5-1-2017

Madness, Medicine, and Witchcraft in Bududa, Uganda

Hugh H. Bartlett
Lehigh University

Follow this and additional works at: https://preserve.lehigh.edu/undergrad-scholarship-eckardt

Part of the Medicine and Health Commons

Recommended Citation

Madness, Medicine, and Witchcraft in Bududa, Uganda
Hugh H. Bartlett
Dr. Kelly Austin
Eckardt Scholar Senior Thesis

Abstract

Many developing nations struggle to provide adequate care for their mentally ill. Mental illness is predicted to affect 10 percent of a given population and left untreated can lead to a life of poverty and vagrancy. Many African countries, including Uganda, have strong belief systems in religion and spirituality which include the beliefs in evil spirits, witchcraft, and prayer healing. Religious and spiritual beliefs are often applied to perceptions of mental illness - evil spirits and witchcraft are seen as causes of mental illness and prayer is an acceptable method of treatment of mental illness. This study qualitatively assessed the beliefs surrounding mental illness by interviewing community members, health care workers, religious leaders, and witchdoctors. The purpose of the study was to generate an understanding of the mental health care system of Bududa, Uganda, to make recommendations of ways to improve the care of mentally ill people, and to direct future study in the region. We found that mental illness is highly stigmatized for its association with acts of violence and idleness and that there is little communication between the formal and informal systems of care even though community members are likely to be treated by both at some point in the progression of their illness. Recommendations for future action include implementing a sensitization program for community members and joining the informal and formal sectors of care in a common referral network.

Introduction

The Bududa district is located at the base of Mount Elgon in Eastern Uganda contiguous with Kenya along its eastern border. The district is rural, isolated from any large urban centers, and is one of the poorest districts in Uganda. As such the living conditions of Bududa are below typical standards in all categories of life. The population tends to live in mud huts, the roads are not paved and are regularly made impassable due to the rain. There is an acute lack of health

care resources including human resources. The population suffers with high rates of infectious disease, the education rates are low, alcoholism is prominent among the population, and teenage pregnancy rates are high – the problems faced by the community are many and extend through all areas of life. These problems create a compounded, difficult health situation.

Mental health care is an aspect of health care that is, throughout the world, often left out of consideration when discussing the health of a population. This is especially true in Uganda and among developing nations. The national budget dedicated to mental health resources is far below international standards and resources are allocated based on a centralized system of care. In a centralized system, care is administered in an institutional setting from one central location in the nation. In the case of Uganda, there is one national referral hospital called Butabika Hospital located in Kampala which receives referral cases from every district in the country. The vast majority of the nation's mental health care resources are located here which means the vast majority of the population is left without access to proper mental health care at a primary level.

Trends set by the World Health Organization ("WHO") and subsequent policy reform seek to redistribute care among the population at large and integrate mental health care into primary health services in order to address the mental health concerns of the population. However, even though this policy was implemented years ago, residents of rural, poor districts continue to struggle because of the inaccessibility of mental health care resources locked up in referral hospitals in hard-to-reach urban centers and the consequent lack of formal mental health care resources at a community level.

Informal systems of care which are based on religious or spiritual healing fill the void of formal mental health services in many societies. In the Bududa district where I performed my research, religious leaders and witchdoctors make up a robust informal system of mental health

care. The community is very religious and holds strong beliefs in spirituality and the efficacy of prayer healing. I set out to explore these beliefs and how they are related to mental health. The objective of the study is to develop an understanding of how people in Bududa perceive the causes and signs and symptoms of mental illness in order to learn more about the stigma associated with mental illness and about how people seek treatment for mental illness in the district. In doing so, I hoped to learn whether the informal system of care could be integrated into the formal system. My findings reveal how the community in general perceives mental illness and how this relates to the stigma that is associated with mental illness. I conclude that the practitioners in both the informal and formal systems of care are able to work together and integrating the informal system of care within the formal system will reduce the stigma surrounding mental illness, connect more people to care, and provide care which suits the mental health care needs of the population.

Literature Review

Gaps in the Formal System of Care

Uganda's estimated GDP in 2015 was 79.88 billion USD, which equates to 2,000 USD per capita. Uganda's GDP per capita ranks 202nd out of 229 making it one of the poorest countries in the world (Central Intelligence Agency). In 2005, the government allocated about ten percent of total expenditure to health and four percent of the health budget went to mental health operations, of which 55 percent was directed to the National Mental Hospital located in Kampala (WHO-AIMS, 2006). This leaves very little capital for primary mental health care. There are only 1.13 healthcare practitioners specially trained in handling psychiatric illnesses per 100,000 population for the country (WHO-AIMS, 2006), the majority of whom are psychiatric nurses. The government spent on average eight dollars per person on health in 2005 (WHO-

AIMS, 2006). In effect, there is very little money being spent at a community level on mental health care which results in a lack of qualified medical personnel, pharmaceuticals, and hospital beds. Uganda is also plagued with a high rate of infectious disease transmission such as HIV, malaria, hepatitis, and schistosomiasis which attract more attention and money from the government health care system as well as international health agencies than mental health concerns do. As a result, the need for mental health care is unmet at a community level. Kasoro et al (2002) published a study of one district in Uganda in which they noted that the formal mental health care system is unable to recognize and provide early care of mental illness and the majority of severe cases are left untreated.

The national government revised its mental health policy in 2001. Previous to this revision the policy was directed by the Mental Treatment Act of 1964. The new policy was reviewed by Ssebyunna et al. (2012) and found to contain a number of successes. The new policy follows guidelines and principles set by the WHO to address global concerns of the mental health care systems of developing nations. Relevant aspects of the policy changes to this study include 1) Strong emphasis on the integration of mental health services into primary care; 2) Promotion of intra-sectoral and inter-sectoral collaboration between non-governmental organizations and government departments; and 3) Promotion of human rights and social inclusion.

However, during the time I spent in the Bududa district, I found that the policies have not translated into action. Simply not enough resources are allocated to the district to achieve many of the goals set forth by the new policy. There are not enough health care workers trained in psychiatry to offer quality mental health services at a primary level. At a tertiary level in the district hospital there are still too few resources. There is no place in the hospital designated for

5

psychiatric inpatient visits, only an outpatient office which is open only once per week. There is a lack of pharmaceuticals at both the lower level health clinics and at the district hospital. No formal referral networks or collaboration of any kind exists between the government health clinics/hospitals and the traditional healers or religious leaders. There still remains a heavy stigma attached to mental illness which the formal health care system seems unequipped to resolve. Kigozi et al. (2010) note that critical components of the WHO-AIMS metric are not addressed in Uganda's mental health policy draft, including financing, addressing the relationship between poverty and mental illness, role of psychologists and social workers in the health structure, provision for welfare for people with mental illness, among others.

