



Mental Health in the face of Cultural Beliefs

A case study from Uganda

Abstract

In addition to limited resources, the mentally ill in Uganda suffer stigma and discrimination that is exacerbated by the existing cultural and religious beliefs as well as the legal structures. These conditions have deprived the mentally ill of adequate health, respect and dignity. While it is necessary to improve the mental health care system of Uganda, it is important to be respectful of the cultural and religious freedoms of the Ugandan society. This paper examines the competing interpretations and treatments between the Western approach and the existing traditional approach. It also suggests how the government and health providers of Uganda can go about implementing the mental health care action plan recommended by the World Health Organization without treating the cultural and religious beliefs of the people as illegitimate.

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POV 423, WINTER 2015

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1) Introduction

Mental health is a crucial component of health that has not received appropriate visibility, policy attention and funding for many years, especially in low and middle income countries. In these countries, between 76% and 85% of people with severe mental disorders receive no treatment for these disorders. The corresponding range is lower in high-income countries, between 35% and 50% (1). In Africa and Southeast Asia, most countries spend less than 1 percent of their small health budgets on mental health services (2). Worse still, these services are mostly accessible to urban populations and are very limited in rural areas. As the population affected by mental disorders continues to grow, mental health care remains a hidden burden in many countries such as Uganda, the case study for this paper. The cost of mental illness to the society is high due to social and economic resources foregone such as reduction of productivity, increased accidents, family costs for treatment, and increased conflicts in a home.

The limited structural and economic resources devoted to the mentally ill in Uganda as well as the stigma and discrimination they suffer has robbed them of the necessary capabilities required for normal functioning and a dignified life. It is in light of this that the World Health Organization (WHO) stepped in to help restore health and social justice in terms of fair equality of opportunity for these individuals. However, because WHO perceives mental illness as a biopsychosocial manifestation, it implements the Western psychiatric approach that is based on science and clinical treatment (3). On the other hand, mental illness in Uganda is believed to be a supernatural manifestation that requires a traditional healer (4). Thus even though the approach by WHO enables the Ugandan government to provide the basic capabilities necessary for the social justice and health of the mentally ill, it cannot be used as a replacement for other mental health treatment as it does not address the cultural and religious frameworks that interpret mental illness outside of biomedical explanations. In this paper, I discuss this tragic choice and propose a hybrid solution that promotes fair equality of opportunity for

the mentally ill without imperialistic interventions that position cultural ideas about mental illness as illegitimate.

To present the tragic choice faced by the government and health providers of Uganda in improving the quality of life of the mentally ill; I will first layout the mental health realities in Uganda highlighting the limited resources as well as the stigma and discrimination the mentally ill suffer. I will proceed to explain the competing interpretations of mental illness contrasting the Western view to the Ugandan construction that is based on cultural and religious beliefs. Then, I will make a moral argument as to why it is necessary to improve the quality of life of the mentally ill in Uganda borrowing mainly from the Human Rights approach, Martha Nussbaum's Central Capabilities and Norman Daniels' fair equality of opportunity theories. Following that, I will discuss the competing treatment approaches elaborating on the World Health Organization (WHO) approach to mental health care provision as well as the traditional medicine approach already used in Uganda. It is at this point that I will elaborate on the tragic choice that the government and health providers of Uganda face and then explain how we can address mental health care while at the same time respecting cultural and religious freedoms within the Ugandan community.

2) Mental Health Realities in Uganda

Uganda is located in East Africa with a population of 37.58 million (2013). It is classified as a low income country based on World Bank criteria, with a poverty headcount ratio of 37.8% and a GDP per capita of \$ 572 per year, almost a hundred times smaller than that of the United States (5). It is a culturally and religiously diverse state with over 50 different tribes and languages as well as many religious groups. An estimated 85 percent of the population is Christian, 12 percent is Muslim, and the remaining 3 percent follow indigenous beliefs, Hinduism, Baha'ism, and Judaism (6).

