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Mental Illness Stigma, Socially Acceptable Treatment, and Barriers to Health

Student Internship with the Social Work Department at Butabika National Referral Mental Hospital

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Academic Director: Charlotte Mafumbo

Acknowledgements:

First of all, I am grateful to the School of International Training for successfully arranging my internship program. I would specifically like to thank my Academic Director Dr. Charlotte Mufumbo, for her assistance and dedication to my education. I also thank Butabika National Referral Mental Hospital for accepting my internship application and for creating such a welcoming work environment.

I would like to thank my supervisor Mr. Maswasa Ayub, a social worker at Butabika Hospital, for his guidance, encouragement, and lessons during the course of my internship. I would also like to express my greatest gratitude for all of the staff at Butabika Hospital for their commitment to education and health care.

Finally, I would like to thank my parents and family for supporting me through my education both emotionally and financially. I would not be here without them. I would also like to thank my friends who send me love from afar and nearby. Thank you.

<u>Dedication:</u>

I would like to dedicate this paper to all of those who suffer from mental illness worldwide. Specifically, this paper is dedicated to my family and friends who suffer from mental illness. My work is dedicated to those who are unable to find help, those who are losing hope and motivation, those who are in pain, and those who it is too late for. My hope is that if more people understand mental illness, people will feel more supported by people in their lives, the society that defines our situation, and the world that is more interconnected than ever before.

I would also like to recognize and appreciate the efforts of people to protect, de-stigmatize, and advocate for those with mental illness. I commend perseverance and determination of health workers, social workers, and families to care.

Abstract:

This paper discusses the topic of mental illness stigma and treatment in Uganda as explored through internship in the Social Work Department at Butabika National Referral Mental Hospital. The objectives of this project were to complete a meaningful internship while exploring causes of mental illness in Uganda, contradictions between traditional and modern approaches to treatment, and the affect of stigma on mental well-being. The internship included a total of 120 hours at Butabika Hospital. Individual research using documentary and literature review methods accompanied the internship. Butabika Hospital did not consent to the completion of formal research at, so any conclusions are not significant research findings but merely educational in nature. The internship experience allowed for the completion of project objectives. It became evident there were three main causes of mental illness in Uganda: gender roles, cultural expectations of family, and poverty. Those who have developed mental illness face stigmatization by their community largely due to misunderstanding and disconnect between tradition and modern medicine. Mental health care providers work to mitigate discrepancies between traditional and modern methods and understanding through a cooperative approach. Improvement of mental well-being of Ugandans will have a large impact on their ability to develop as a nation. Commitment to both traditional and modern traditions is crucial to providing socially acceptable health care.

Abbreviations:

ADU – Alcohol and Drug Unit

FHRI – Foundation for Human Rights Initiative

NGO – Non-Governmental Organization

HSSP – Health Sector Strategic Plan

MHAPP – Mental Health and Poverty Project

PHP – Private Health Practitioners

PNFP – Private-Not-For-Profit Organization

PTSD – Post Traumatic Stress Disorder

SIT – School for International Training

TCMP – Traditional and Complementary Medicine Practitioners

UNMHCP – Uganda National Minimum Health Care Package

WHO – World Health Organization

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<u>Introduction:</u>

Mental health is one of the most important concerns for a nation seeking

development. Unhealthy citizens are unable to participate and contribute as productive

community members. Whether physical illness or mental illness, a person's ability to

function productively depletes. Understanding the importance of health, services must be

adequate, accessible, and culturally sensitive. The 1978 Declaration of Alma-Ata states,

"primary health care is essential health care based on practical, scientifically sound and

socially acceptable methods" (WHO). If care is not socially accepted, no amount of

resources will ensure a healthy life. The use of science and medicalization to support

health need not neglect the culture and demands of the people.

An American journalist, Ethan Watters discusses how the medicalization of

mental health in America has influenced the world in his book *Crazy Like Us: The*

Globalization of the American Psyche (2010). Watters believes America is homogenizing

how the world understands the human mind. In his book, he traces how manifestations of

mental illness have changed across place and time and how American definitions and

treatments of illness have become international standards. Watters notes, with the

increasing speed of globalization, "indigenous forms of mental illness and healing are

being bulldozed by disease categories and treatments made in the USA" (Watters). The

few mental illnesses popularized in the United States such as depression, PTSD, and

anorexia now appear to be spreading around the world. The socially constructed language

used to discuss and understand mental illness has important implications on one's

experience of illness. Cultural expectations of how one should react to trauma affect

one's reaction, physical and mental health, and the public's perceptions surrounding such

experience. In a globalized world, language used in one place is largely affected by the

sharing of global information, concepts, and culture. Uganda still faces impacts of their

colonial past. This influence can be seen through the organization of a variety of

institutions such as religion, education, government, legal systems, media, health, and

language.

I am fascinated by how our bodies manifest internal pain. I am intrigued by the

ways in which socialization affects manifestations of mental illness on a small scale and

on a global scale. I want to study the factors that have influenced the way mental health is

handled in Uganda, how colonialism and globalization have affected the ways mental

health is understood here. Uganda gained independence from the British in 1962, yet the

legacy of colonialism still lives today as seen by the influence of Christianity, the English

language, medical practices, and other formal institutions along with internalized beliefs.

I wonder to what extent the impact of the medicalization of mental illness internationally

is affecting health in Uganda compared to their commitment to traditional healing. Many

Ugandans maintain a strong connection to their family's history, language, and culture.

For instance, in the capital city of Kampala, many people still speak Luganda, perform

traditional dances, music, and ceremonies, and seek mental health care from traditional

healers instead of a medical professional. I want to better understand how mental

illnesses are manifested and treated in Kampala while navigating contradictions between

traditional and modern health care.