Faith Healing

Uganda is a predominantly Christian. Forty-five percent of the population reports observing some sect of Protestantism while 39.3 percent practices Roman Catholicism. Islam is practiced by 13.7 percent of the population, a relic of the Arab trade in the late 19th century. It is uncommon for people in Uganda to report observance of the traditional religions as their primary religion. However, many practice traditional religions concurrently or at least hold a belief in the spiritual aspects of the traditional religions. African traditional religions are the indigenous religion of the African people. The term traditional religion includes a diverse set of locally originating spiritual belief systems. Despite the wide variety in Uganda and throughout the African country, there are a few themes/beliefs/values that are common among most traditional religions. These include: the belief in a supreme, omnipotent God (separate from the Christian God), the removal of the supreme God from daily worship, the idea that lesser gods take residency in objects and places, the recognition of the spirits of the ancestors, the idea that the spirit world of the ancestors is as real as the living world, and the roles of chiefs, elders, religious leaders in balancing the spirit and the living world (Berry 1995, Worldmark).

6

Beliefs about the etiology, causation, and treatment of mental illnesses vary widely across cultures and are the products of large institutions like religion and the health care system of a nation (McAlpin and Mechanic 2011, Kleinman 1980, Kleinman et al. 1978, Jenkins 2015). Studying mental illness from the perspective of medical anthropology is, as Arthur Kleinman puts it, "an exploration of the borderland between anthropology, medicine, and psychiatry" (Kleinman 1980). In this way, the experience of mental illness is uniquely situated in medical anthropology at the junction of human health, healing systems, and their sociocultural contexts. In Africa, traditional spiritual beliefs have a significant effect on how people think about and treat mental illness. Traditional healing is a system of care which existed in Africa long before western biomedicine was introduced and continues to be relied upon for treatment (Ovuga et al. 1999; Abbo et al., 2009; Degonda and Scheidegger, 2012) and traditional healers play a significant role in the treatment of mental illnesses at a community level (The, 1998; Ovuga et al., 1999; Tabuati et al., 2003; Abbo et al., 2009; Degonda and Scheidegger, 2012).

In Uganda efforts have been made to research the role of the traditional healers at a community level to document their practices and evaluate the efficacy of their treatment in order to make recommendations regarding the integration of the traditional healers within the formal system of care. Ovuga et al. (1999) interviewed 29 traditional healers in one district in Uganda and found that every participant believed that mental illnesses were cause by evil spirits, witchcraft, or curses and almost all of them treated patients with mental illnesses. In the diagnosis of mental disorders, typically traditional healers do not differentiate among mental illnesses (Traditional Healers and Uganda's Success, 2003). In Ovuga et al. (1999) traditional healers relied on signs and symptoms they believed to be associated with mental illness which include incoherent speech, red eyes, undressing in public, and other abnormal behavior and

appearance. Degonda and Scheidegger (2012) evaluated the outcomes of 978 patients and families treated by six spiritual healers in Uganda. They found that 92.2 percent of patients who received only spiritual healing reported a positive outcome (recovered). Traditional healers are a good option for addressing the psycho-social-cultural issues of people (Kleinman and Sung, 1979**,** Degonda and Scheidegger, 2012**)** but they cannot address physical diseases such as HIV or malaria. Thus, it is important that traditional healers refer patients to the local hospitals for medical evaluation. Ovuga et al. (1999) report that almost all of the traditional healers in their constituency were amenable to referring patients to the local hospitals. In another study performed in Uganda by Tabuati et al (2003), fifty percent of traditional healers would refer patients to the local hospitals. Traditional healers make up a very important part of the mental health care system in African countries at large and specifically in Uganda by delivering efficacious care to patients and traditional healers are generally amenable to collaborating with the formal sector. The informal system of care thus fills the gaps in the formal system of care by filling the void in the lack of human resources and by applying culturally appropriate methods of care for a relatively low cost.

Stigma

Worldwide, people with mental illness face a barrage of stigma and discrimination and resulting human rights abuses (WHO 2001, WHO 2005, Funk and Drew 2010, Drew et al 2011). Human rights abuses in mental institutions have been documented throughout the world in both developed and developing nations (Funk and Drew 2010, Drew et al 2011, Human Rights Watch 2012, WHO 2005). Laws and policies, particularly of developing nations, explicitly or implicitly restrict mentally ill peoples' social, economic, political, civil, and cultural rights (WHO 2005, Perlin 2013). The international movement to improve the status of mentally disabled people

throughout the world is a movement that has begun only very recently (Katz 2006). This has resulted in an increase in data illuminating the plight of the mentally ill throughout the world that makes it clear that, compared to healthy individuals, mentally disabled people experience a significantly disproportionate amount of discrimination and abuse (WHO 2001, WHO 2005).

<u>Social Determinants of Mental Illness</u>

Social and cultural influences on mental illness have thus far been considered with regard to their role in the treatment systems that arise in a community. Social factors also have strong relationship with the development of mental illnesses. Adverse social conditions are strongly correlated with an increased incidence of mental illness which may be the product of a causative pathway or of gene-environment interaction in somebody pre-disposed to mental illness (McAlpine and Mechanic 2001).

Poverty is one social factor that is often related to mental illness and is an important consideration in the context of Bududa, Uganda. Interestingly, absolute measures of poverty such as income are generally not associated with mental illness (Sturm and Gresenz 2002; Patel, 2007; Das, et al. 2007). Rather it is useful to consider poverty in context as a multidimensional social phenomenon in which intermediate factors must be involved that mediate poverty's determining influence on mental illness (Patel and Kleinman, 2003; Das 2007). Araya et al. (2003) suggest that education is an important intermediate factor which strongly influences poverty's effect on the mental health of a person. Patel and Kleinman (2003) and Lund et al. (2010) point to insecurity, hopelessness, social change, education gender and comorbidity. In Araya et al (2003), the determinative relationship of poverty was ameliorated if a person was able to gain an education despite living in poverty. In Bududa, 71 percent of students fail to make it past the seventh grade. Patel (2007) proposes the concept of poverty and its relationship with mental

illness as a cycle, in which depression and anxiety, alcohol abuse, and ill health contribute to reduced productivity and increased health expenditure which leads to malnutrition, low education, inadequate health care and lack of social networks which revert cyclically to ill health.

Drug abuse is one of the most frequently reported causes of mental illness in my study. Patel (2007) places alcohol abuse in his cycle of poverty and mental illness as an effect of low education and lack of social networks. There certainly exists a dialectic relationship between alcohol abuse and Patel's proposed causes of it, as well as a dialectic relationship with mental illness. The mentally ill are stigmatized and excluded from society so they turn to drinking and drug abuse which contributes to even worse health and confirms the community's negative image of mentally ill people as drug abusers (Crisp et al 2000).

Method

This research is based off thirty-one interviews with thirty-five participants as well as participant observation. The interviews were conducted over an eight-week period from June to July 2016 across the Bududa district in eastern Uganda. The participants of the study can be categorized depending on their role in the mental health care system as either a general community member, a health care professional, or a religious/spiritual leader. Participants of separate categories were recruited differently; the researcher relied heavily on relationships formed in the village and in surrounding villages to draw general community participation while health care professionals and religious leaders were recruited by visiting clinics and places of worship. All interviews were audio recorded and later transcribed and analyzed. The language that the interview occurred in was left to the discretion of the participant who was encouraged to use any language which he/she felt most comfortable using. Although English is the official language of the nation, the tribal language of the people, Lugisu, is spoken throughout the district

and much of the general population does not speak English. For interviews conducted in Lugisu, I was aided by a local translator.