Suffered with plenty of civil conflict, increasing influx of refugees from neighboring states, widespread HIV/AIDS and growing substance abuse, Uganda has a growing population with mental illness. The Northern Uganda region has particularly been involved in civil war since the 1990s against the Lord's Resistance Army (LRA). Led by Joseph Kony, the army abducted many children and recruited them as child soldiers. As the war slowly comes to an end, more and more young soldiers attempt to reintegrate and reestablish their lives. However, agonized with trauma of the war, they suffer higher rates of mental illness (7). Studies have also linked HIV/AIDS with high risk for mental disorders. With the adult HIV prevalence rate as high as 7.2% as of 2012, the Ugandan population has an even heightened risk to mental illnesses (8). A study by Kaharuza et al (2006) showed that depression was common among HIV-infected persons in rural Uganda and was associated with low CD4 (9). These factors have come together to increase the prevalence of mental illnesses in Uganda. In 2012, close to 20 percent, 6.8 million, of the population of Uganda suffered from some degree of mental illness ranging from anxiety to severe madness (10). This rate is higher than the average burden of mental disorders in low income countries like itself which is 7.88% (2).

Limited Resources

Despite these growing numbers, the structural, financial and human resources devoted to mental health care in Uganda are extremely limited. Uganda has only one National Mental Hospital, 27 community based psychiatric inpatient units, one day treatment facility and no community residential facilities (11). In 2006, there were 1.4 beds per 100,000 general population in the community based psychiatric inpatient units and 1.83 per 100,000 beds in the mental hospital. Additionally, there were only 1.13 human resources working in mental health per 100,000 population (11). According to Fred Kigozi, the director of Butabika Hospital, the main mental hospital in Uganda, "the country has only 32 psychiatrists yet the number of mental cases seems to be increasing..." (10). The 2006 WHO study on

mental illness in Uganda reported that the government expenditure on mental health in primary care was only one percent of health care expenditures, which were at 10.3% of the total government expenditure. However, with donor support and other areas of the general health budget, the total expenditure on mental health was about 4% (11). Though the expenditure on mental health in Uganda is above the average compared to other low-income countries (2.26%), it has a higher than average burden of these illnesses (2). The statistics above elucidate the inadequate resources devoted to the mentally health care in Uganda.

But like other low income countries, these scarce resources are inequitably distributed around the state with many more of these services provided in the capital city, Kampala. Of all the expenditures spent on mental health, 55% is directed towards the National Mental Hospital, Butabika in Kampala yet approximately 88% of the Ugandan population is based in rural areas (12). Given these circumstances, individuals living in rural areas, who are often times the poorer population, barely receive treatment; and those that do, have to pay additional costs in transportation and accommodation. As a result of these limited and unequally distributed resources, it is estimated that over 65% of the mentally ill persons in Uganda do not receive treatment (10).

Stigma and Discrimination

The mentally ill face immense social stigma and discrimination in many societies. For example, between 2009 -2011, England launched a national campaign called the *Time to Change* to address the ignorance of mental illness, cultural stereotypes and myths and general beliefs that created prejudicial attitudes against the mentally ill (13). Erving Goffman's theory states that a stigma is an attribute, behavior or reputation which is socially discrediting in a particular way (14). The labels given to the mentally ill in the Ugandan community such as "mad" or "idiots" classify these individuals as undesirable and endorse their rejection from society. Particularly, individuals with chronic illness are perceived as

unable to understand and if not physically separated are allowed and encouraged to sit around and do nothing such that they slowly become a parasite on the family which is exactly what is expected of them (4). Goffman also speaks of courtesy stigma that is suffered as a result of association with a person who is marked by a stigma (14). The stigma against the mentally ill often extends to affect families associated with the mentally ill causing them to keep the patients in isolation and further exacerbating the stigma. The culture and inadequate legal structure of Uganda, which I will soon discuss, have exacerbated the negative attitudes towards the mentally ill increasing violence and verbal insults against them, neglect from their community/homes, reduced likelihood of marriage among the females, withdrawal from school for children and even exclusion from employment opportunities.

The current standing legislation on mental illness in Uganda is an outdated act known as the Mental Health Treatment Act (MHTA), passed in 1964. The WHO-Assessment Instrument for Mental health Systems (WHO-AIMS) study of 2006 revealed that this act is not only outdated but is also inadequate at protecting and promoting the rights of those with mental disorders, citing a number of its shortcomings (11). Some of these shortcomings include; firstly, the reference to mentally ill persons as 'idiots' implying 'of low intelligence', secondly, the failure to differentiate between different mental disorders leaving all mentally ill persons to be treated in the same way and thirdly, its bedrock principle that people suffering from mental disorders should as often as possible be treated in the same way as those suffering from physical disabilities (15). Furthermore, a study by Cooper and colleagues revealed that the main focus of the MHTA legislation was to remove persons with mental disorders from the community and keep them in confinement without serious consideration for clinical care (12). While the Ugandan government has recently attempted to replace the old and outdated MHTA of 1964 with some assistance from WHO officials, the new proposed bill was rejected by Parliamentarians in 2011 (15). Thus the existent loopholes in the operating legislation on the mentally ill in Uganda (MHTA), reinforce the offensive attitude towards these individuals.

