Approaches to "Mental Health" in Low Income Countries: A case study of Uganda

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Introduction

There have been arguments from the turn of this century that low and middle income countries have a scarcity of resources for mental health, inequity in access to them and inefficiencies in their use which have serious consequences for people suffering from mental ill health. Treatment gaps between poor and rich countries have been estimated by WHO and others (cf. Khonet et.al, 2004; WHO, 2004; Saxena et al., 2007) as being as large as 76-85%. In response to such arguments WHO launched its Mental Health Gap Action Programme (mhGAP) in 2002 (WHO 2011) and shortly afterwards a 'Global Mental Health (GMH) movement' was also set up (Manning & Patel, 2008). Both aimed for the `scaling up' of services, particularly in primary care, for mental, neurological and substance use disorders in low- and middle-income (LMI) countries.

In reality there is hardly any reliable and relevant data on mental illness in such countries and the mhGAP and GMH campaigns were largely based on estimates arrived at by projecting western statistical parameters and concepts of mental illness onto the developing world. This has raised significant concerns about the relevance of importing the principles and practices of western psychiatry to such communities (cf. Summerfield, 2012).

Recommendations of the GMH movement and mhGAP programme are predicated on the assumption that a particular approach to mental health difficulties holds general validity, and can therefore be universally applied with advantageous results. The approach is that which has acquired influence in western culture over the last fifty years. It reflects a characteristically individualistic view of human experience and behaviour, arguing that mental health difficulties reflect personal dysfunction and are best addressed by "treating" the individual as one might were they suffering from an identifiable somatic illness. This is known as the medical model and the recent growth of its influence on western psychiatric practice is considerable and well documented (Insel & Quiron, 2005). It is a technological paradigm which assumes that mental health problems arise from faulty processes within the individual that can be modeled in causal terms and are context-independent. Derived interventions are instrumental and in practice amount to administering psychoactive compounds, psychological therapies or, less commonly, electro-convulsive therapy and very occasionally psychosurgery. The growth of this approach over the last half century has enriched the pharmaceutical industry,

enhanced the academic and professional status of psychiatry and provided a rationale for many hours of paid counselling and/or psychotherapy. All of this has been accompanied by criticism of both the evidence for the value of these treatments and the motivations of those promoting them (Angell, 2011; Angell, 2011a; Frances, 2010; Carey & Harris, 2008).

In summary, critics of the clinical science underpinning western psychiatry argue that if and when drug treatments work, this is as likely to be due to strong placebo effects as it is to genuine pharmacological effects. Furthermore, as much as 85% of the variance in psychotherapeutic outcome can be attributed to non-specific aspects of the encounter such as client variables, extra-therapeutic events, relationship variables, expectancy and placebo effects. These conclusions extend to the widely promoted cognitive-behavioural therapy. It is salient that a commentary expressing these views (Bracken et al, 2012) which was recently published in a prestigious and widely read psychiatric journal has drawn very little dissent. Half a century of experience with psycho-pharmaceuticals and directive psychotherapy leads, in the view of many, to the conclusion that they are no more a "solution" than earlier approaches involving, for example, dousing with cold water, leucotomy, sleep deprivation or any other of their now discredited antecedents. These criticisms of the medical approach to mental health difficulties imply that the GMH movement and mhGAP programme are pursuing a particular ideology with no intrinsic superiority over others. A prominent feature of the development of this ideology is the part played by the commercially driven interests of the pharmaceutical industry in promoting it through the selective publication of clinical trials findings, research funding and other academic support and direct marketing to prescribers and users of their products (Healy, 2002). It is hard to exclude the possibility that the same commercial interests play a role in the GMH movement and the mhGAP programme.