Conducting interviews with community members, health care professionals, and religious leaders was necessary to gain a holistic understanding of the complex perceptions of mental illness informed by biomedical, religious, and spiritual belief systems. Interviews elicited important information about how people perceive mental illness and those afflicted by "madness." Information on the perceived causes of mental illness, the perceived efficacy of different forms of treatment, and the stigma surrounding mental illness is a product of intertwining social, cultural, and religious beliefs. The development of an understanding of how religion, medicine, and culture interact in the mind of the community to create a perception of mental illness is important to exposing gaps in the mental health care system and to offering suggestions to improve the quality of care and quality of life of those afflicted with mental illness in the district.

Prior to conducting interviews, I received approval from the Institutional Review Board at Lehigh University. Care was taken to ensure that participants' privacy was protected and risk minimized for participants. Mental illness is heavily stigmatized in the district and is a topic that is taboo to confront. Interviews took place in a private setting often in the home of the participant, an office room of a clinic or hospital, or in my host family's residence. Participants were informed of the purpose of the study and of the risks associated with participating before being asked to sign (or thumbprint) the consent form to proceed with the interview. The researcher explained that once they had agreed, participation was not mandatory and participants were free to refrain from answering any questions. Participants received compensation that varied based on the participant's status. High ranking health officers and religious leaders

received 20,000 UGX, low-level health staff and lower level religious leaders received 10,000UGX, and community members received 5,000UGX or a collection of tea, sugar, and soap. For reference, 1 USD is approximately 3500 UGX.

The researcher interviewed a total of seventeen community members of whom eight were females and nine were males. Six of the interviews were conducted in English in the presence of the translator in case any clarification needed to be made. The participants who spoke English fluently enough to conduct the interview in English had completed schooling up to at least a form six level. Among the participants who spoke English were a social worker, a program director of a charter school with a Master's degree in marketing from Makerere University, a police officer, and two teachers. These participants hold a high status within the community. The remainder of participants did not speak English and were generally peasant farmers. The researcher spent considerable time cultivating relationships with the community members of his host village. This included playing soccer with the men of the village, talking with people at the trading centers, and meeting with the elders of the community. The terrain of the Bududa district is mountainous and rugged. The majority of people living in the district do not live close to the major road where the host village was situated. To collect a representative sample of the community, I hiked with my translator into the mountains and sampled community members in villages isolated from roads.

Seven health care professionals and one government worker participated in the study. The constituency consists of four clinical officers, two nurses, and a midwife. One clinical officer is a long-time friend of Dr. Austin's and was employed by the FIMRC clinic, which is supported through donors in the United States. Two of the nurses and the midwife were also employed by FIMRC. The senior clinical officer of Bukigai health center and a nurse from the

same health center were sampled by simply visiting the Bukigai health center. The two remaining clinical officers who were interviewed are clinical psychiatric officers. Clinical psychiatric officers have advanced training and qualifications in mental health care. In this district, clinical psychiatric officers hold the highest degree of training with regards to mental health care. The clinical psychiatric officers interviewed for this study are the only two clinical psychiatric officers in the district responsible for the mental health of a population of about 170,000 people. In addition to the aforementioned clinicians, the study includes the district health educator who is not a health care practitioner but who is intimately involved in the health care system of the district. All interviews with health care professionals were conducted in English.

Nine religious leaders participated in the study; the only female in the religious constituency was one of the traditional witchdoctors. Collection methods included using connections established through the translator and drawing on relationships developed by the researcher. The religious constituency is comprised of participants from multiple denominations of Christianity including two Roman Catholic priests (one of which did not allow recording), a Roman Catholic catechist, an Anglican pastor, and a Pentecostal preacher and his assistant. Christianity is the dominant religion in Uganda and in Bududa. Islam is the second most common religion. The study includes one Imam. Two traditional witchdoctors, referred to as "umufumu" in Lugisu, participated in the study. Interviews with the Imam, the catechist, a leader in a church, and the two umufumus were performed through the translator.

The local translator was a huge asset to the research. His contacts with community members, Christian church leaders, and traditional healers provided invaluable sources of data.

The translator's contribution to the study went beyond supplying participants and simply translating questions and answers during interviews. The wording, phrasing, and order in which the researcher posed questions to the participants heavily influenced the quality of the interview. The translator and the researcher adjusted the interview guide according to the translator's understanding of his own community.

Interviews across the three categories of participants retained the same core line of questioning. In each of the interviews the researcher inquired about the 1) causes of mental illness, 2) signs and symptoms of mental illness, 3) if mental illness can be treated and how, 4) if mental illness can be prevented and how, and 5) how the community responds to the mentally ill. Additional questions arose to explore the participants' responses. The researcher asked health care workers, in addition to the core questions, about the mental health care resources available in the district and the incidence/frequency of continued educational opportunities specific to mental health. For religious leaders, interviews included questions intended to allow the participant to explain his religious beliefs and about the role the church plays in the community.

Upon returning home, I transcribed each interview using the software ExpressScribe. I read through the interviews three times. Through the first reading I re-acclimated myself to the interviews. The second reading, I annotated the interviews and pulled out power quotes for future reference. Power quotes are quotations from an interview that convey an idea in more clear or powerful language than the researcher could achieve; they tend to validate themes. Finally, on the third read, I coded specific responses to generate quantitative data of the frequency of responses.

The paper will follow the structure of the core questions of the interview guide. Findings of the 1) perceptions of the causes/signs and symptoms, 2) the community's response towards

mental illness, and 3) treatment seeking behavior and the role of the religious, medical, and traditional systems in the care of the mentally ill. In the discussion of the causes and signs and symptoms, health care practitioners' views will largely be left out and the discussion will focus on the general community's perceptions of mental illness and how medical, religious, and traditional beliefs blend together to create the collective understanding of how mental illness is caused and recognized. The community's response towards mental illness will cover the stigma that is associated with mental illness and attempt to answer the question why the mentally ill are stigmatized in the community. The paper will then turn its attention to describing, in detail, the holistic system of mental health care paying particular attention to how the three systems of care interrelate and conflict with one another. This section will focus largely on the shortcomings of the formal health care system and the conflict between religion and witchcraft in the district. There are common themes which span all aspects of the discussion, and these will be noted throughout. These include the pressing issues faced by the district such as poverty and malaria, the weak health care system, beliefs in divine intervention and spiritualism, and the conflict between religion and witchcraft.

Findings

The purpose of this research is to inevitably generate useful recommendations to address the issues faced by this community in particular and to contribute generalizable information on the social perceptions of mental illness in poor rural areas with robust religious and spiritual beliefs. To accomplish this goal, it is prudent to develop a holistic understanding of the population studied, the population's beliefs, and the institutions and actors involved in the health care of the population. The findings section will discuss how religious values, spirituality, and knowledge of biomedicine inform beliefs surrounding the causes and manifestations of mental

illness and how in turn these beliefs perpetuate a system of stigmatization and abuse of mentally ill persons within the community and direct treatment seeking behavior.