Within the cultural beliefs among Ugandan communities, which I will elaborate on soon, the mentally ill are considered to bring shame and disgrace to the families associated with them.

Particularly, shame more often surrounds those in whom the illness takes a more chronic course as it seems less like bad luck (4). John H. Orley in his book *Culture and Mental Illness; A study from Uganda* highlights the embarrassment families feel through citing that members of a patient's family often seem to dislike discussion of the mad episodes and are extremely reluctant to take the patient back home after being in Butabika Hospital (11). Direct actions by family members to rid of the mentally ill further elucidate this shame. For example, if an already married woman gets a mental illness, she is usually sent back to her parents by her husband.

Thus the limited resources available to the mentally ill in Uganda as well as the immense stigma and discrimination they face, reflect the poor mental health care system in Uganda. More so, because poverty by itself is a source of stigma, the poor people that suffer from mental illness are even more prone to stigma and other unfavorable consequences of mental illness than individuals with a higher socio-economic status (16). In the study by Cooper et al, one mental health service user's comment read as follows;

"The stigma which these people face is the most disabling part. Because once you are labeled that you are mentally sick then you lose your job, you lose access to opportunities, you lose your integrity in society, people have negative attitudes towards you; however much you can deliver, people don't believe you can. So you are treated as if you do not even exist"

Therefore, the mentally ill in Uganda not only suffer a decreased health but are also resource deprived and stigmatized by the society. This has resulted in their discrimination from the labor force and worsened their living conditions.

3) Competing Interpretations of Mental Illnesses

Western perception

The explanatory models of illness in Western medicine are based mainly on physics, chemistry and biology. More so, conventional biomedicine asserts that all causes of illness and by extension mechanisms of action underlying legitimate treatment approaches, are grounded on biological processes described in Western science (3). Western psychiatry particularly rests on a coherent body of theory, research and clinical data and continues to build off fundamental scientific advances in neurophysiology, pharmacology, molecular biology and genetics (3). This form of psychiatry broadly thinks of mental illness in the context of the biopsychosocial framework as well as cognitive neurosciences. One of the perspectives of Western psychiatry, the disease perspective assumes that the defining characteristics of mental illness are discrete abnormalities of brain structure or function (3). This perspective also assumes that unambiguous correspondences exist between etiology, pathological condition and clinical entity (3). Given that the Western countries have led the world in technology advancements, Western psychiatry is strongly driven by science and research and geared mainly towards clinical utility/ treatment.

The diagnosis of mental illnesses within Western psychiatry currently applies the Diagnostic and Statistical Manual V (DSM V) (17). The manual was adopted in an effort to shift towards a more continuum measure and has evolved with science and clinical research, from DSM I to the current DSM V. DSM V was developed after numerous proceedings and conferences supported by cooperative agreement between the American Psychiatric Association (APA) and WHO (17). Its main purpose is to serve as a manual for clinicians to diagnose mental disorders for clinical utility. In particular, the DSM V aids clinicians to determine prognosis, treatment plans and potential treatment outcomes for their patients. According to DSM V;

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually

associated with significant distress or disability in social, occupational, or other important activities... (17).

The definition above endorses a clinical and scientific approach to mental disorders but neglects the spiritual perspectives on human consciousness. More so, while the DSM has changed significantly, a reliable overarching definition of a mental disorder remains elusive and validity remains unestablished for most DSM syndromes. This transition has however managed to overcome the downside of lumping all mental illnesses and has resulted in more than triple the number of diagnosable disorders of the first DSM criteria. These include depression, anxiety, psychotic disorders, bipolar disorder, Alzheimer's disease and many others (18). More diagnosable illnesses has improved treatments and care for the different individuals affected.