What also emerges from mature reflection on clinical evidence accumulated over the last half century is that the most effective psychotherapeutic interventions are those which enable the development of a supportive and including relationship. This is the conclusion of several meta-analyses of outcome data from psychological therapy trials (Budd & Hughes, 2009; Cooper, 2008; Castonguay & Beutler, 2006; Stiles et.al, 2008). The acknowledged importance of expectancy and other placebo effects in determining the outcome of drug treatments (Kirsch et al, 2008) also suggests that relational dynamics are central in determining the outcome of any intervention for "mental health problems". These cannot be optimised without attention to indigenous views, beliefs and perceptions on what is considered to be `mental health' and `mental illness'. Questions must be asked about the intentions of any major initiative that does not take these criticisms of western approaches to

"mental health and illness" into account. These approaches reflect their development in the context of two hundred year's progressive industrialisation and its associated individualistic discourse. It also reflects attachment to technology and the growth of a medical approach to deviance through many decades of systematic confinement and bureaucratised management. Settings without this long history of industrialisation can be expected to have their own, indigenous approaches to deviances that western approaches identify as "illness to be treated". Given the contextually specific nature of western approaches and their apparently ideological rather than evidential basis, indigenous approaches deserve closer and more sympathetic attention than the GMH movement and mhGAP programme appear willing to give them (cf. Kohn et al, 2004)

We have taken the opportunity of visits to, and familiarity with, one developing country, Uganda, to develop a case study of these concerns and to highlight the relevance of traditional approaches, particularly focusing on the work of traditional healers. Uganda is a useful case study because it is fairly typical of low income African countries - in terms of its development of mental health policy and mental health services (Kigozi et.al., 2010).

Background of Mental Health services in Uganda

Although there are estimates (WHO AIMS, 2006), there is in fact no real evidence available on the prevalence of mental health problems in Uganda. Thus there are no hard data defining the 'mental health gap'. Despite this lack of data, the main social causes of mental difficulty are said to be "well known by government" (Basangwa 2009; Kyeyune, 2010) and are:

- Childhood distress and emotional deprivation attributable to orphan-hood from AIDs, or material hardship resulting in conflict, domestic abuse or disability. Significantly this is associated with reduced psychological resilience in adult life. Civil strife and political instability, most recently in the North West, are associated with trauma and economic decline
- Poverty, with high levels of unemployment and job insecurity and poor housing
- Urbanisation and the move of people from their villages and into the urban centres, which may not be in their own tribal area with resulting likelihood of discrimination
- HIV and AIDs, which are a relatively recent source of trauma and
- distress

The plausibility of this assessment is supported by literature on risk factors for mental illness (CF Bhavsar & Bhugra, 2008; Prichard, 2008; Mckenzie, 2008). However, only 1% of health care expenditures are

specifically targeted at mental health care in Uganda, though donor support from the African Development Bank has raised this expenditure to 4% of GDP. Of this funding 55% is directed towards Butabika National Hospital in Kampala, reflecting a disproportional distribution of resources between urban and rural areas. There is a ratio of 1.2 doctors per 10,000 population in Uganda (compared to 30 in the UK) and of the 28 psychiatrists in Uganda the majority are based at Butabika. There are less than 0.05% of psychiatrists and 0.3 psychiatric beds per 10,000 (compared to 1.5 and 5 per 10,000 in the UK) (WHO, 2013). This perceived workforce shortage is being addressed by the Ugandan Ministry of Health by training a cadre of `psychiatric clinical officers' to diagnose and prescribe for common mental disorders. Psychotropic drugs and some other drugs for common mental illness are available in health centres free of charge, but these are subject to availability and supply problems are common. By western standards Ugandan, mental health services could be described as embryonic but improving.

Although Ugandan mental health services can be traced back to the founding in the 1930s of psychiatric units in prisons and in Mulago General Hospital Kampala, mental health services in Uganda have had a low profile. Perhaps as a consequence, more traditional beliefs in the nature, aetiology and treatment of deviances called `mental illness' in the west has predominated. What follows are findings from interviews undertaken in the course of fieldwork during two visits to Uganda in 2010 and 2012. They were conducted in order to explore traditional views and treatments of mental illness and their relationship with more western mental health services.

