climate-related migration and changes in national economies (Martin, 2017). Provision of educational programs in mental health in universities would increase accessibility for patients; however, this would require acceptance of the field of psychology across political and cultural landscapes (Watts & Shuttleworth-Edwards, 2017). The academic literature outlined some barriers that patients at JCRC face to get mental health support but also outlined the societal challenges that JCRC may face when starting to incorporate more mental health support into their philosophy.

All of the main themes identified through the thematic analysis suggest that larger issues in Uganda, as well as other developing countries, are acting as barriers to their systems of providing mental health care to citizens. The challenges to the emergence of a more developed mental health system include a lack of available resources, lack of educational opportunities in the psychological field, and the prioritization of the established health system within Uganda to treat physical ailments. Taking all of the main themes into account, the key barriers for individuals seeking mental health treatment include cultural views and beliefs regarding mental illness; stigma; and accessibility and availability of professional treatment.

## Common Barriers for the Treatment of Mental Illness in Uganda

### *Cultural views and beliefs regarding mental illness*

In Uganda, the collectivist culture is in contrast to more individualistic western countries. The cultural difference manifests in the ways people cope with mental illness; for example, a focus on family and community instead of the individual means that discussing individual problems, such as mental illness, is stigmatized because it may imply that the community has failed the individual (Papadopoulos et al., 2013). However, when dealing with mental illness or highly sensitive issues, family support, although extremely important, may not be sufficient.

In Uganda, there is a readily accepted belief that mental illness is caused by evils spirits, witchcraft, or ancestral spirits held by rural and less educated, and a portion of urban more educated populations (Murray et al., 2015). This belief creates one of the largest barriers for those who need psychological treatment. These beliefs were witnessed through observations and conversations with staff at the hospital and supported via past research (Adewuya & Makanjuola, 2009; Murray et al., 2015) and the statements from the clinical psychologist (JCRC-02). The psychologist informed me that due to this belief, many people who show symptoms of a mental illness often go to

church for treatment, or to local naturalistic healers before seeking professional help as a last resort. The psychologist also confirmed the observations that these beliefs are also present in some educated populations and mentioned it is common for medical personnel to not associate with the psychologists in fear that they will “catch” a mental illness or that they will be seen with a psychologist and people will assume they are sick.

Such beliefs were once popular in Canadian psychological history but have long since been debunked by science and through education. A study done by Adewuya & Makanjuola (2009) provides evidence that these beliefs are not isolated to Uganda but are also prevalent in other African countries. The researchers used a sample from Southwestern Nigeria to find out their preferential treatment for mental illness. 41% of participants chose spiritual healers, 30% endorsed traditional healers, with only 29% of individuals preferring hospitals and western medicine (Adewuya & Makanjuola, 2009). However, because these beliefs are dominant in cultural and religious practices in Uganda, it may prove challenging to change this way of thinking. These beliefs contribute to patients not only seeking inappropriate treatment but to reinforcing social stigma against practitioners. A concern that arises from the persistence of these beliefs is that as more people become environmental, economic, climate, or political migrants, they will not access care in countries where it could be of benefit to them (Mistri & Das, 2020; Stites, 2020).

### *Stigma*

Canada and other western countries have come a long way in decreasing the stigma around mental illness. In Uganda, however, evidence shows that a common challenge of individuals experiencing mental illness is an inability to seek treatment because of stigma (Corrigan & Watson, 2002; Goldner et al., 2016). This stigma ties back into the main theme of the gap in education regarding mental illness that resulted from the observations and expert consultations in the field. One of the areas Canada has invested in to decrease the stigma is educating the public on what mental illness is, the causes, and treatment for it with media campaigns and other means of publicizing mental health. Even if an individual in Uganda seeks assistance, there is also the issue of availability and the prioritization of resources.

### *Accessibility and availability of professional treatment*

The availability of professional treatment is a significant issue for the mental health system in Uganda, especially with a population of over 44 million (World Population Review, 2019). There is a shortage of psychological professionals in Uganda. In conversation with a psychologist, it was explained that a rough estimate of only 16 psychiatrists and 40 clinical psychologists are in Uganda. Environmental scanning revealed approximately 28

psychiatrists (Quinn & Knifton, 2014) and five practicing clinical psychologists (Hall, 2013) in Uganda. Both estimates are troubling for a country with such a high population. This shortage creates not only the lack of accessibility due to over-worked professionals, but also creates a lack of mentors and instructors for educational programming, and a need for individuals to use extra resources to travel to the nearest practicing psychologist for help.

The government of Uganda has been criticized for contributing to poor mental health outcomes in two ways. The first was their reliance on climate change-contributing economies, which leads to migration to urban centers and exposure to greater health threats (Cooper et al., 2010; 2020). The second is in the governments’ emphasizing of natural sciences and economic development studies over social and medical sciences. Psychology course options are not offered at many universities and are not encouraged as a priority by government agencies, and less than 1% of the country’s annual health budget is currently devoted to the mental health system (Kigozi et al., 2011; Murray et al., 2015). The latter, however, may be due to necessity prioritization in which resources are allocated to other needed areas, such as economic growth and development of the country, over mental health. Normalizing mental illness throughout the population may aid in pushing the government to add more educational opportunities within psychology and deploy more resources into the mental health system. A possible issue with this, however, is if there is enough student interest to sustain added courses in psychology. In comparison, the Canadian education system offers psychology programs at multiple universities as undergraduate classes, degree programs, and graduate programs. Psychology is also offered at the high school level. The government of Canada allocates 7% of health spending on direct mental health services seven times that of Uganda, yet Canada is still struggling with meeting needs (Canadian Institute for Health Information, 2009; Bartram, 2017). Even just a basic level of knowledge can contribute to a better understanding of mental health and how important it is, which students in Uganda are currently not getting unless they go to a specific university that offers psychology courses or go to graduate school. Other contextual unknowns include whether there have been attempts to incorporate psychology into medical programs, or whether the differences between the two nations in this paper are accounted for by a greater need for these services due to pressures not yet existing in Canada, or prioritized, as in Uganda.