Perception among Ugandan communities

The Ugandan community is a deeply cultural and religious society exercising a form of religious pluralism such that while a large portion of society believes in a supreme God, they also believe in the existence of small gods. For example, the Buganda ethnic group, the largest in Uganda, traditionally recognizes the influence of the spirits: the Katonda, the supreme creator; the Balubaale, the ancient humans and the recently deceased ancestors (Mizimu); and spirits that are associated with physical features such as mountains and forests (19). This is the case with most other ethnic groups in Uganda. It is also the case in a number of African societies like among the Kassena- Nankana of Northern Ghana, one informant observed that "we know there is a mightier God, though we worship our ancestors the lesser gods" (20). Given that, the explanatory models of medicine among many Ugandans rely heavily on metaphysical arguments postulating nonphysical causation of mental or spiritual states. Van Gorcum Jansen (1973) in writing on the Bomvana (Xhosa) makes it clear that "religion, medicine and magic are closely interwoven ... being parts of a complex whole which finds its religious destination in the well-being of the tribe" (21).

Traditional beliefs have for a long time associated illnesses with spiritual forces in many communities in Uganda. For the Baganda, in the central region of Uganda, 'strong' illnesses are understood to have their origin in the spiritual world and rituals are performed to ensure that good fortune prevails and misfortune is neutralized (4), (19). In another example, Heike Behrend (2007) writes that with epidemics, the more people die, the more witches or cannibals seem to be active and responsible. He gives the example of the AIDS epidemic that took on this cultural expression in the Tooro region of Western Uganda. In a study by Karen Im focusing on breast cancer in Northern Uganda, one patient mentioned that people from her village may believe that cancer comes from bewitched spirits (22). This association between spiritual powers and illnesses has also been cited in other African communities like Northern Nigeria where the smallpox epidemic was seen as a manifestation of witchcraft. (23). Similarly among the women in Northern Ghana, strange diseases (such as breast cancer) are perceived as a punishment from the gods (24).

Like many physical health issues, mental illnesses have been associated with supernatural forces based on cultural and religious beliefs as identified in studies of Uganda. Because of the strength and depth of culture and religion, disorders of this sort have been understood as spiritual curses for many generations now. The more common mental disorders in Uganda referred to through this cultural lens include madness, epilepsy, and suicide. Contrary to Western societies, it is common belief in Uganda, even among the local personnel working in mental hospitals, that depressive illness is very rare among Africans (4). Orley in his book explains that "when people become 'mad' they behave in a way quite out of keeping with their usual personality, as if they had become another person. Similarly, during an epileptic fit, it seems as if the patient has been possessed by some outside force and is no longer able to control his actions. It is therefore reasonable to think of both conditions as being caused by spirits which take control of the patient's body, causing him to behave in a strange way" (4; 16). That the symptoms which accompany many of the mental illnesses can be explained by these traditional beliefs, adds more

strength to this framework of psychiatry. The psychiatrists at Butabika Hospital, the main mental hospital in Uganda, estimate that 90% of Ugandans believe that mental illness is linked to curses or demons (25). More so, Nsereko et al (2011) in their study on mental health problems in Uganda reported that, there was unanimous agreement among the respondents that cultural perceptions of mental disorders as supernatural, “spiritual” illnesses or a product of “evil forces” were widespread within the Ugandan society (26).

...most people think that it is bewitching. Others associate it with disagreements with their elders, for instance we have sengas [aunties] And Kojjas [uncles], when they talk ill about somebody and then that person eventually gets a mental problem they say that it is the quarrel he/she had. And also leads not to quickly go for medical attention...” (Community development officer, rural district)

The above information highlight how traditional cultural and religious beliefs among the Ugandan people have played a key role not only in the classification of mental disorders but also the ideas concerning the origin of these disorders, how they progress as well as their treatment as we shall soon discover later in this paper.

While the above beliefs create the underlying framework of interpretation of illnesses in Uganda, it is important to note that interesting complex differences still exist among different groups. The extent to which these beliefs are embraced varies on grounds of economic class, education status, rural versus urban populations and even within different religious affiliations (catholic, Pentecostal, ‘traditionalist’, muslim). For example, since the more educated are more influenced by the Western culture given the British education system, they are increasingly shifted away from these traditional beliefs. That being said, the cultural beliefs in the power of spirits plays an important role in the perception of mental illness among a significant number of Ugandans.