<u>Causes, Signs, and Symptoms: The Community's Perceptions</u>

The reported causes of mental illness by community members importantly reveals the underpinnings of their beliefs of mental illness. Common causes in the community include references to a biomedical understanding such as, "something wrong with the brain," references to spirituality such as demonic possession, and references to personal liability such as drugs. In fact, many of the reported causes of mental illness reflect the belief in personal liability. That is, those with mental illness or their family did something to deserve the affliction. Understanding the causes of mental illness is very important to understanding how people seek treatment for mental illness. For example, spiritual possession and bewitchment is a very real source of mental illness in the community and many believe that the biomedical interventions available at the hospital can not treat such cases.

The following response of a social worker in the community is a good report of the most common causes that came up in the interviews when prompted by the question, what is your understanding of the causes of mental illness?

> *Ok. I would assume depression. Is mental illness depression mental illness or it leads to mental illness? I don't know but I would think. I have a friend who was depressed and she broke down and sometimes she she doesn't function OK mentally, yeah. So I would think it is depression and the other cause would be it is genetical. It can be passed on from the parents to the children, it is in the generation. And uh yes I think also witchcraft in this community it is there. I really believe that some people can bewitch others to becoming mad. That's what I can those are the only three I can think of. Also maybe malaria.*

This passage identifies depression (although the participant is somewhat unclear about whether depression is a mental illness or causes mental illness), "genetical," witchcraft, and malaria. Later in the interview, this participant also mentions drug abuse as a cause of mental

illness. This passage serves to highlight the general uncertainty surrounding the topic. This participant is a highly educated social worker working in the community. Even so, beliefs about mental illness were hard for her to convey because it is not a commonly talked about subject.

Summing all interviews with community members and religious leaders yields a list of the most common causes of mental illness which will be discussed in this paper: drugs, stress, over-thinking, malaria, and witchcraft/spiritual possession. To facilitate comprehension these causes are grouped by theme and the realm of thinking to which they belong. Drugs and stress are social determinants of mental illness and introduce themes of personal responsibility and reflect an understanding of mental illness as psychological and/or pathological in nature. Malaria permeates every aspect of life in the Bududa district, Uganda, and much of Africa and any discussion that ignores the effect of this monumental disease would be ignoring a facet of everyday life. The final group of causes is spiritual possession/witchcraft. The belief that witchcraft and spiritual possession can cause mental illness is based on a fundamentally different epistemological origin, which is a product of religious and spiritual belief systems.

Drug abuse and stress are social problems that can manifest themselves as mental illness in an individual. Alcohol abuse is common among the men in this community. Uganda as a nation boasts a very high alcohol consumption per capita of 23.7 liters of pure alcohol for those age 15 and above; the average for men aged 15 and above is 25.6 (Global Status Report on Alcohol and Health 2014). The drink of choice in Bududa is the local brew, or malwa, which is beer that is locally produced and consumed or distilled into crude gin, called waragi, for consumption. Drugs which were mentioned include marijuana and opium and also seem to be regularly abused in the community. Drug abuse is often mentioned as the result of living an idle life which applies to youth who are supposed to be productive through school and employment.

The two following quotations illustrate the community's association between drug abuse and

mental illness as well as provide examples of the association between drug abuse, idleness and

age. The first quotation is from a community member and the second is from a pastor.

> *"...youths are starts being stubborn not listening to the parents and then the*
> *person goes on starts drinking after starting to drink he will go on to do drugs*
> *and with time with time the person starts to lose his brains and ends up mentally*
> *disturbed."*

> *"You find somebody resulting to drinking which may result into mental illness*
> *simply because this person does not have anything to do. Unemployment is one of*
> *the key factors that are contributing to a lot of mental problem. And not going to*
> *school. That's one of the problems because some of the people result to drinking*
> *result to gambling, bad habits. Yeah. So if the government can put in place a*
> *mechanism whereby the youth are productive uh engaged in productive activities*
> *it can reduce. If they can control the drug uh drug abuse by overdrinking that can*
> *also."*

The notion of a direct causal relationship between drug abuse and mental illness is clear in

these two passages. The concept of drugs "spoiling" the brain is widely shared among the

constituency and suggests an understanding of mental illness as being somehow rooted in the

physical and biomedical. In this case, community members relate the act of consuming a

chemical drug with a set of symptoms characteristic of mental illness which are attributed to

some physical pathology of the brain. This is a physical, biomedical interpretation of mental

illness. The community associates the incidence of drug abuse, particularly among the youth, to

the lack of employment opportunities in the district.

Stress is a widely reported cause of mental health problems worldwide and this holds true

in Bududa. An important consideration is the cause of the stress. The scope of this question is

broad and responses vary. In this constituency it was common for men to cite the major stress of

having to provide for the family as cause for mental illness. Romantic relationships were also a

commonly reported source of stress. Other sources of stress unique to the Bududa district

include traumatic stress associated with losing family, friends, and loved ones to landslides in the district, traumatic stress experienced by soldiers fighting for the UPDF, and worries over certain coming-of-age rituals. When staging psychosocial interventions and preventative strategies it is ultimately necessary to acquire a full understanding of the stresses that people of a community face; however, a comprehensive discussion of the stresses in this population is too focused to be viewed clearly by this paper's broad lens. Instead the paper will consider the general term stress and its causal relationship with mental illness among the community members.

> *"…and over-thinking because of the poverty which brings about stress…"*

> *"Is one thing. If you if you are poor and you can't afford you tend to always be in need of something and that can always lead to a person having a mental problem."*

Reports of stress as a cause of mental illness relate stress to the development of what biomedical practitioners term psychological disorders. The idea that distressing experiences, living conditions, adversity, and pressure can have an observable effect on the behavior and the health of an individual reflects the understanding that mental illness is not simply caused by a pathogenic agent such as alcohol or opium. Rather, the mental health of an individual can be influenced by events in a person's life and how a person deals with such adversity. Stress can also be seen as a social determinant of mental health because poverty is a key contributing factor to facing stressful situations which can then lead to the development of a mental health problem.

Malaria is the largest threat to the health of the population of Bududa. Malaria is referred to as "the sickness," or "kumusungu" in Lugisu, and true to its name it is the most common sickness in Bududa. In 2011, the DHO records indicate that 88,847 cases of malaria were

diagnosed by health facilities in Bududa (Bududa District Local Government 2012). This is 38 percent of all cases seen in total (Bududa District Local Government 2012). Many more cases go undiagnosed. Despite its commonality, infection by *Plasmodium falciparum* is severely life threatening especially among infants and young children, pregnant women, and the elderly. Severe malaria may develop from approximately one percent of malaria cases and is manifested as anemia, hypoglycemia, metabolic acidosis, seizures, coma, organ failure, and death. A neurological complication of severe malaria is a condition called cerebral malaria (Idro et al. 2010). The exact pathophysiology of cerebral malaria is still not completely understood – what is known, and felt in the district, is the effects of cerebral malaria if a person is to survive. The following passage is quoted from one of the clinical psychiatric officers of the district.