Methodology

In 2009/10 readily available data were collected and interviews conducted with key officials in the Health Ministry, the Director of Butabika Hospital and University staff. This information, continually updated, was then developed into field research in 2012 which consisted of interviews with staff in a rural mental health service, together with staff at an international NGO providing mental health care. It also involved interviews with two traditional healers and 22 in-depth interviews with Ugandans from the Buganda (Bantu) area, with a mix from the rural (12) and the urban (10). Twelve were women and 10 men. Access to these `lay' respondents were negotiated through the village chief in the rural area and the chairman of the Local Council in the urban area. Meetings were then held to describe the project to local people and participants were recruited. Interviews were approximately 60 minutes in length and conducted either in Luganda or English (using a sociologically informed interpreter), translated where necessary, taped and then transcribed. Data were analysed using a cognitive mapping technique (see Jones, 1985 and Shaw, 2004)

Ethical guidelines of the British Sociological Association and the University of Nottingham were followed. A small ex-gratia payment was made to respondents (UGS 10,000 – approx £3).

Ugandan perceptions of mental illness

It is salient that the peoples of Uganda are not a homogenous population. Besides the religious and tribal differences there are also significant differences between rich and poor, urban and rural, and between tribes and clans within tribes. This fieldwork was unable to capture a full spectrum of perceptions of mental health across these divides, but it does offer an understanding of the context and a focus on those areas where indigenous traditional medicine is most used. Mental illness in a Ugandan context has many different meanings. Some of the more affluent and western educated may well adopt western understandings and concepts but these understandings are different amongst the majority, especially for people of the rural and urban poor Buganda communities. As Kyeyune puts it:

"Differences in understanding mental illness exist within the rural and the urban context. While traditional beliefs in witchcraft are still strongly held in the rural communities, the urban folk are more likely to have a scientific understanding of mental illness, attributing it to biological psychological and social causes" (Kyeyune 2010 p5)

Interestingly this author goes on to point out that deviant behaviour amongst young people is likely to be attributed to alcohol or drugs, whereas deviant behaviour in the middle-aged and elderly is more often attributed to witchcraft:

"…the perception of mental illness in the community is someone who is fighting and throwing rocks and beating everyone… people look at mental health in terms of mania cases. They forget about the simple things like anxiety, alcohol dependency and depression" (Hospital Manager, Rural district)

As one may expect, these diagnostic terms do not have equivalents in Luganda. To people in the Buganda community it is all termed *mularu* (madness). The respondents recognised *mularu* because of the deviant behaviours people exhibit and in interview may use the term interchangeably with "madness".

In general, and especially in the rural districts, mental illness is associated with the spirit world. This informs help seeking:

".. spiritual (traditional) healers do a better job than the doctors. *Mularu* has a spiritual cause and only spiritual healers can talk with the spirit world. Muzungu (White) medicines make things worse… people are not healed they are pacified - doped up. But (spiritual) healers they really get to the real cause – they attack it!" (Man, Rural district).

However, the interface between perceptions of spiritual aetiology and help seeking are not always clear cut. Kayuma describes the case of a 30 year old man who has a diagnosis of epilepsy. Epilepsy is considered "madness" in Uganda, and indeed in many other low income countries. In the west it is considered a medical condition. The man's mother said that her son was still a small boy when a fierce dust-churning gust of wind swept into the compound and disappeared at the spot where he was sitting, and that his epileptic seizures started from that point. The mother acknowledged that the western drugs helped her son in that the seizures reduced, but the aetiology was still seen to be possession by a spirit and spiritual healers were also consulted, especially as the drugs were not always available in the health centre and they couldn't afford to buy them on the open market. (Kayuma, 2010).

The causes of *mularu* (madness) are not only seen to be the roving spirits that can inhabit an individual but also witchcraft and, particularly perhaps for the religious, fate. People who are in a dispute over, for instance, land or cattle, can be accused of hiring a witch to put a curse upon the person they are in dispute with.

"Witchcraft and curses are very common in land or marital disputes and illnesses are often attributed to that cause" (Man, Urban region)

This was seen to be one of the reasons for low take-up of mental health services "most people seek help locally from spiritual healers. They think they are bewitched. They only come to us as a last resort, no one thinks of going to a hospital or health centre first." (Health service manager, Rural district).