Background:

Mental health is more than the absence of disease or disorder. It is "a state of complete mental wellbeing including social, cognitive, spiritual and emotional aspects" (Ssanyu, 2007). One 2004 study estimated that 35% of Ugandans suffer from some form of mental disorder (Basangwa, 2004; as cited by Kigozi et al 2008), which is much greater than the generally accepted estimate of 13% global prevalence rate (Ndyanabangi, et al., 2012). However, instead of something requiring medical attention, in Uganda mental illnesses have traditionally been considered a curse. Treatment was provided by local traditional healers and focused on the casting out of evil spirits (Nsereko, 2017). However, mental health care has changed over time due to local and international pressures to improve services through medicalization. The government has been pursuing policies that encourage the medicalization of mental health and inclusion of mental health care into the public health sector.

The journey towards improvement of care for the mentally ill began in 1916 when healthcare services became nationally recognized under the influence of the evolving mental health laws in England. The first official mental health services began in the Hoima prison not far from Kampala in the 1920's. This mental health unit was built to house those adjudged by society to be mentally unfit (Nyombi, Kibandama, & Kaddu, 2014). As demand increased, the few resources and facilities were no longer unable to supply adequate services. Worry of the poor conditions and treatment at Hoima led to the creation of a mental health ward at Old Mulago hospital in the mid 1930's. Mulago provided health services for patients Hoima was unable to support and eventually took responsibility for the care of all mentally ill inmates. To increase capacity from the

limited space at Mulago mental health ward, Butabika Hospital opened in 1955. Butabika Hospital initially served as a mental asylum for psychotic patients providing mental health care for people from anywhere in East and Central Africa (Nsereko, 2017). Today Butabika Hospital operates as the National Referral Mental Institution in Uganda and offers a wide range of care including inpatient and outpatient mental health services, nursing and psychiatric training, community education, and resettlement assistance (Butabika Hospital, 2017).

A draft mental health policy was developed in 2000 using The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) to strengthen mental health services in the country. Information collected by WHO-AIMS outlined strengths and weaknesses within Uganda's mental health system to inform policy reform (WHO-AIMS Report on Mental Health System in Uganda, 2006). The draft policy of 2000 includes reforms to include the decentralization of mental health services, integration of mental health services into Primary Health Care (PHC), construction of mental health inpatient units within the Regional Referral Hospitals, training of staff at all levels, and the involvement of the Civil Society Organizations, traditional healers, and other relevant sectors. The Ugandan government is moving in the right direction toward raising awareness of mental health concerns and improving care. Many other developing countries still have no public mental health services. Over 40% of developing countries do not even have a draft mental health policy and over 30% have no mental health programmes (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010). Thirty years ago, any person in the country suffering from mental illness was either locked up in a room at a hospital or sent to Butabika Hospital as punishment. The

decentralization and governmental support for mental health care allows people to receive treatment at regional facilities across the country instead of traveling far distances to Kampala (Kavuma, 2010) (see Appendix A for a map of Uganda's regional and national referral hospitals). Patients are referred from regional health centers to Butabika Hospital if the case is too severe, but lower level care is increasingly available.

Problem Statement:

Mental wellbeing is closely connected to economic wellbeing and is as much an issue to development as poverty is. Programs addressing socioeconomic challenges resulting from mental disorders are just as important as medical attention. In Uganda, an estimated 35% of the population suffers from some form of mental disorders, the most prevalent being common depression (20%) and PTSD (9%) (Ssanyu, 2007). Regardless of the high demand, per 1000 of the population, there are only 183 beds in mental hospitals and 140 beds in community based psychiatric inpatient units (see Appendix B for a chart of the gap between the number of Ugandans with mental disorders versus the number receiving treatment). The total personnel working in mental health facilities is 310 while only 0.8% of the medical doctors and 4% of the nurses had specialized in psychiatry (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010). Poverty exacerbates mental illness, the Ugandan government does not prioritize mental health care funding, cultural beliefs stigmatize the mentally ill, and modern medicine is at conflict with traditional methods of health care.

Objectives:

I. To fulfill the tasks of my internship as I shadow members of the Social Work Department at Butabika National Referral Mental Hospital.

II. To learn the main causes of mental illness and how it impacts people's lives.

III. To examine treatment strategies, namely the influence of external knowledge and the relevance to cultural beliefs.

IV. To assess the availability of mental health care, how stigma serves as a barrier to access, and what is needed to improve the emotional well-being of Ugandans.

Justification:

Butabika Hospital is at the heart of mental health in Uganda as the only National Referral Mental Health Institution in the country (see Appendix C for details on Uganda's national referral hospital system diagram). Since Butabika Hospital is the largest and most modern mental health facility in the country, it is the best place to learn about the extent of mental health treatment available. Working there will allow me to gain a strong understanding of the direction mental health is heading in Uganda. I will be able to interact with patients, doctors, and social workers to hear their stories and will experience what it is like to work as a mental health care provider. I will learn how socially and culturally accepted mental health care is by the greater community especially in contrast to traditional interventions for mental healing.

Literature Review:

As productive as these initiatives have been, scholars contend there is still progress to be made. Even though Uganda has a draft mental health policy, there is still no separate comprehensive Mental Health Strategic Plan, no national policy in full effect (WHO-AIMS Report on Mental Health System in Uganda, 2006). Mental health legislation is considered to be outdated and offensive, services are underfunded and skewed toward urban areas, and many Ugandans remain ignorant of such issues. The human rights of people with mental disorders remain largely unprotected by legal developments (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010). Furthermore, even though the government is making efforts towards improving regional mental health care, mental health patients from all over the country are mainly referred to Mulago or Butabika for psychiatric intervention (Nsereko, 2017).