> "*If we see a hundred patients here 26 of them will be epileptics. The reason for that is malaria. People usually take long without treating malaria. At times it is poorly treated. And you know once you leave a child to have that febrile state for long, then the child is likely to develop seizures. And you know at every seizure there are brain cells that what, which die. Brain cells are affected. So the more brain cells which are affected the more damage is caused to the brain inside. So malaria is one of the major causes for this mental problems especially epilepsy. It can also cause other confusion just like that apart from causing epilepsy it can cause just other confusion, organic states whereby you have someone just presenting with a common psychiatric problem but it will end up being malaria.*"

In this passage the clinical officer describes malaria as a causative agent of epilepsy and other general "confusion." According to him, a major problem in the district is that people are not seeking immediate attention for high fever. The overwhelming attitude in the community is to postpone going to a health clinic or the hospital for care. Instead people will self-administer pain killers, fever reducers, and anti-malarial drugs. This attitude seems to be a product of the commonness of malaria in the district.

Community perceptions of malaria as a cause of mental illness are similar to those of the clinical psychiatric officers. The community recognizes that malaria can affect the brain and as such is a cause of mental illness. One community member offered a succinct explanation (through the translator) of the causes of mental illness - "So madness to her is caused by sickness that can affect the brain like malaria." This response indicates a level of understanding in line with the basic principles of biomedicine. That is, mental illness is the result of pathogenic attack on the brain. Another respondent offered a deeper response associating malaria's neurological effects with the timing of the disease and treatment delay.

> *She said um mental health is caused by a sickness, like malaria, when the head pains you a lot and you don't get early treatment or first treatment you can keep on you know having a mental headaches which would maybe transform into a mental health illness.*

This respondent recognizes exactly what the clinical officer warned of – delaying treatment for malaria can cause mental health issues. Malaria's prevalence and its morbidity in relation to mental illness make it a serious concern of the district.

Community members reported malaria, as well as stress and drugs, as causes of mental illness, thereby demonstrating an understanding of mental illness as caused by psychological or pathological damage to the brain. Beliefs regarding spiritualism and witchcraft are fundamentally different. Instead of mental health being rooted in the well-being of the mind or the body, beliefs about witchcraft and spiritual possession express the belief that mental health is rooted in the spirit.

Witchcraft is the ritualistic practice of bewitching a person by casting malevolent spirits on them. An elder community member quoted below describes a particular way in which somebody can go about bewitching another person.

Yeah people like they get soil for example like where you passed a person would come the one who wants to bewitch you get maybe soil from that your footstep and carries it not in his hands not with his barehands but within a leaf and takes it to the people who carry out the witches, the witchdoctor.

This response is more specific than most. More generally, community members say that if you want to bewitch someone you must consult a witchdoctor. There is also the belief that spirits can inhabit a person without any ritualistic witchcraft being practiced.

"Witchcraft" is the most commonly reported cause of mental illness in the community member constituency with twelve of the sixteen community members reporting witchcraft as a potential cause of mental illness. The following passage describes the relationship between witchcraft/spiritual possession and mental illness.

"He is saying that some of the causes can be people being bewitched by others using witchcraft and there are those who are cursed by other people and then some people get stressed like maybe a student or a kid might want to study but due to failure of the parent paying school fees ends up being disturbed and ends up being mentally disturbed."

This passage is important because it demonstrates how the community thinks about witchcraft compared to how they view drugs and stress as causes for mental illness. Witchcraft is described as a cause of mental illness just like stress and drugs, highlighting the ubiquity of the belief of witchcraft as a cause of mental illness. The passage also alludes to the idea that the mental illness resulting from witchcraft and from drugs/stress is indistinguishable. This sentiment is echoed directly by one respondent:

I: Like when you look and you have two people and one has demons and one is caused by virus that they are behaving quite similarly?
R: yes They present same signs.

The signs and symptoms of mental illness reported by the community follow a general theme of perceiving those with mental illness as uncontrollably mad. An analysis of a community's perceptions of the signs and symptoms of a disease is important because it predicts

how, when, or even if people will be referred to care. A biomedical understanding of mental illness would predict people to report different signs and symptoms for different discrete psychiatric illnesses. Instead, the general responses that I collected were all quite similar and the average community member made no attempt to differentiate signs and symptoms based on different mental illnesses.

Common responses tended to vilify the mentally ill by labelling them as violent offenders. Consider the following passage:

> *"To know that the some of the people or a certain person has a mental problem you can find him or her moving with weapons like pangas, like pangas trying to maybe chop off peoples heads or cut someone or you can find those ones who want to beat up people on the road or the streets that would be a sign that this person is not mentally fine."*

The state of being mentally ill is often described as a violent state in which a mentally ill person is likely to destroy property or assault another individual with no reason or provocation. Another respondent whose wife suffers from a mental illness reported to me that his wife is known to thrown stones at people if she wanders out of the house without his accompaniment. This type of behavior describes the mentally ill as animal-like.

> *"So like also when it comes to what they eat like you will give them food on a plate and they leave to eat from the plate and decide to eat food that has fallen down on the ground. Sometimes like maybe if you have pigs instead of uh eating with people you will find him maybe with animals for example like pigs trying to eat what they are eating. That would be a sign that this person is mentally ill."*

Other common animal-like descriptors included blood-shot eyes, incomprehensible speech, irrational or unpredictable behavior, and uncleanliness. The image of mentally ill people that the community holds in its mind is a terrifying image akin to a rabid animal and the community's response towards the mentally ill is accordingly similar.

<u>Community Response: Stigma and Abuse:</u>

The community's attitudes of and response towards the mentally ill is in part determined by their perceptions of the mentally ill. The mentally ill people in the community are often considered as "wasted" people. In this sense, their condition is hopelessly incurable and they are a burden on the shoulders of the community. The association of mental illness with drug abuse and subsequent idleness contributes to the imagining of the mentally ill as wasted peoples and their perceived violent and unpredictable nature make the mentally ill not simply wasted but a threat in the community. As a result, the community's response towards the mentally ill is harsh.

> *"No. He is taken as someone who is wasted. Somebody who is wasted. Even children with epilepsy. I have one in my home. for my brother. and you find the brother is … takes him as someone who is wasted. People don't want mental ill persons. They feel they are now out of place."*

> *"Yes wherever they go they just keep chasing them so they tend to gather in dirty places where the rubbish pits are they keep moving to those other places where they cant be chased away otherwise they just move everywhere."*

The mentally ill are excluded from participating in the community. In the first example a child is described as "out of place" because of his/her mental illness and the father is ready to dissociate himself from the child because of the child's condition. The next two subsequent examples describe mentally ill people being beaten or chased away from interacting with the community. In many cases, the mentally ill people are assaulted or chased away without doing anything wrong. They are simply recognized among the community as being mentally sick and preemptively turned away. Among these examples there seems to be no empathy for the mentally sick among the community, but of course that is not wholly true.