4) Moral argument for Improving Quality of life for the mentally ill in Uganda

So far, I have presented the mental health realities in Uganda focusing on the limited resources devoted to mental health care as well as the stigma and discrimination suffered by the mentally ill. I went on to explain the competing interpretations of mental illness contrasting the Western perception to the Ugandan cultural framework. Now, I will give a moral arguments as to why given the cultural and religious beliefs of the people, it is still necessary to improve the quality of life for the mentally ill.

Human Rights Argument

Human rights are the rights inherent to all human beings regardless of nationality, race, sex, ethnicity, color, religion or any other status. The human rights argument presents a moral principle that like every human being, the mentally ill are entitled to basic human rights. As the first institution to champion health as a fundamental right of every human being, the World Health Organization, WHO has been at the forefront in advocacy for the rights of the mentally ill (27). Uganda is a member state of WHO which defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (27). With this definition, WHO considers mental health as part and parcel of body health. In 1948, the right to health was internationally declared as a fundamental human right by the United Nations Universal Declaration of Human Rights. Health was acknowledged as inherent to every human being and states were required to protect and fulfill the enjoyment of this basic human right. The Constitution of Uganda indicates that state and society are obliged to recognize the rights of people with disabilities, including those with mental and/or intellectual disabilities, to respect, dignity and integrity (12).

However, as indicated above, the mentally ill are referred to with derogatory labels not only by the society but also within the Mental Health Treatment Act, legislation endorsed by the government. They are a neglected minority in Uganda whose rights and needs are barely protected. The stigma that they face, especially when exacerbated by cultural beliefs, robs them of their dignity and respect since they

are viewed as invalid individuals. The study by Cooper et al revealed that the patients within government mental health facilities were frequently subjected to inhumane and degrading care (12). More so, in a story to BBC, Joseph Atukunda, a mental health activist in Uganda living with Bipolar Affective Disorder, admits that Butabika Hospital “can be a tough place,” alluding to the harsh treatment they are given. He narrates that “one time, during a manic episode, he was (simply) stripped naked and given medication...” (25). Rather than improving the wellbeing of the mentally ill, some of the treatment units in Uganda have been showed to further rob these patients of their dignity. Additionally, the lack of adequate psychiatric centers especially in the rural areas denies mentally ill individuals access to their right to health care. While the human rights argument is very popular and applicable in many countries including Uganda, the confused and confusing abstract debate surrounding what human rights are and why they ought to be promoted has weakened its moral basis for social justice.

The Capability Approach

The Capability Approach is one theory to social justice that has been championed as it remains closer to the ground and not does not employ any highly rarefied theoretical concepts (28). Martha Nussbaum, an advocate for the Capability Approach in her book *Creating Capabilities* charges that justice requires the protection of the ten Central capabilities of each human being in order to promote human dignity and a life worthy of it (28). Because these Central capabilities protect our freedoms to choose and lead to functioning, they ought to be provided at a threshold level for social justice to be achieved. In her argument, Nussbaum emphasizes that those who need more help to get above the threshold basic capabilities ought to get more help, “In the case of those with cognitive disabilities, the goal should be for them to have the same capabilities as “normal” people ...” (28). By virtue of having a mental disorder, the mentally ill have a weaker health system and therefore require more help to get above the basic capabilities. The current state of mental health in Uganda, as elaborated on earlier, is

socially unjust since it deprives the mentally ill from a number of Nussbaum's Central capabilities that are required for normal functioning within this community. These include life, bodily health, bodily integrity and senses, imagination and thought. I will now proceed to explain how these capabilities are not protected among the mentally ill in Uganda;

Life Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to not be worth living (28). The mentally ill often suffer lower life expectancy than the general population because in addition to the higher suicidal rates, the neglect they face as well as the direct dangers of having fits especially among the epileptic put their lives at high risk (4). The social stigma and discrimination that the mentally ill in Uganda face is so disabling that it demeans the lives they live and causes them to seek means to end their lives. Joseph begins his testimony to BBC by recalling his attempt to kill himself having felt that he 'had lost the battle with deep depression' and needed to end things (25). The debilitating environment that surrounds the mentally ill directly shortens the length of their lives relative to the normal length in Uganda.