There is a general lack of trained human resources and a scarcity of funding needed to provide adequate mental health services. When the Ugandan mental health policy was developed in 2000, only one percent of the national budget was allocated specifically towards mental health care (WHO-AIMS Report on Mental Health System in Uganda, 2006; Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010). Donor support to the government has raised the expenditure on mental health to approximately 4% of health care expenditure, yet a large chunk of the budget is directed towards hospital construction work (Kavuma, 2010). As for drugs, resources are limited. Government hospitals can only get medicines "equivalent in price to the amount of money provided by central government, which is often far less than the demand" (Kavuma, 2010).

Cultural perceptions remain a large barrier to mental health care as seen through the conflict between traditional and modern care. While traditional healers known as "witchdoctors" have historically been the primary mental health providers, the majority of available university programs and counselor education trainings are tailored around western curriculum, not based on the needs of the people in Uganda. The professionalism and medicalization of mental health services was an idea brought as early as 1956 by expatriate psychiatric workers. Many indigenous mental health workers were trained by westerners in Uganda or sent abroad for specialized training (Nsereko, 2017). Despite these trainings, the Mental Health and Poverty Project (MHAPP) report of 2008 shows that the majority of Ugandans, especially in rural areas, believe that "mental illnesses are caused by supernatural forces, such as witchcraft, and, therefore, cannot be cured by modern medicine. In 2001, the World Health Organization estimated that up 80% of mental health patients who reported to health centers first visited traditional healers" (Kavuma, 2010). Traditional healers remain trusted and culturally accepted even though they often provide conflicting explanations for the cause of mental disorders (Ssanyu, 2007). Contradictory methods of healing remain a problem in developing adequate policy measures and health services.

Community education would help create a common understanding of mental illness, raise awareness, and destigmatize those affected. According to MHAPP, it is common for health workers to not want to specialize in psychiatry because of the stigma associated with mental illness. One official from the Ministry of Health is quoted in MHAPP as saying that "medical students in Kampala believed that once one became a psychiatrist, they would, in time, develop mental health problems themselves" (Kavuma,

2010). Not only does stigma affect the availability of health care professionals, but people with mental disorders in Uganda experience some of the worst forms of discrimination. Many are denied the chance to enjoy basic social services, are excluded from development programs, and struggle to find work. The belief that mental illness is contagious intensifies such discrimination (Ssanyu, 2007). Issues of stigma, discrimination, and violence against the mentally ill, make the absence of an adequate mental health law even more problematic (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010). In order to prevent human rights abuses and improve the overall mental wellbeing of the people of Uganda, further research is imperative. Only 2 - 4% of all publications in Uganda were on mental health, yet there remain shortcomings in resources and services available (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010).

Methodology:

I interned in the Social Work Department at Butabika National Referral Hospital four days a week from October 27th until November 24th, 2017. I met with Butabika Hospital staff to negotiate the terms of my internship, where they need the most help, and where best my skills meet the demand of the patients. I shadowed and engaged with patients and staff to improve upon my basic understanding of causes of mental illness and social problems that arise from mental illness. I did not receive permission to conduct research at Butabika Hospital to conduct research, but participatory observation and informal interviews benefitted my individual learning objectives and analysis. I was able,

however, to conduct document review and literary analysis previous to my internship and through reading assignments given to me by my supervisor.

Description of Host Institution:

Butabika Hospital is the only National Referral Mental Institution in Uganda and offers a variety of mental health services financed by the Ministry of Health and donors. Due to recent initiatives to decentralize health services, mental health treatment is now offered at Regional Referral Hospitals as well. Private care providers and NGO's also offer mental health services. Patients receiving mental health care at Butabika Hospital are the most severe cases, especially by people who cannot afford private care. Even for wealthy Ugandans, Butabika Hospital provides the most advanced mental health care in the country. All services at Butabiks Hospital are free, however private services are available along with the purchase of more expensive drugs. The patient's come from a wide range of socio-economic backgrounds, geographic locations throughout Uganda, cultures, languages, and mental health severity. Patients range from completely disorganized to attentive and focused, very young to old, underweight to overweight, men and women, but all are Ugandan citizens with a mental illness and have somehow made their way to Butabika Hospital – either by choice or by force of their family, friends, or the police.

Butabika Hospital provides inpatient and outpatient mental health care, nursing and psychiatric training, community education, and resettlement assistance. The hospital is organized by wards and departments that specialize on particular focus areas or groups. Butabika Hospital is divided by inpatient and outpatient care, an Alcohol and Drug Unit,

a children's ward, separated female and male units with varying degrees of severity in care, and Kirinya Ward. Kirinya Ward is where the Social Work Department is located. It focuses on patients with social problems and forensic patients but also provides space for overflow patients. Other noteworthy services include a Recovery College and occupational therapy. The administrative departments, procurement department, and pharmacy also serve the hospital and keep the train rolling.

Description of Tasks Performed:

Job Title and Place of Employment:

For the period of 27th October – 23rd November, 2017, I worked a total of 120 hours as an intern in the Social Work Department at Butabika National Referral Mental Hospital. I completed and shadowed mentors who completed tasks required of a social worker. A social worker is a trained professional who identifies social needs and meets them.

Qualification:

My Sociology and Race, Ethnicity, and Migration studies at Colorado College and my Development and Public Health studies through the School for International Training in Uganda helped to qualify me as an intern at Butabika Hospital. My work experiences at a non-profit in Seattle that focuses issues of social justice surrounding young female athletes of color known as All Girl Everything Ultimate Program (AGE UP) and as a volunteer at the El Paso Country Sheriffs Office have helped better educate me on issues of social inequality and how to navigate difficulties in the workplace. Furthermore, growing up with friends and family who have mental illnesses has taught

me many lessons surrounding stigma and implications involved in having a mental disorder.