> *"In some communities because those ones who are mentally disturbed tend to have bad manners, most times they are beaten up by the people in the community so the role of the church is to run to their rescue and take them up to be prayed for to get better.*

"*Him as a catholic a person who leads in church they always go and advise the families mostly the families of the patients to just don't be negative to these people take them as fellow humans not treat them like animals and always be there for them, love them… encourage the community to invite them to go and talk to pray for the people with mental illnesses and counsel them.*"

The quotations above come from two Christian religious leaders of different denominations. The respondents here position the church in a protective role. It is the church's responsibility to preach the Golden Rule and develop an understanding among the community that mentally ill people are children of God and should be treated in a respectable manner.

The role of the health care system and the government is to sensitize the community about mental health issues. One health care worker reported that she went into the community to sensitize people about mental health care issues.

"*Yeah we do when we go for outreaches. For example, currently we have uh you can go for we have interpretive community outreaches whereby when you reach there you can still sensitize the community about the existing mental health conditions, how to prevent them, the interventions available in the health facilities that are nearby and maybe in the hospital and then we refer them. Then we also train the VHTs, the village health teams to keep sensitizing them in their meetings.*"

It is the hope of this health care worker that if the community develops a better understanding of mental health from a health care practitioners' point of view they will tolerate the mentally ill in their community and will learn when to refer people to the health clinics for medical treatment. Sensitizing VHTs, or village health teams, is an important part of this. VHTs are village health teams, are teams of community members who volunteer to be health advocates within the community. They are residents of the community in which they work and aid in the dissemination of health information. These sensitization programs rarely target mental health issues but are abundant for other health care issues in the district.

"The problem is to continue with the sensitization but the gap I realize at the moment is you see this political will the commitment of the community leaders in trying to sensitize the people about facts like it has been neglected it is not a priority its not a priority."

"In fact, the community to respond on these mental problems first I said early on they haven't been sensitized. They don't know what to do and they don't know the direction where to move to. That's why I said if the government can start a program of sensitizing like when they started Malaria, hm, and other diseases like TB, hm, this is tuberculosis and whatever, hm, and HIV. Because that building, hm, which is now being turned as a clinic was that hall was put there to sensitize the community. You see sometime back because people were saying HIV is just someone witched."

The first passage is from a health care worker who blames the lack of sensitization efforts on the political will of the leaders of the community. The second passage is from a former government worker. It seems that at least during his recent tenure there were no government sponsored sensitization programs covering mental health issues; however, he recognizes the importance of sensitizing the community. His example of the effects of sensitization on beliefs about HIV speaks to the efficacy of sensitization programs and how they can decrease the stigma of a disease. This point also questions whether the relationship between witchcraft and mental illness is born out of the beliefs of witchcraft or whether witchcraft is simply used to explain the unknown derivations of mental illness and the population could also be convinced by the biomedical sciences through sensitization programs. Both passages point to the fact that mental health issues are simply not a priority in the district; rather, government money is allocated for sensitization programs of communicable diseases.

Treatment Seeking Behavior: The Roles of Formal and Religious Systems of Care

The community has strong beliefs in the power of prayer as a healing method for mental illness and this directs the treatment-seeking behavior of the community. It is not possible to identify one pathway by which community members seek treatment for mental illness.

Depending on a person's beliefs and their resources and access to the formal health care system a

person might first seek the counsel and treatment of religious/spiritual healers and subsequently

decide to visit a health clinic or might visit the health clinic first. In general, the treatment of a

person with mental illness often incorporates both systems of care. The following quotation

illustrates the community's belief in the power of healing through a personal anecdote of its

success.

> *T: Apart from medication they also tried to pray for the child but she was telling*
> *me that every time they tried to pray for the child for example if the child had*
> *fainted from here he would gain the energy to just run and climb the tree.*
> *I: After they prayed for her?*
> *T: During the process of praying. He would just run away or run and climb that*
> *tree. But she has tried to go different places for prayer but it hasnt also worked*
> *out*

In this case the respondent confirms the efficacy of prayer healing but the passage is more

complicated in the way that it incorporates doubts about the efficacy of prayer healing and

concurrent treatment by the formal health care system. The respondent acknowledges that they

did visit the formal health care system and the child was on medications during the prayer

healing sessions. The respondent also notes that while prayer healing seems to have an effect on

the child during his fits, it also has not "worked out" in the sense that the child continues to

struggle with such episodes.

The belief that prayer healing can cure illnesses born of spiritual causes is often at the

exclusion of the power of biomedicine to cure these illnesses.

> *Ok those who are bewitched cannot be taken to hospital and they get cured but*
> *they can be taken to the traditional healers who can try to cure them um. those*
> *those who have stress can be taken to hospital and they are cured.*

This creates confusion among the community about which sort of treatment to seek. As noted in

this report, it is difficult for people to differentiate between mental illnesses caused by drugs or

stress and those caused by witchcraft. Community members might also seek treatment from

religious or spiritual leaders for mental illnesses that are ostensibly biomedical in origin, as is

evident when one respondent explains that prayer healing is indicated for people with mental

illnesses that they were born with: "Like the ones who are born with it they can cure maybe

through prayers you can take them to church and they are prayed for."

Community members may independently seek treatment from both the formal and informal

sectors of care simultaneously but also the formal and informal sectors of care may refer patients

to each other. The following three passages are quoted from a Christian healer, a traditional

healer, and a health worker respectively.

> *"yeah they advise the family of the patients to take them to hospital because they might think that these people are attacked by maybe the spirits but in actual sense theres maybe uh cerebral malaria or it can be because these people are just stressed so they always advise them to just take them to hospital."*
>
> *I: "Do they ever advise people to go to the hospital?"*
> *T: "yes"*
> *T: "they said if you treat and you fail they tell you they advise you to send those people to the hospital."*
>
> *"spiritually some mental illness can be treated because Im saying this because sometimes it is just an attitude someone is just thinking negative is just feels negative or sad about everything but with spiritual intervention this person calms down and gets to realize the truth the ideal. Sometimes it does help. For those coming in with the spiritual interventions as they take our medication here we we do encourage them."*

These passages indicate that the religious leaders, both Christian and witchdoctors, are amenable

to referring patients to a health care practitioner. The health care worker acknowledges her belief

that prayer and spiritual healing can lead to a positive treatment outcome. This does not mean

that the three domains of care are equally as amenable to working with one another. While the

witchdoctor said that he refers patients to the hospital who are not getting better or who are not

affected by spirits, multiple health workers in this study distrust witchdoctors and said they would not refer a patient to a witchdoctor nor would they allow a witchdoctor to see the patient in the hospital.

> Now the the religous leaders are going to give spiritual counseling and somehow the also attack the psychosocial aspect of life. But the spiri... they traditional healers for them they believe this person is cursed, this person has been bewitched, and they first of all they will discourage the medication we give because they say this medication and there intervention are not supposed to be run concurrently and what they do they will maybe give these people herbs which they dont even know they will tell them bring a goat we must slaughter a goat for this to happen they will say you have to tie this around your neck or around your waist their beliefs are really funny and we feel they can not be of help. Instead they worsen the situation because the patient will drop the medications they are on they may even drop some of the advice given to them and the condition worsens.