Bodily Health Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter (28). One issue that is often cited is the shortage of psychiatrists which compromises the health services received by the mentally ill. More so, the facilities that are available for mental health care are so under-resourced that they compromise the health of the mentally ill. Many respondents in the study by Cooper et al, particularly the mental health care service users lamented about the poor ventilation of mental health facilities, inadequate mosquito nets, and insufficient food supplies, all conditions that compromise their health (12). Also because the mentally ill are often abandoned or kept in isolated areas, they are denied proper housing. Orley (1970) writes that an epileptic may be left to sleep in the kitchen which is usually a separate hut away from the main house

(4). Therefore, in addition to the poor mental health suffered by the mentally ill, they often suffer poor physical health.

Bodily Integrity Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction... (28) As mentioned earlier, the mentally ill are often locked up to control their movements and fits. One patient mentions that she was taken in by a pastor who looked after the sick by chaining up his patients until his prayers had an effect (25). Mental health care services have also been associated with tying up of patients or locking them away for no reason at all (12). Tying up or locking up of the mentally ill reduces their ability to move freely outside their homes or the hospital and in so doing minimizes their integrity.

Senses, imagination and thought Being able to use senses, to imagine, think and reason- and to do these things in a “truly human” way, a way informed and cultivated by an adequate education, including but not limited to, literacy and basic mathematical and scientific training (28). Children diagnosed with mental illnesses almost invariably have to end schooling because some believe that the child may spread the disease while others think that since mental illness makes the child stupid, further education would only be wasted (4). Denying these children education limits their literacy and basic skill set such that their thought and imagination process is compromised. More so, especially for those in whom the illness started at an early age, they often take on the attitude of their family and agree that their ‘brains are spoilt’ (4). This mentality precludes these individuals from developing their thoughts and imaginations.

Affiliation (B) Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of nondiscrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, and national origin (28). As elaborated earlier, the mentally ill are often discriminated against in the work force as well as the society in general. People with mental disorders are regularly denied employment. In the study by Cooper et al, a

respondent indicated that in public service they question whether you have ever suffered a mental illness and if you declare so, you are automatically disqualified (12). Orley (1970) also points out that madness and epilepsy exclude a man from ever becoming a chief or inheriting from anyone, even if cured since the judgment of the person can never be fully trusted. Further humiliating for the mentally ill is that they sometimes lose their second names and are instead referred to for example as 'the leper' (4).

Nussbaum argues that the failure to provide for the threshold level of any of the ten central capabilities, denies individuals dignity and is a form of social injustice (36). Because the mentally ill are even further away from the threshold level, they require more help and resources to experience a dignified life. As highlighted above, the resources devoted towards the mentally ill are far below the basic threshold of the Ugandan society which infers an existing social injustice.

Fair Equality for Opportunity

Norman Daniels (2008) in *Just Health* presents another moral justification for the improvement of the quality of life of the mentally ill. Daniels draws on Rawls and argues that justice requires for fair equality of opportunity in order to protect primary social goods like health. He contends that health is a primary social good because the loss of function associated with disease and disability reduces the range of opportunities open to that individual compared to what it would be were he/she healthy or fully functional (29). As the mentally ill in Uganda are perceived as unable to think and reason, they are often times denied employment opportunities and education. The denial of these opportunities pushes the mentally ill into poverty which further deprives them of more opportunities. As these opportunities are considered social determinants of health, the mentally ill are unable to enjoy the same health outcomes like the rest of the Ugandan population. Daniels then charges that if there is a social obligation to

protect fair equality of opportunity, then we have a general framework for thinking about what justice requires for normal functioning of the mentally ill. Improving the health of the mentally ill would allow them to choose from among the life plans they can pursue as set by the Ugandan community, given their talents and skills. Because the mentally ill have fewer opportunities than 'normal' individuals, they are considered worse off which according to Daniels implies that their health needs ought to be met for fair equality of opportunity to be achieved.

Responsibility for Justice

The existence of legislation that enforces the stigma and discrimination against the mentally ill in Uganda establishes a structural injustice as defined by Iris M Young in *Responsibility for Justice*. Young (2011) argues that structural injustice exists when "social processes put large groups of persons under the systemic threat of domination or deprivation of the means to develop and exercise their capacities, at the same time that they enable others to dominate or have a wider range of opportunities for developing and exercising capacities available to them" (30). The standing MHTA legislation of Uganda not only encourages the stigma against the mentally ill through derogatory language but also encourages their exclusion by focusing on removing them from the community. This legislation as well as the cultural beliefs in Uganda act as institutional and social rules that constitute a stubbornly objective and difficult-to-change aspect of structural processes. The operation of these social- structural processes leads to an unfairly limited range of options for the mentally ill that leads to their social exclusion and creates a structural injustice. From Young's point of view, since the societal processes and rules in Uganda, create a health system such that some are able to benefit but others are left deprived, then it is the responsibility of those with a vested interest, those with power and/or privilege and groups with collective action to see to it that justice is served through structural changes that allow for an all-inclusive health care system (30).