Working Condition:

Butabika Hospital is located in Biina District in Kampala, Uganda. The hospital has a large, beautiful outdoor campus with large trees, flowers, and green grass filling the space. Each ward is gated to prevent patients from wandering away and every patient is wearing a green jumpsuit to differentiate patients from the staff. The administration and department staff dress in professional business attire, doctors covering their clothing with a white coat, some nurses wear white and others wear pink uniforms while all female nurses wear nursing caps, and the cleaning/maintenance crew wears orange uniforms. I would wear professional business attire with a nametag indicating my name and role as a Social Work Intern. My working days and hours would depend on the schedule for the week, but I worked three to four times a week. On a typical day, I would arrive to the hospital at 9:00am and leave at 4:30pm.

Job Relationships:

Maswaswa Ayub was my mentor and supervisor. He is very passionate about his job and is one of only three social workers at Butabika. The head social worker, Jackie, was in the field for the entirety of my internship. I was able to spend time with the other social worker, Justine, who just transferred to Butabika the first day of my internship. For the first week of my internship, there was another intern in the Social Work Department, Gorreti, who is a Ugandan student studying social work for her undergraduate degree.

Specific Duties and Responsibilities:

- Assess/interview patients with social problems

- Attend ward rounds to listen for social needs of patients

- Attend Alcohol and Drug Unit sessions to better understand needs of patients

- Track for patient's families and resettle them

- Place babies in homes

- Perform community outreaches

- Offer psycho-education for patients

- Link patients to required services

- Mediate conflicts between patients and a conflicting party

- Advocate for patients' rights

Job Summary:

My first official day at Butabika Hospital, I expected a typical orientation by a supervisor, to be taught the specifics and expectations of my job. However, just as my supervisor Ayub and I were about to head for lunch, he received a call that his presence was requested to represent a patient at her child's funeral. The child, named Trinity, was born prematurely and was moved to Watoto Baby Home where she was taken care of by nurses and mothers. Sadly, health complications kept Trinity in and out of the hospital and eventually led to her death. Trinity's mother is a sixteen-year-old patient at Butabika Hospital suffering from severe mental illness. Her mother does not she had a child and is not in a mental state where she would have been able to attend her child's funeral and burial. Ayub took photos of both ceremonies to show the mother when she regains her health. I cannot imagine showing someone photos of their baby's funeral and burial. Ayub said this day was one of his hardest ever on the job.

The rest of my days as an intern at Butabika Hospital tended to be more regular and scheduled. Most Mondays, I would visit the Alcohol and Drug Unit (ADU) for their morning session. Most Tuesdays and Thursdays, I would sit in on the ward round at Kirinya Ward. Wednesdays, I would often spend time in Ayub's office talking to him, other social workers, or patients if I was not reading a book. I spent most Fridays in the field or would use that day to work on assignments for or have meetings with school personnel.

Spending time at the ADU was very rewarding and informative about the cultural beliefs surrounding drug use and abuse. ADU sessions would begin at 10am and end around noon. Group therapy sessions are offered for patients with alcohol and drug addictions every morning from Monday through Thursday. Wednesday and Thursday sessions are spiritual therapy while Monday and Tuesday sessions are not specifically tied to spirituality or religion. The ADU only house male patients, but female patients, other male patients that are unable to fit in the space provided at the ADU, and out-patient addicts attend sessions as well. Similar to the patient population of Butabika Hospital as a whole, some come voluntarily seeking care, but most come by force of their families, friends, or police.

Monday sessions were led by a variety of professionals: guest lecturers, ADU counselors, and the head nurse and administrator at the ADU. The lecturer for the day would often remind patients to consider individually why they are each here, because the motivation is different for each person. Patients would be reminded that they are here for them, not to please who brought them. It was common for the lecturer to focus on one topic for the whole session, be that patience, motivation, communication, assertiveness,

or dangers. Patients would have the possibility to tell stories, ask questions, problem solve, and give advice to each other. I heard stories from many men who had been coming home from drinking expecting sex from their wives without paying attention to whether or not their wives want to have sex with them. Most patients reported issues with alcohol and/or drugs impairing their judgment and therefore affecting their ability to properly communicate with people in their lives. Poor communication affected their personal motivation, relationships, and often resulted in quarreling. Patients discussed strategies of communicating well, listening, and being assertive with their answers to requests. Focusing on healthy, honest thoughts helped patients support each other, get clean, persevere, and avoid relapse. Most importantly, the emphasis on mending relationships with friends and family members with the help of the ADU at family therapy sessions provides comprehensive care.

While most patients attending sessions at the ADU did not have another mental illness besides their addiction, during ward rounds at Kirinya Ward on Tuesdays and Thursdays, patients with more severe mental illnesses were examined. During ward rounds, a panel of psychiatrists, nurses, counselors, and social workers meet with individual patients for either the first time or for review. Sometimes the patient attends unaccompanied, while other times patients are joined by family members, friends, co-workers, or employers. The patient would sit on a chair against the wall facing everyone in the room as to reduce paranoia. I would sit in a line of chairs with other Ugandan psychiatric students and we would have the opportunity to occasionally ask and answer questions. The panel of doctors would ask the patient questions regarding their medical conditions and background, mental status, readiness to change, relapse potential, threats

to safety, general ability to function, and vocational skills. If the patient had social support present, the doctors would ask these people questions about the patient's condition as well. Social support was especially helpful when the patient was unable to respond to questions. The doctors would utilize many tactics to best assess the mental state of the patient to create an appropriate treatment plan. I would take notes on social needs of patients and, if necessary, report to Ayub where intervention of a social worker might be helpful.

I also benefited from my experience in the field, from my time sharing stories with co-workers, and from texts I was able to read throughout my internship. I spent three full days of my internship in the field resettling patients. Each time I would go to resettle patients, Ayub would dress them in smart clothing that had been donated to the hospital. They always need more clothing and shoes, but Ayub was able to make each patient look clean and well dressed. The first time I went to resettle patients, I accompanied a group of seven psychiatric students. Each psychiatric student was responsible for the resettlement of one patient. They read the patient's diagnosis, assessed their mental capability, and asked about social needs. We dropped each patient off at their home and the psychiatric student responsible for that patient would greet the patient's family, educate, and encourage them to care for the patient.