This was also confirmed by urban NGO health staff. In general people would first seek the assistance of the spiritual/traditional healer to see if a curse has been laid and to have it removed, which is not really surprising. Both spirit possession and neurological disorders are, to the lay person, mysterious and invisible processes. People seek explanations and will believe whatever experts in a respective field are saying is the solution. As such explanations cannot be verified custom and opinion prevail, whether that is to seek a traditional healer or a western doctor. Traditional healers have been there far longer than western medicine and have the same world view and meaning systems as their patients (de Jong, 2013). Also "traditional healers have the additional advantage that they sustain themselves and thus are less dependent on the whims of

failing government's and donors. They stay even when the public health structure crumbles due to war or disaster" (ibid., p.7)

Mental illness and stigma

Mental illness is widely associated with stigma and that is as much the case in the Uganda as elsewhere. Seemingly mentally unwell people can often be seen roaming the streets and are not always treated humanely. In 2011 a woman suffering from mental illness was stoned to death for killing a child in Kabalagala, a Kampala suburb. The press reported that she had recently been discharged from the psychiatric hospital. The same thing happened to a woman who was perceived to be *mularu* a few months earlier when she scalded a child with hot water in Masaka Nkuhne Village (Uganda Vision, 14/6/2011). All the respondents in the study were clear that stigma was extended not just to the person with *mularu* but also to their family, which was one reason why families can `cast them out', to distance themselves from stigma and its consequences.

"if people think you are mentally ill you can lose your job, and there will be bad attitudes towards you. Family will disown you as it is seen as a bad omen" (Man, Urban district)

"if there is a mad person in the family it is hidden. If it is known (then) work, social and marriage prospects would suffer. It is a great family shame." (Woman, rural district)

One exception was a rural respondent who knew of a rich family where the son inherited and was cared for within the family. He could often be seen within his compound "fighting banana trees thinking that they were lions".

Furthermore `casting out' could also be linked to a commonly held belief that mental illness may be contagious:

"Psychiatrists I think are mentally sick, if you work with the *mularu* you are bound to become *mularu* yourself- if you do it for long enough" (Woman, Urban district)

This view was expressed by seven of the respondents. It may be related to a fear of the mental hospital. It wasn't a place that any of the respondents wanted to go:

"…if a person has that problem (*mularu*) and he is taken for help then the only place to go is Butabika… he will be treated badly there. The doctors are not all sane. Everyone would prefer a private place, but it is not affordable. If it was me I would run away" (Man, Urban district)

The Buganda Health Minister interviewed did acknowledge that there was a high degree of fear as well as stigma in being associated with psychiatric services:

"Mental illness is a priority but we know that there is political interference and corruption in the system here. Politicians who challenge government can end up being committed to Butabika and in doing so are discredited politically… husbands can bribe doctors to commit their wives in order to get possession of the wife's property. It is not a `place of safety'… In such circumstances I'm not really surprised that the people seek assistance from traditional healers"

Indeed there seems to be less stigma associated with being the recipient of a curse, it's a misfortune rather than spirit possession which may point to misdeeds in life. A draft report shared by Kyeyune contained a corroborative quote by a nurse at a rural hospital. Here it was noted that patients come to the health facilities as a trial only and shortly go back to traditional healers unless there is a rapid improvement "…the moment a patient stays for a few days without improving they will immediately say `ebekka (exclamation), it's because I quarrelled with so and so. The hospital will not manage' and they run away" (Kyeyune 2010 p.38).

Seeking help from traditional healers and herbalists is often the first resort of people faced with physical as well as mental illness. Traditional healers are highly valued members of the community and were trusted by all of the lay people interviewed. "They (traditional healers) have peoples' best interests in their heart, particularly if you consult them often and they know you" was a common view. The role of `faith' should also not be underestimated. One respondent (Woman, Urban district) said of people with *mulalu* "it is just their (fate)". This is also tied up with notions of mystic or external causal factors. The same respondent said that "keeping faith in God means that you stay healthy, if you are feeling low then you need to pray harder and give your life to The Lord". This was a common thread in 8 of the interviews, especially with women from both the rural and urban districts. Feelings of sadness or anxiety were seen as spiritual rather than psychiatric or health issues and best dealt with through prayer in church, the mosque and/or with guidance from a traditional healer (people usually said they would use both) rather than through organised medical services. There was clearly the view with 9 of those interviewed that what in the west would be called `mild to moderate depression or anxiety' was something people could deal with themselves perhaps with spiritual guidance and not something that necessitated medical help seeking.