If the witchdoctor truly believes that this patient's problems are spiritually based then he is much less likely to report the patient to the hospital, instead referring the patient to another witchdoctor. In fact, the same witchdoctor as quoted above also stated that the medications that the hospital gives interfere with his work and that it is necessary to discontinue their use for the rituals to work. This confirms the truth of the reason the health care worker in the previous quotation distrusts witchdoctors - witchdoctors do encourage patients not to take their medications.

> "The spirits would work on that person not to take the drugs. yeah. And those drugs wont work unless that person is brought here and once that person is brought here that person cant continue taking the drugs."

A patient may seek care from both religious leaders and witchdoctors but there is much conflict between these systems of belief and care. Religious leaders believe that their interventions will not help a person if that person's faith is shared with witchcraft. The two witchdoctors reported losing a lot of patients to religion explaining that once people converted to

Christianity or Islam it was rare for them to visit the witchdoctor, but that it did happen.

The decision-making process that goes into the decision to adopt a new system of care can often be explained by the shortcomings of treatment and monetary considerations. The hospital is very limited in the resources that it can provide mentally ill patients, and the drugs are expensive to purchase if the hospital does not have them in stock. If a patient is not seeing results from the formal health care system, he/she is likely to drop out of the system and put his/her care in the hands of religious/spiritual healers. Likewise, if a person is not seeing results from the prayers of one pastor he/she may visit another pastor, or a witchdoctor, or the health clinic. One community member who is a Christian told me that they would consider going to a pastor for prayer first because that is a free method of treatment as opposed to the health clinic and the witchdoctor both who charge fees for their service.

> *"much you tell them go to the hospital but they will find themselves with no cash to take the person to the hospital and you know the doctors like now in teh hospital here whoever is the doctor who works mental illness. They will only refer you to Mulaggo. Now as a person from this community we will find that no transport, no money to go and keep themselves in the hospital so you just they will look at the person there maybe as mostly children. They look at them there this one is spoiled, they say ah this one is wasted."*

> *"In Christianity people are more voluntary like if you bring your patient they will just pray for him but when you go to a witchdoctor they ask for goods they ask for hens and meat and things like that and money. Yeah so they can maybe try to heal but after in case a person gets much more worse they would ask for extra things to try. So thats why for him as a Christian he would opt to go to be prayed for in a Christian setting because the pastor or the church leader would pray with you fast with you voluntarily without you paying him any money"*

Discussion

Beliefs about mental illness are heavily influenced by religious beliefs in Bududa. In Bududa, the community readily believes in the efficacy of prayer healing and in the power of witchcraft to induce mental illness. Mental illness is perceived to be manifested by violent,

unpredictable, and animal-like behavior and is often associated with idleness and drug addiction. There is a heavy stigma towards mentally ill people in the district and they are often seen as "wasted" people because of the unlikelihood of ever becoming cured.

The treatment of mental illness is fragmented into a tripartite system comprising the formal health care system, the religious system, and the traditional system. The religious and the formal health care systems are amenable to mutual cooperation however this rarely extends to the traditional system because their beliefs and rituals set them apart as outsiders.

The purpose of this research is to describe the system of mental health care to influence and direct future study and to make recommendations for the community based on the data gathered. To improve the conditions of mentally ill people in Bududa, the community's stigmatized treatment of the mentally ill must be addressed and gaps in the health care of the population must be closed. Educating the community, including health care practitioners and religious/spiritual leaders about mental illness will go a long way to accomplishing both goals.

In order for information to disseminate to the masses in this district information must flow from the top down. Information flows from the District Health Officer to a Health Assistant in each of the 16 sub-counties and then the information is passed down a wider net of sub-county coordinators and parish coordinators who are ultimately responsible for training the VHTs in their parish. Currently mental illness is not a top priority for the local government. The local government's agenda is aimed at reducing the morbidity and mortality of communicable diseases such as TB, malaria, HIV, and onchocerciasis and consequently no efforts are made to develop a sensitization program about mental health. This is unacceptable. It has been shown here that the mental health care system is lacking and that the mentally ill of the population face a heavy stigma which contributes to a poor quality of life on top of their illness. The clinical psychiatric

officers in the district should draft a pamphlet outlining the important points that they wish to make about mental illness and provide it to the DHO to copy and disseminate.

Sensitization programs for the community in the district have been shown to work. In the example given in the findings section, the community totally modified previous beliefs about HIV to conform to what is generally understood about the disease and stigma went down and treatment went up. If the public's index of suspicion for mental illness increases, the formal mental health care will be flooded with patients that the resources cannot support. This is a good problem to have, in a sense, but underlies the larger issue with the Ugandan government that there are simply not enough resources being allocated to mental health, especially in the rural districts.

The formal system of care works in a referral system of its own. Lower level health clinics refer cases to the hospital that the health clinic does not have the resources to support. This is critical because there are no advanced practitioners trained specifically in managing psychiatric disorders in the lower level health clinics. Every health clinic is required to staff a psychiatric nurse but I suspect that not all of these health clinics are able to meet this mandate. So, efforts should be made to further educate the general health care population about recognizing and managing psychiatric disorders. To formally accomplish this would require a great deal of logistics and money on the part of the Ugandan government. Thus, these educational initiatives should arise locally. The CPOs could host three training sessions a year under the mandate that all health care practitioners in the district attend at least one. This local initiative will strengthen the formal health care system and can be carried out with a reasonable budget thereby circumventing the inadequacy at the national level.

The referral system between the religious leaders and the health clinics is equally as vital

to address the health concerns of the population. Concurrent management of treatment seems to be the option that best suits this population. However, this should not mean that religious/spiritual healers treat a patient for a period of time before concluding that, because their treatment methods are not working, it must not be a case of spiritual possession – which, according to my data, is how people report being able to tell medical from spiritual illnesses. Rather the government should set up a formal network of referrals between the formal and informal institutions that requires all religious/spiritual healers first to refer their patients to a health clinic. This is important for two reasons: One, there are medical diseases or conditions such as cerebral malaria, syphilis, and traumatic brain injury which can only be addressed by biomedical intervention and postponing treatment to such patients is severely life-threatening. Second, which has been mentioned, addressing the issues from both a biological and psychological perspective could lead to the best patient outcome.

The religious leaders hold a great deal of influence in the community. One pastor likened himself to a father in the home with respect to his relationship with the community at large. People seek advice and share intimate problems with the pastors. When the pastors stand at the lectern and speak they garner considerable amount of power to influence the thoughts and actions of the community. With this influence religious leaders can have a massive effect on the stigma that is associated with mental illness in the community. Not only should religious leaders incorporate specific lessons about the treatment and understanding of the mentally ill but health care practitioners should join with them at the pulpit to spread the message. Health care workers, government officials, and VHTs tasked with educating the community about mental illness should exploit the communal gathering of church congregations and take to the venerable pulpit to spread their message to the community.

Local research generates a local understanding used to make local recommendations. The health of the community and the conditions of those in the community suffering from a mental illness are in the hands of the community and the leaders are responsible to promote the prosperity of the people. Large scale interventions such as an increase in expenditure on mental health care at a national level and the redistribution of resources throughout the country are difficult to enact due to forces outside of the control of even the national government. On the contrary, local initiatives can be executed in a short amount of time at relatively low expense with immediate results. The deciding factor is whether somebody from the community will accept the responsibility to advocate for people with mental illness who are unable to advocate for themselves.