The other two times I went to help resettle patients, instead of dropping them off individually all the way to their home, I went with Ayub and another social work student named Joshua to drop patients off at the taxi stage in Nakawa and the taxi park in city center. Each day, we dropped forty patients off on buses or taxis heading to their home village. Ayub and Joshua resettle large groups of patients like this every month for two

full consecutive days of planning and negotiating. Only two patients were refused entry

on buses by drivers due to their mental state, otherwise all other patients got safely on

buses or taxis home.

When sitting in Ayub's office, I had the opportunity to discuss pertinent issues

with co-workers in more depth. Justine also told me about how social workers are not

paid well in Uganda and are only recently being valued in the hospital setting and

understood by other hospital staff. Ten years ago, along with the rise of HIV/AIDS and

NGOs, the demand for social work increased. Justine commented during this surge, it

was very easy to find a job as a social worker, but when these programs ran out of donor

funding, they would stop and she would have to find another job. Working as a social

worker for a government institution is more sustainable in the long term, but the salary

working for an NGO in the short term was more favorable.

One day, another social worker named Maureen came to visit Ayub at his office.

She works for an organization called 'You Belong Home' that helps connect patients to

families and educates both parties to improve relationships and care. Maureen came to

discuss a book she had been reading, but wanted Ayub to help her understand parts that

were confusing. Ayub, Maureen, and Justine were all able to teach each other about what

has been effective in ensuring patients are able to stay with their families long term and

ask each other questions. It is important to emphasize to patients that life is going to be

different when they are home compared to life at Butabika Hospital where they are fed

and cared for by hospital staff.

I read Justine's trainer manual distributed by the Colombo Plan Drug Advisory

Programme (DAP) titled *Case Management for Addiction Professionals* one day while

sitting in Ayub's office. From Justine's case management trainer manual I learned the basic principles and functions of case management, types of substance abuse disorders, and what to look for when assessing patients with a substance abuse disorder. I also researched causes of mental illness and what the symptoms of the different types are, especially focusing on the ones most prevalent at Butabika Hospital. Ayub assigned this homework, so I could better assess the social needs of patients and simply to assist in my learning and ability to communicate with patients.

I also completed significant research the first two weeks of my internship time before my official internship began. I researched the history of care providers, policy developments, pitfalls in the system and legislation, barriers to health, human rights, trainings available, perceptions and stigma in the community, connections to the criminal justice system, and the importance of culturally sensitive psychiatric diagnosis and treatment in providing adequate care. The findings of my research and experience interning at Butabika Hospital are summarized below.

Output of the Internship Experience:

I completed all of my stated objectives through my internship in the Social Work Department at Butabika Hospital. I completed assigned tasks while I shadowed members of the Social Work Department as listed above. I learned the main causes of mental illness and how it impacts people's lives. I examined treatment strategies, focusing on the influence of external knowledge and relevance to cultural beliefs. I assessed the availability of mental health care, how stigma serves as a barrier to access, and what is needed to improve the emotional well-being of Ugandans. I also created specific learning

objectives with Ayub that are more focused on work I was doing at the hospital that we worked together to ensure my completion of. My knowledge objectives were to understand the work culture in a Ugandan government hospital (specifically, at Butabika Hospital), understand the roles of a social worker in a Ugandan government hospital (specifically, at Butabika Hospital), learn how social functioning is enhanced in families with patients who have mental illness, and once again, learn the impact and cause of mental illness in Uganda. My skill's acquisition objectives were to improve my interviewing skills and assessment of social needs of patients and gain community sensitization skills.

I gained those skills and knowledge and through working diligently at my internship. From perspective as an outsider and insider, I was able to uniquely assess the system of mental health care in Uganda. Even though I did not complete formal research, my experience allowed me to brainstorm a few main causes of mental illnesses specific to Ugandan culture. The exact cause of most mental illnesses is unknown, but "it is becoming clear through research that many of these conditions are caused by a combination of biological, psychological, and environmental factors" (The Kim Foundation). Examples of biological causes of mental illness are an abnormal balance of neurotransmitters, genetics/heredity, infections, brain defects or injury, prenatal damage, poor nutrition, and exposure to toxins. I learned about the significance of many of these factors during ward rounds, through my own research, and through conversations at Butabika Hospital. However, as a student of sociology and social work intern, I am less interested in biology and more interested in addressing psychological and environmental factors affecting mental health. Psychological causes of mental illness include severe

childhood trauma, important early loss, neglect, and a poor ability to relate to others. Examples of environmental causes are dysfunctional family life, living in poverty, significant life changes, and social or cultural expectations (The Kim Foundation). Whether I was in the field or at the hospital, I was able to connect patient's stories to a combination of factors leading to their mental illness.

I came to understand the causes of mental illness in Uganda to develop through three main categories: gender roles, cultural expectations of family, and poverty. Trauma is another leading cause of mental illness in Uganda, however most patients suffering from Post Traumatic Stress Disorder (PTSD) are not at Butabika Hospital. They are up north and so receive treatment there if needed or seek private treatment in the central region. I am not expressing gender roles, familial expectations, and poverty as a significant research finding, but as a collection of knowledge from my internship experience.