### *Locally Based Solutions*

Multiple barriers faced by people with mental illness create a necessity for reviewing and recommending changes to mental health systems so that patients receive the treatment they need. Multiple avenues can be approached

to improve the mental health support in Uganda. With mental illnesses such as depression commonly comorbid with a chronic illness like HIV, it is recommended that JCRC, and the Ugandan health system overall incorporate more extensive means for supporting mental health. One solution is an initiative created to improve education on mental health put in place by students involved in programming such as planetary health through the Queen Elizabeth Scholarship program in 2020. For example, Shelby Rabb, a Global Health Student placed at JCRC for her Queen Elizabeth Scholarship placement, created an initiative to help with education surrounding mental illness in Uganda (S. Rabb, personal communications, July 11, 2019). Her initiative included a curriculum for educating hospital staff, students, health care workers, and teachers on mental health. It included what mental illness is, the different disorders, and how to recognize symptoms. It aimed to address the issue of stigma and increase knowledge around mental illness within Uganda. The goal was to implement the plan at JCRC, with doctors and nurses going through the curriculum. The medical staff at JCRC would be trained how to ask specific questions to identify emotional issues as well as educate the patient on mental health. The goal of the proposal will also be going beyond JCRC, with Community Health Workers also going through the training program and then able to spread the education to communities as well.

Another suggestion may be to add a unit of psychology study to medical university courses to help incorporate mental illness education without needing to devote resources to add a whole course(s) if that is not an option with the current health/education budget. This also addresses the possibility of overcoming too few students registering to sustain the courses by themselves. By incorporating mental health education into other health-related courses, it helps spread awareness and appreciation among future health care workers without devoting resources that are not within realistic parameters.

### Limitations and Challenges

There were challenges faced when trying to obtain screening measures as a part of this research, and to make recommendations to JCRC. Originally, a request for permission to get the screening measures used at Mulago hospital was put in, but communication through phone and email was slow and eventually fell through. The measures are not being administered nor interpreted by psychological professionals at JCRC and therefore cannot be used in a concrete diagnosis. Another research challenge was the cultural and language barriers. Communication was slow and at times difficult with interpretation of different contexts between the cultures, regardless of whether both parties spoke English. It was also challenging to obtain information on mental health with limited learning opportunities/activities pertaining to mental health and no

psychological professionals at JCRC. There were limitations to the methods as well; the observations were from a subjective viewpoint and confined to one city, Kampala, one point in time (summer 2019), and may not be generalizable to all of Uganda. The included supporting research on mental health in Uganda, however, attempts to counterbalance this limitation. The thematic analysis was only done by one researcher, but was reviewed and discussed with three supervisors. This limited the possible perspectives that may be interpreted from the information. Future researchers with an interest in travel and mental health should request placements at either Mulago Hospital or Butabika Hospital, both of which have direct care for mental health, and in Kampala, to get more first-hand experience within the mental health system. Future studies may also want to look at replicating this work in a different region or country within Africa.

Despite the challenges, the hope is that these recommendations may help even a small population of those suffering with a mental illness to get the support they need. Helping to improve Uganda's mental health system will provide a mentally stronger population that is better able to handle the struggles of living in a developing country facing climate change challenges.

### Conclusion

When an adequate mental health system is in place, individuals and communities can feel better supported to face challenges within the country. Without an appropriate and adequate mental health system, individuals do not get the help they need to support their mental health and therefore handle daily stressors as well as larger environmental stressors.

Screening measures for mental illness will be an asset to have at JCRC. Although definitive diagnoses require proper evaluation by a mental health professional, screenings will give the staff at JCRC another resource to help in identifying mental illness and increase the ability to get patients the help they need. It is also recommended that while involved in HIV medication programs, screening measures be used and information brochures on mental health be developed and distributed. This will help reach populations engaging in high risk lifestyles who may be more at risk for mental illness. This can aid in prevention of HIV (Lundberg et al. 2011) and increase awareness in surrounding communities. Another recommendation is to extend the policy on the limit of how many counselling sessions a patient can have when showing emotional distress. The four sessions limit is inadequate, especially given that these sessions often occur with undertrained counsellors, not trained psychologists. It is also recommended for researchers and practitioners to apply for funding grants to help evaluate and create further resources for mental health support. Other options include hiring a clinical psychologist

to be stationed at JCRC, even if only for a few days per week. This will eliminate patients with HIV's need for extra resources to travel to a hospital that has a clinical professional, as the patients are already at JCRC to get their medication. Lastly, JCRC is a welcoming institution that encourages accepting a positive diagnosis and ending the stigma around HIV. Because the hospital already has an excellent platform for ending the stigma around HIV, it can use this to help decrease the stigma around mental illness by adding materials, people, and stories to campaigns about mental health.

It is imperative to address the issues that countries face in mental illness treatment to be able to reach a higher level of overall community wellbeing. Although more work needs to be done to improve the mental health system in Uganda so that it is aligned with eliminating barriers to mental health services and education, similar to those currently in use in developed countries, these recommendations are the first of many steps in creating movement in the right direction. Future researchers should consider doing observational research in other areas of Uganda to explore whether similar themes are found. Doing formal interviews may also give more insight. Future researchers should also focus on gaining insight into mental health systems within other countries around the world. Communication between countries regarding mental health systems, and different approaches to mental illness, will help bridge the gap and improve global health discourse.

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