5) Nussbaum's Tragic Choice: Competing treatment approaches

As explained above, the mentally ill in Uganda not only suffer a lack of adequate health but also social injustice. However, from this point on, I will focus on the provision of mental health since as Daniels' argues, its provision will aid in restoration of social justice. It must be noted though that other interventions such as reform of the legal structures may also be necessary to fully restore justice towards the mentally ill. Since the mentally ill in many other countries also suffer a lack of adequate health, WHO as a global institution formed to protect the health needs of all human beings, intervened in its member states including Uganda to ameliorate the situation. However, WHO adopted a Western-leaning intervention plan that even though seeks to restore social justice of the mentally ill, implements a Western biomedical treatment approach that does not address the cultural framework of the people of Uganda. This presents a tragic choice to the government and health providers of Uganda in that by adopting the approach recommended by WHO, they position cultural ideas about mental illness as illegitimate. The Ugandan society is entitled to health capabilities as well as cultural and religious freedoms; therefore, choosing one at the cost of the other involves doing wrong to someone, as in a tragic choice.

WHO Intervention

It is in light of the social injustice and deprivation of health suffered by the mentally ill around the world that the WHO dedicated the 54th World Health Assembly in 2001 to Mental Health. WHO took a stand and made mental health its priority program in 2001 so as to raise awareness of the nature and scope of mental problems and the life circumstances of people suffering from them, to generate political will for national action and disseminate the evidence and science related to prevention and care (33). Young (2011) states that international institutions like WHO are indeed important and powerful agents relevant to transforming structural processes to make them more

just. She charges that political struggle about state policy must involve vocal criticism, organized contestation, a measure of indignation and concerted public pressure (30). WHO therefore, took on its responsibility to develop policies to limit the ability of powerful and privileged actors to do what they want without much regard to its cumulative effect on others and to promote the well-being of less powerful and privileged actors.

In 2006, the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was launched in Uganda as a tool for collecting essential information on the mental health system in place. It was intended to enable Uganda develop information-based mental health plans with clear baseline information and targets (11). The action plan set by WHO relies on six-cross-cutting principles and approaches including Universal health coverage, human rights, evidence-based practice, life course approach, multi-sectoral approach and empowerment of persons with mental disorders and psychosocial disabilities (1). In addition to the numerous aspects geared towards the restoration of dignity and worthy living among the mentally ill, this approach for treatment and prevention is stipulated to be based in scientific evidence and/or best practice, taking cultural considerations into account.

That being said, WHO grounds its treatment interventions on knowing and understanding mental illness as malfunctions in the neurological or brain systems (34). It believes in the effectiveness of treatments, derived from this knowledge and technology, for the restoration of functioning and productivity of the mentally ill. This belief is much more representative of Western medicine and construction of mental illness which has many fortes. As mentioned earlier, research and technology have enabled an accumulated wealth of knowledge on mental illness in the Western world allowing for the specification of various disorders. With more clarity on brain functioning and psychosocial factors, treatments have been developed for most disorders. In fact, WHO charges

that, “with the current treatments, most persons with mental, brain or behavioral disorders can become functioning and productive members of the community and live normal lives” (1). In addition to antipsychotic drugs, psychosocial therapies are another treatment approach promoted by WHO in order to alter the faulty thinking patterns and equip patients with helpful strategies to combat mental illnesses (1).

WHO also champions the shift away from outdated mental asylums to community-based services and the integration of mental health care into primary health care. This shift that is already evident in Western countries like Italy, England and Spain is supported by evidence based studies in countries like France which has created geographically defined areas called *sectors* for the organization of comprehensive psychiatric care (1). WHO cites that chronic mental disorders require integrated treatment and support services to reduce disability, increase social functioning and improve quality of life (1). WHO rightly contends that based on accumulating evidence of the inadequacies and failures of the psychiatric hospital coupled with the appearance of “institutionalism”, (the development of disabilities as a consequence of social isolation and institutional care in remote asylums) many developing countries need to initiate the process of de-institutionalization (1).