Gender norms are changing in Uganda as Western beliefs have spread in this globalized world. Women are at a critical point in defining the relationship between tradition and modernity. I discussed how gender norms in Uganda impact women's health with Justine extensively one morning in Ayub's office. Justine mentioned how the cultural expectation for women to have children and many of them significantly affects the perceived worth of women. Women have also traditionally not been taught to refuse sex, leading them to be more passive in sexual relationships and potentially contract a sexually transmitted infection. Furthermore, women do not have many options to leave their husband if he is abusive due to financial dependency and cultural norms encourage them to tough it out. Knowledge gained from my conversation with Justine was

continually reinforced through assessing patients at Butabika Hospital. For example, one female patient assessed during a ward round at Kirinya was suffering from severe depression. Her speech was uncoordinated, so the reality of her statements is unknown, however she expressed deep sorrow regarding the death of her husband. She also alluded to the fact that her husband was cheating on her and the psychiatrist believes that is when her symptoms began. Furthermore, gender based violence increases due to impaired judgment from alcohol and drugs or from symptoms of mental illness and harms relationships. Social and cultural gender expectations play a significant role in the development of mental illness. Both men and women are pressured to adhere to gender norms. Failure to do so leads to stress, anxiety, and fear, which have an immense affect on one's physical and mental health.

Cultural expectations of family function to impact health in a similar way that gender norms do in Uganda. Connection to family is constantly stressed as being of utmost importance. In this way, Ugandan culture is more traditional. Especially in rural villages, children do not stray far from their parents and other relatives. Family units are also expected to remain intact regardless of difficulties. However, gender norms affect the stability of marital relationships, especially when traditional culture is at odds with preaching of female empowerment. It is not uncommon for men in Uganda to pay a dowry for their wife, to sleep with women besides their wife, or to expect their wife will appreciate sex whenever they want it. How husbands and wives treat each other though has an affect on the health of their children. If the family seems to be dividing or is dividing, children are often neglected, stressed, or abused. Not only does the family have to navigate relationships within the home, but their community's investment in each

other's relationships plays a role as well. Personal and societal expectations of an intact and prosperous family connect to both psychological and environmental causes of mental illness.

Lastly, poverty causes and exacerbates mental illness. Worrying about how to provide nutritious food on the table, how to pay for medical bills, how to pay for school fees, and whether the people you are supporting will succeed are all significant stressors. Uganda remains "one of the poorest countries, ranking 145 on the global Human Development Index" (Ndyanabangi, et al., 2012). At face of poverty, when hard work does not pay off, it is easy to feel unmotivated. For example, one patient at Butabika Hospital graduated university in 2014, but has not been able to get a job since. His parents separated when he was very young and is the only child of his mother. His biggest fear is being a failure. Maureen said major cause of mental illness in Uganda is poverty. Boredom and hopelessness when not remedied create problems. I have witnessed boredom leading to alcohol and drug addiction, depression, mania, and even psychosis induced by alcohol.

The development of mental illness has a serious impact on one's life especially in relation to stigma, due to misunderstanding and disconnect between tradition and modern medicine. I did not talk to a single patient or staff member at Butabika Hospital who did not mention stigma as one of the most deterring forces in their life or in efforts to provide care. Two stories in particular come to mind. One ex patient I met told me about her feelings upon recognizing she was at Butabika Hospital for the first time. She told me at that moment, she knew her life had ended. She would forever be stigmatized as crazy. She has come a long way and is now studying community psychiatry, but most people

here do not understand the mentally ill can live normal lives. Upon returning to boarding school after her first visit to Butabika Hospital, her three roommates had moved all of their stuff out of their room. Other students would move their seats away from wherever she sat. She was completely discarded and isolated. Another story provides insight on the impact mental illness has on a person in Uganda. When I resettled one patient back to their home, it was clear the patient had a sibling who also had a mental illness, likely epilepsy. The sibling, who was a young boy, was hitting himself on his head and when his mom mocked this behavior, he continued in laughter. The psychiatric students I was with encouraged the family to bring this boy to Butabika Hospital as well. The misunderstanding and abuse of the mentally ill in Uganda exacerbate the illness and prevent effective treatment. Many patients are abused, beaten, and isolated by members in their community due to misunderstanding. Since mental illness is still so strongly connected to traditional beliefs and ideas surrounding curses, those affected are considered at fault or deserving. The community fears what they have done and what they will do.

Despite barriers those with mental illness face to receive treatment such as stigma, funding, availability, and ethnic and linguistic diversity, there are ways to mitigate challenges regardless of financial resources. I came to understand these barriers through independent research and my experience interning at Butabika Hospital. One day I came on a Thursday for the ward round, but the doctors were on strike, so no ward round happened that day. They were protesting low pay and lack of resources for the hospital. Doctors throughout the country continue to protest as long as the government continues to underfund the health sector. Patients do not receive adequate nutritious food. The free

drugs provided have harmful side effects. It can sometimes be a challenge to interpret the patient's language for the present medical professional. Treatment becomes even more of a challenge when the patient's family has given up or has not even provided contact information for the hospital. Butabika Hospital emphasizes importance of both tradition and modernity in their treatment strategy. They consider the patient's belief system and that of their community while also emphasizing the importance of medication for treatment. It is the job of a social worker to help community religious leaders to understand the necessity of religion and medication in promoting mental well-being.

Moving forward, it is important for a larger percentage of the Ugandan population to be educated on mental illness, especially on warning signs to prevent severe illness and improve open communication regarding mental well-being. Even though many consider mental illness as a sign of weakness, it is a disease that can affect anyone. Therefore, we must emphasize the strength of those fighting and caring for themselves. Butabika Hospital is stigmatized as a mad house instead of a place of strength and healing. People who end up there are forever viewed as crazy. Many Ugandans do not understand that people with mental illness can live normal lives, work, and be productive. Since many Ugandans do not understand mental illness and have traditionally understood it as a curse or misfortune, something contagious, they work to avoid these people. While education on mental illness in increasing effort to reduce the stigma surrounding such disorders, most psychiatriatric training still occurs in a Western model. Butabika Hospital is working in the right direction to build strength in their connection between tradition and modern medicine. Changing perceptions, changing culture takes time.