As well as having the trust of the community and being accessible, traditional healers are also preferred because of the affordability of their

services and their hospitality. As one traditional healer in the study reported:

"It is well known that no one gives counselling as good as that given by traditional healers, because they spend time talking to clients and giving them food and drink if necessary. You don't find that in medical services. Our charges are also very affordable and in most cases negotiable… we make clients feel comfortable and they are happy with us" (Healer 1)

Healers are well known in their villages and widely consulted. When asked about his work, another traditional healer stated:

"We take time to talk with people to understand their problem so that we can treat the whole person, the physical and the spiritual, often illness has a spiritual cause but not always and the traditional healer can judge the difference. If it's a physical problem and I think it is better the client goes to a hospital I will tell him so" (Healer 2)

It was interesting that sickness was seen to be the result of "a failure of someone's self-healing power caused (not by bacteria or virus, but) by the loss of the body's balance or energy" (Healer 1). The cure is perceived in terms of restoring the body's "wholeness". In other words the healers believe that therapy is essentially grounded in both flesh and spirit," a process of restoring self-healing power" (Healer 1)

This is why some people may consult both traditional healers and medical doctors in extreme distress. The traditional healer restoring the spirit while the doctor helps restore the biological functioning. This is not unique to Uganda. De Jong writes of the irritation he felt as a doctor when he treated someone with tuberculosis: "the honor of my success would always go to the healers. The reason for this was clear to my patients, but not me, the healer had dealt with the cause" (de Jong, 2013 p6).

This also raises an issue for medical services within Uganda around the interface with traditional healers. As they are the first place much of the population to go to seek help, it would seem sensible to incorporate traditional healers into service development with clear and agreed pathways of care and interfaces between them and medical health services. This is something that has only recently been acknowledged in Ugandan policy. It has yet to be fully integrated into service delivery (Basangwa, 2009). However there is prejudice to overcome if this is to become a reality. Kyeyune reports that few western trained health workers recognise traditional healers as providing legitimate care (Keyune 2010). This is highlighted in sociological studies in other parts of Africa:

"In reducing African medicinal systems to "witchcraft," global readers and Africans consume such anthropological or colonial renderings of those

systems and, invariably, fail to appreciate the layers of indigenous (medicinal) knowledge possessed by various members of a community and the ideational basis of the systems' approach and therapy." (Konadu, 2008 p2)

This is also clear in the data from the Ministry and health service staff respondents who contributed to this study. They viewed traditional healers as having "a low occupational level", though one health worker - while sceptical of their herbal remedies – did recognise their counselling skills: "It's all mumbo jumbo of course – no scientific basis, and in many cases traditional healers can do real harm with their herbal remedies... We sometimes have families bringing a member who is has been bound and gagged, sometimes on the advice of a traditional healer. They really need to stay away from serious cases and know their limits…. They do seem to have good counselling skills though and have the time to talk and build up good relationships with their clients" (Health Centre Nurse – Rural district)

This is problematic as in mental health care "lay people often do as well as professionals and new psychotherapies are no more effective than older ones" (de Jong, 2013). In not seeing traditional healers as their equals and fully incorporating them, mental health workers may be missing an important opportunity to improve population health.

Reflections

It is apparent and widely recognised in Uganda that traditional healers are key players in the provision of mental health services and the first source of help for the vast majority of people with a mental health problem (Kyeyune, 2010, Konadu, 2008). Traditional healers vastly outnumber western trained health service personnel in much of Africa (Sawadogo, 2013), and this is the case in Uganda.