As I discuss, there is a need to develop policy which unites the tripartite system of care under a common referral network, and, equally as important, is the need for the leaders of each system of care to meet with one another to share beliefs and develop a system that works within the community. On my last day as a researcher in Bududa, I held a forum to which I invited some of the most influential people of each system of care. Two clinical psychiatric officers, a catholic priest, an Anglican pastor, a Pentecostal pastor, an Imam, a witchdoctor, and a social worker all convened under the same roof to share their beliefs and collaborate to find a better way to address the needs of the mentally ill in the community. Together, the participants of this forum identified many of the same issues with the system that I observed independently and came up with the solutions that are laid out above. Each participant learned a great deal about the other's way of thinking about mental illness and about the important role that each were playing in the treatment of mental illness. At the conclusion of the event, the group acknowledged that nothing like this collaboration had ever been done before in the community and that it was

outrageous that it took an outsider to prompt such a gathering. I agreed.

The study had certain limitations, including the language barrier. Some interviews were conducted through an interpreter and others in English, and in each case, there were issues assessing the meaning of word choices in the translations. The IRB protocol did not permit us to interview any people with a mental illness so the data collected regarding the path of treatment for mental illness was limited to heresay. An important part of the informal sector of care in the district is the care provided by witchdoctors; however, I only interviewed two witchdoctors. Thus the understanding that I developed about the spiritual system of care is limited by sampling error.

Further research is required to better grasp the system of mental health care in the district. To identify concrete pathways of treatment, future research should directly study mentally ill peoples' experience of seeking treatment. To test the efficacy of combined treatment of pharmacological agents with prayer and/or ritualistic healing a clinical trial must be constructed. This type of research could be performed by the clinicians working in Bududa through a retrospective study if data were collected that recorded the interventions that patients received and the outcome. Only two witchdoctors participated in this study. Research focused solely on witchdoctors in the community will provide a more complete and representative understanding of the work of a witchdoctor which might illuminate trends in the types of cases seen, the care delivered, and the outcomes of the patients. Also, more research is needed to answer the question why mentally ill are stigmatized in the community.

Bibliography

Aboo, C., S. Ekblad, P. Waako, E. Okello, S. Musisi. 2009. The prevalence and severity of

mental illnesses handled by traditional healers in two districts in Uganda.

Berry, L. 1995. Ghana: A Country Study. Federal Research Division, Library of Congress. 3rd edition.

Bududa District Local Government Statistical Abstract. 2012. Web.

Central Intelligence Agency. The World Factbook: UGANDA. Central Intelligence Agency. https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., Rowlands, O. J. 2000. Stigmatization of people with mental illnesses. The British Journal of Psychiatry. 177: 4-7.

Global Status Report on Alcohol and Health 2014. WHO. 2014. Web

Das, J., Do, Q-T., Friedman, J., Mckenzie, D., and Scott, K. 2007. Mental health and poverty in developing countries: Revisiting the relationship. Social Science and Medicine. 65:467-480.

Degonda, M., Scheidegger, P. 2012. Traditional healing in Uganda: A statistical analysis of treatments by a group of traditional healers. African Journal of Health Sciences. 20(1-2): 50-55.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chavez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L., Saraceno, B. 2011. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. The Lancet. 378: 1664-75.

Funk, M., Drew, N. 2010. Mental health and development: Targeting people with mental health conditions as a vulnerable group. WHO. Geneva.

Human Rights Watch. 2012. Like a death sentence: Abuses against persons with mental disabilities in Ghana

Idro, R., Marsh, K., John, C.C., Newton, C.R.J. Cerebral Malaria: Mechanisms of Brain Injury and Strategies for Improved Neurocognitive Outcome. Pediatric Research: 68 (4). 2010.

Jenkins, J.H. 2015. Extraordinary Conditions: Culture and Experience in Mental Illness. University of California Press. Oakland, California.

Kasoro, S., Sebudde, S., Kabagambe-Rugamba, G., Ovuga, E., and Boardman, A. 2002. Mental illness in one district of Uganda. International Journal of Social Psychiatry. 48(1): 29-37.

Katz, E. 2006 Human rights abuses in mental institutions common worldwide, Perlin says. https://content.law.virginia.edu/news/2006_spr/perlin.htm.

Kigozi, F., J. Ssebunnya, D. Kizza, S. Cooper, S. Ndyanabangi, and the Mental Health and Poverty Project. 2010. An overview of Uganda's mental health care system: results from an assessment using the world health organization's assessment instrument for mental health systems (WHO-AIMS). International Journal of Mental Health Systems. 4:1.

Kleinman, A. 1980. Patients and Healers in the Context of Culture: An exploration of the borderland between anthropology, medicine, and psychiatry. University of California Press. Berkeley and Los Angeles, California.

Kleinman, A., Eisenberg, L., and Good, B. 1978. Culture, illness, and care: Clinical lessons from anthropological and cross-cultural research. Annals of Internal Medicine. 88: 251-258.

Kleinman, A., and Sung, L. H. 1979. Why do indigenous practitioners successfully heal? Soc Sci Med Med Anthropol. 13 B(1): 7-26.

Ovuga, E., Boardman, J., Oluka, E.G.A.O. 1999. Traditional healers and mental illness in Uganda. Psychiatric Bulletin. 23: 276-279.

Patel, V. 2007. Mental health in low- and middle-income countries. British Medical Bulletin. 81 and 82: 81-96.

Perlin, M.L. 2013. Sanism and the law. AMA Journal of Ethics. 15(10): 878-885.

Prevention Gap Report. UNAIDS. 2016. Web.

Ssebunnya, J., Kigozi F., and Ndyanabangi, S. 2012. Developing a national mental health policy: A case study from Uganda. PLoS Med. 9(10). Accessed online.

Sturm, R., and Gresenz, C. R. 2002. Relations of income inequality and family income to chronic medical conditions and mental health disorders: national survey. BMJ. 5(7328): 20-23.

Tabuati, J. R., Dhillion, S. S., and Lye, K. A. 2003. Traditional medicine in Bulamogi county, Uganda: It's practitioners, users, and viability. Journal of Ethnopharmacology. 85(1): 119-129.

The, R. N. 1998. The role of traditional medical practitioners: in the context of the African traditional concept of health and healing. International mental health workshop. Web.

WHO. 2001. Mental Health: New Understanding, New Hope. *World Health Report*.

WHO. 2005. WHO resource book on mental health, human rights, and legislation. World Health Organization, 2005.WHO-AIMS Report on Mental Health System in Uganda, WHO and Ministry of Health, Kampala, Uganda, 2006

Worldmark Encyclopedia of Religious Practices. "African Traditional Religions." Encyclopedia.com. HighBeam Research. http://www.encyclopedia.com/religion/encyclopedias-almanacs-transcripts-and-maps/african-traditional-religions

McAlpine, D., and Mechanic, D. D. 2011. The influence of social factors on mental health. Principles and Practice of Geriatric Psychiatry, 3rd ed.