Personal Assessment of the Experience:

  I gained skills and knowledge through my internship at Butabika Hospital that I will cherish for the rest of my life. As an outsider, I was honest regarding what topics I felt ignorant or unknowledgeable about. My honesty allowed me to be vulnerable and ask many questions. I am typically uncomfortable in situations where I am unsure of acceptable protocol, so I feel grateful for the opportunity to practice the skill of being adaptable in the workplace. I improved upon my observational skills, interview tactics, and understanding of cultural divestiy.

  However, that is not to mean that I did not experienced challenges. I do not speak the local languages fluently, therefore was unable to communicate with patients of lower socio-economic standing with less educational opportunities. I was unable to hear the totality of conversations Ayub or doctors at ward rounds would have with patients. I would often ask for an interpretation or summary though there was not always time. I also simply will never understand the complexity of the cultural differences between American and Ugandan culture. For instance, implications of marital violence are far different in America than they are in Uganda due to social norms and economic opportunities for women. Since one of my primary objectives was to understand implications of mental illness in Uganda, I made grasping Ugandan culture a priority. I built close relationships with co-workers and patients. I spent significant time both in the field and at the hospital and on independent research to gain the knowledge I sought after. The time was short, especially since I officially started my internship two weeks after time allocated for. Instead of six weeks working an internship, I was only able to complete four weeks at Butabika Hospital. I spent the first two weeks researching and pursuing my internship, frequently visiting the hospital and navigating bureaucratic processes.

The short amount of time was a challenge, though language and cultural barriers were more significant in preventing me from feeling productive with my time.

Overall, my internship was very informative regarding causes and implications of mental illness, treatment strategies, and barriers to mental health in Uganda. I know what I have learned will have an impact on my academic and professional career. I learned how to be adaptable in the workplace and with my own cultural beliefs. I gained knowledge on causes, signs, symptoms, and treatment of mental illness. I practiced promoting stigma-reducing strategies through educating families when resettling patients at their home. I also developed a greater understanding of the importance of perseverance and patience when dealing with such defeating social inequities.

In relating my own work and the work of others at Butabika Hospital, it seems as though we have a similar development paradigm that most closely guides our actions and behaviors. This paradigm is the Human Development Paradigm and focuses on human capital development and creating equal opportunities. The goal of the Human Development Paradigm is to maximize welfare through an emphasis on social/ethical economics. The staff at Butabika Hospital agree with me in the importance of advocating for and lifting up the vulnerable populations (i.e. the mentally ill). Those who have a mental illness in Uganda are discriminated in schools, the workplace, and their communities which prevents them from having an equal opportunity to succeed. Regardless of working conditions and low pay, the staff continue to work for their patients (with the occasional strike to assert pressure on the government). They understand the importance of mental well-being to the health, productivity, and development of Uganda.

Conclusion:

Mental illness will always be there, so it is crucial we reduce stigma to protect the safety and well-being of those in our communities. Normalizing discussions surrounding mental illness are critical to reducing stigma. The more we are able to freely discuss emotions with friends, family, and health providers, the greater understanding we will have regarding the human mind. However, I am aware that my expectations regarding expression of emotion are determined by the culture I was raised in. It is evident that stigma is harmful to Ugandans with mental illness and those with mental illness worldwide, but interventions to increase understanding must be culturally acceptable.

The Americanization of the human mind also threatens the maintenance of traditional beliefs as modern medicine is placed on a pedestal. Cultures have been "swallowed up by a form of cultural imperialism in which psychiatric knowledge and practices displace local frameworks of identity and systems of healing" (Kirmayer, 2012). Diverse understandings of health allow for progress, innovation, and development. Americans can learn from Ugandans and Ugandans from Americans. Social problems, especially those as complicated as mental illness in a nation, must be contextualized.

<u>Ethics Statement:</u>

I did not conduct any formal research since I was working an internship and did not receive consent from Butabika Hospital to do research. My reflections and conclusions are not significant research findings, but an analysis of knowledge I gained throughout my internship. That being said, I used my judgment when needed to avoid harming others or making people around me uncomfortable, I listened a lot, and did not lie about who I was or my intentions. I was working with a vulnerable population, so I followed ethical guidelines provided by the School for International Training (SIT). I completed and adhered to the SIT Application for Human Subjects Review form. I also ensured my work abided by the policy and regulations of Butabika Hospital including dress, punctuality, and employee behavior.

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Appendix A

Uganda Regional and National Referral Hospitals Map:

Figure 11. **Mapping Health Care Services in Uganda**
Source: reference (2)

(Ndyanabangi, S. et al., 2014)

Appendix B

Mental Illness Prevalence Versus Treatment Chart:

Figure 8
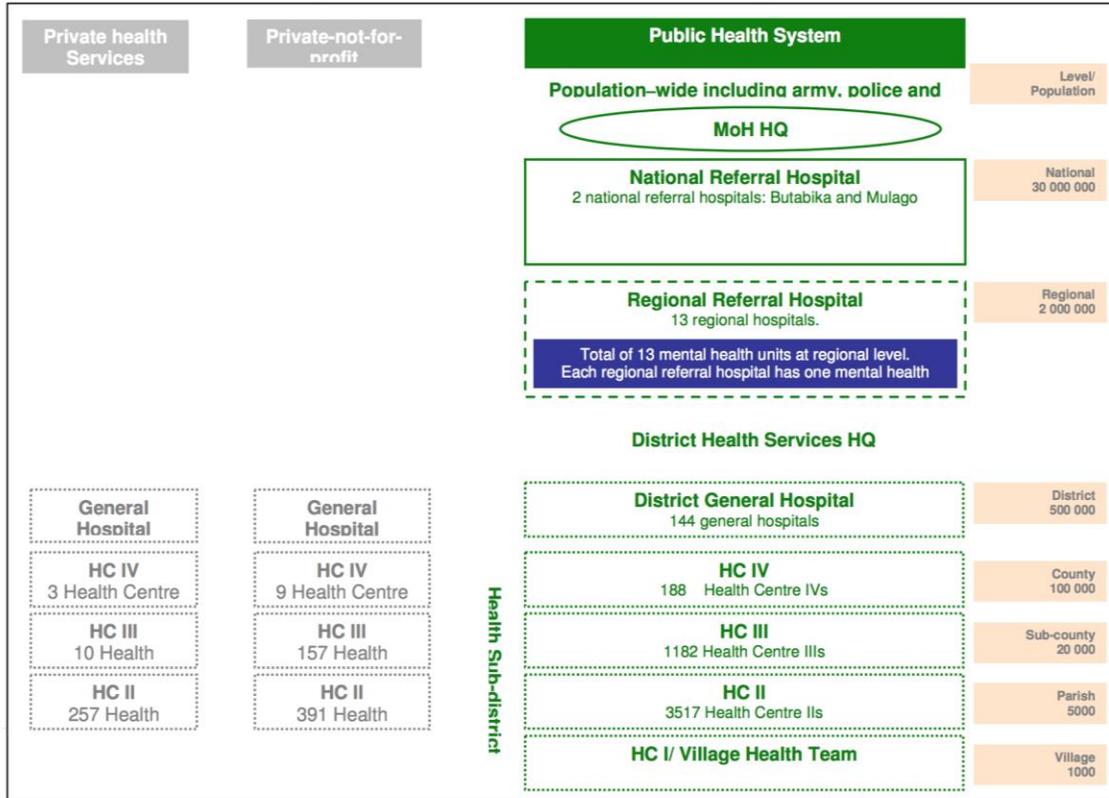**Treatment gap for severe mental disorders in Uganda**
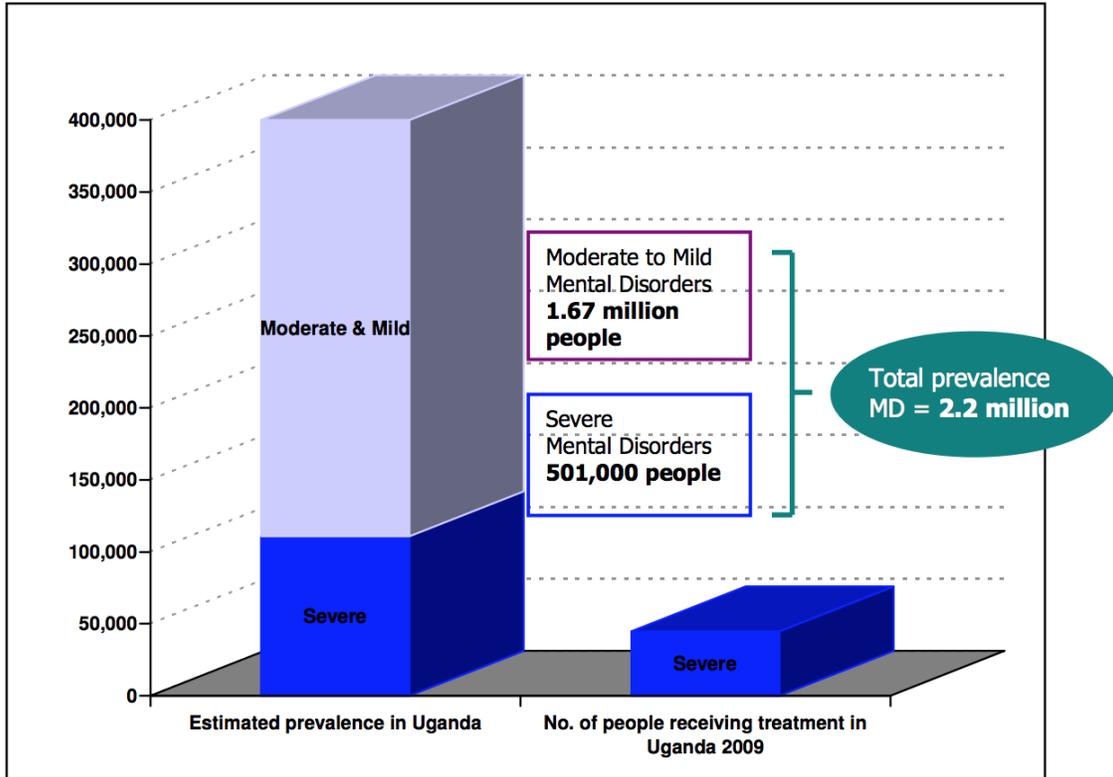
(Ndyanabangi, S. et al., 2014)

Appendix C

Uganda Referral Hospital System Diagram:

Figure 10. **Mental Health Services within the General Health System**

Private health Services	Private-not-for-profit		Public Health System		Level/ Population
			Population–wide including army, police and		
			MoH HQ		
			National Referral Hospital 2 national referral hospitals: Butabika and Mulago		National 30 000 000
			Regional Referral Hospital 13 regional hospitals.		Regional 2 000 000
			Total of 13 mental health units at regional level. Each regional referral hospital has one mental health		
			District Health Services HQ		
General Hospital	General Hospital		**District General Hospital** 144 general hospitals		District 500 000
HC IV 3 Health Centre	**HC IV** 9 Health Centre	Health Sub-district	**HC IV** 188 Health Centre IVs		County 100 000
HC III 10 Health	**HC III** 157 Health		**HC III** 1182 Health Centre IIIs		Sub-county 20 000
HC II 257 Health	**HC II** 391 Health		**HC II** 3517 Health Centre IIs		Parish 5000
			HC I/ Village Health Team		Village 1000

(Ndyanabangi, S. et al., 2014)