Since 2005 mental health policy in Uganda has incorporated a commitment to strengthening collaboration between mental health workers and traditional healers "to encourage sharing of information, referral of cases and participation in research" (UMH, 2005 para 3.7a). Strikingly the traditional healers interviewed knew little of it. The main thrust of policy appears to be on widening access to mental health services ,through a service decentralisation policy in line with the WHO mhGAP programme. Thus, there are clear challenges to this aspiration, and it is unclear how genuine it is, or how much it reflects a perceived need to acknowledge current expectations whilst pursuing a separate agenda. Konadu argues that the indigenous and the biomedical systems in Africa are irreconcilable at their very core, and the very notion of integrating them seems misguided (2008). However, cooperation may be possible if both systems "acknowledge and accept their areas of expertise

and limitations, perspectives and cultural foundations from which they operate, and are genuinely concerned about the difficult but necessary task of being human" Konadu (2008, p2). The mhGAP programme may be attempting to impose an unnecessary burden upon the Ugandan economy. There are many who argue that western mental health service practices over-medicalise human distress (Angell, 2011a). As Nemade, Reiss and Dombeck point out (2007) "if emotional disturbances are not considered within the realm of disease, depressed individuals might not readily seek out psychiatric or mental health care for depressive symptoms" (p.27). This is something that is seen to be common in developing countries (Saxena et.al, 2007).

If people are coping with their distress and finding means to deal with it, is that problematic? When criticisms of western approaches to mental health difficulties are taken into account, it may well be imperialistic to suggest that they are unquestionably "better" than what is already available and culturally accepted.

The matter of epilepsy is a particular issue in this context. Tropical diseases associated with central nervous system infestations, such as Cysticercosis, are amongst several reasons why epilepsy is far more common in developing countries (Pradhan & Yadav, 2004), and so it is much more part of everyday life than contemporary western experience. Furthermore its manifestations of striking behaviour change, apparent mental breakdown, and its historical association with "possession" mean that it is grouped with other conditions which western medicine regards as psychological, even though western medicine has demonstrated to general satisfaction that it is usefully understood as a neurological condition and treated accordingly. Few contest the view that epilepsy is more successfully provided for by western medicine than by traditional healers. Epilepsy and other neurological conditions are explicitly included amongst the conditions targeted by the mhGAP programme (WHO 2011). Drugs work for epilepsy. The success of drugs for epilepsy is used to promote western approaches to mental health across the board. Many people in developing countries think epilepsy has all kinds of obscure causes, but in reality it is a neurological disorder and the best treatment at the present time is medication. The mhGAP and GMH campaigns try to persuade people in LMI countries that all mental health disorders should be thought of in the same way as epilepsy.

Rather than experiencing different approaches to healthcare as expressions of either primitive and outmoded "traditional" practices on the one hand, or the expression of an act of cultural imperialism on the other, perhaps both should be validated as legitimate attempts to resolve health and social care difficulties, with their own potentially complementary strengths and shortcomings.

Furthermore, a developing public health approach to improving mental health is beginning to emerge (Knifton and Quinn 2013). This recognises the importance of social contexts in determining mental health, and focuses upon changing social structures, regeneration and community building. This approach attempts a deconstruction of the categories of mental illness and the construction, instead, of a single continuum with recovery as the prime goal. This approach highlights the importance of balancing population level work with targeted interventions (shifting the balance of priority within Uganda's mental health policy) to focus upon health equity rather than simple population health gain.

There is strong evidence that lower socio-economic status is associated with poorer mental health. Poorer sections of the population are at twice the risk of mental illness than those with average incomes (Fryers et al 2003). This approach would focus on early years, vulnerable communities and strive for incentives for employers to recruit from areas of high unemployment. This public mental health approach is concerned with investments in areas of greatest need in line with proportionate universalism (Marmot, 2010). However the approach extends beyond socioeconomic factors to address gender, disability and ethnic inequalities that can manifest in discrimination and stress. The importance of this movement has been recognised by WHO in its Programme on Health Rights (www.health-rights.org) but needs importing into its mental health policy. Huge inequalities characterise many developing countries, and they certainly exist in Uganda. In many instances these are also a reflection of the same cultural colonialism we see driving the mhGAP, as a small proportion of the population begins to obtain access to highly sought after trappings of western consumerism. Ironically this may be undermining the public mental health of such countries whilst at the same time purporting to improve it. There is a strong case for considering the constructive enablement of the peoples and communities of developing countries such as Uganda to be a much more effective way of improving public mental health, than the slavish importation of western medical psychiatry into cultures where it may not have the same significance, and where valuing it undermines traditional and socially valued practices.

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