Existing treatment approach in Uganda

George M Foster (1976) writes in his discussion on disease etiologies that, “the kinds of curers found in a particular society, and the curing acts in which they engage stem logically from the etiologies that are recognized” (31). Because of the wide spread ideology on the causation of mental illnesses in Uganda, a majority of the mentally ill population has sought treatment from traditional healers. Thought of as a supernatural illness, mental disorders are believed to be recognized and treated by traditional healers. This notion is supported by the study by Nsereko et al in which many

respondents indicated that traditional healers were seen by many individuals in the community to be the most appropriate source of care. One of the respondents, a primary health care nurse noted that 'before visiting the hospital, the mentally ill have to try native medicine because they all think they are bewitched'. Another respondent narrated an encounter remarking that:

"...we wanted to take him to hospital, but the parents told us it is culture. That they have demons in the family and don't accept the hospital part of it..." (Secondary school teacher, rural district) (26).

For this reason, many of the mentally ill seek treatment from traditional healers as a first priority. Therefore, because the mentally ill are perceived as having spiritual conflicts going on within their body, traditional healers are sought out since they have the ability to reconcile one's spiritual self, using appropriate rituals. This is the case with many other illnesses mainly because of the strong belief in the powers of the traditional healers that is reinforced by the culture and religion of the people. For example, the Buganda tribe, like many other tribes of Uganda, believes that "spiritual issues come largely under the jurisdiction of clan leaders and each clan has medicine men, the Basawo, who deal with spirit-related sickness and misfortune" (19).

At this point, it is necessary to note that while traditional healers are sought out by many because of the cultural beliefs, the availability, easy accessibility and affordability of traditional healers have also contributed to their frequent use in the Ugandan community. As indicated earlier, the mental health care services in Uganda are very under resourced and poorly distributed. Most of the mental health services in Uganda are provided in the capital city, Kampala and are very costly. In order to access these services, the mentally ill in rural areas have to incur transport costs to the city as well as accommodation costs while they receive treatment. On the other hand, traditional healers are very wide spread and much easier to access as they exist in nearly every village. Additionally, their services are much more affordable compared to other treatment options. This aspect is

highlighted by the comments of respondents in the study by Nsereko et al (2011) such as *“traditional healers are cheaper than others, it is negotiable...”* and *“There are so many traditional healers here as compared to the medical workers”* (26).

While many individuals seek out traditional healers for treatment, some individuals seek guidance and healing from religious priests who have the power to cast these evil spells out of the mentally ill. One studied example is the Uganda Martyrs Guild (UMG) that was formed in 1897 and evolved into an organization for Catholic action. This group had the ability ‘to go and free people from evil in abandoned places,’ that is, they took up the practice of witch-hunts, now called ‘crusades’ in which they cleansed souls from the evil (23). Such actions have been observed even more recently. Some participants in the study by Nsereko et al (2011) attested to seeking help from religious leaders and terminating treatment with hope that prayers would bring about permanent recovery (26).

The effectiveness of traditional medicine in Uganda has been questioned and has produced mixed results. Recently, the government of Uganda has expressed negative attitudes towards the wide spread belief and use of traditional healers. This attitude has been expressed in the approval of the enactment of a bill to regulate the proliferation and operation of traditional doctors and herbalists in Uganda (32). In defense of the bill, a government official said, “Our people tend to trust these traditional herbalists more. They even stop taking clinical medication on the advice of these untrained traditional doctors.” (32) On the other hand, a number of mentally ill individuals have attested to the healing they have received from traditional healers. In his story to BBC, even though Joseph Atukunda considers himself lucky that he was admitted to Butabika Hospital, he still thinks that the traditional healer he visited saved his life. A full-time activist for mental health causes, Joseph further recognizes the possibility that tradition could have a wider role to play in mental

health care. While it could be the case that the traditional healers are only capable of creating placebo effects, James Lake gives us interesting insight on effectiveness of psychiatric treatments. Lake (2007) notes that particular kinds of treatments are often ineffective or partially effective because they fail to address the complex causes or *meanings* of mental illness (3). He acknowledges that while biological treatments are beneficial in many cases, they may be of limited value in cases where psychological, somatic, spiritual, or energetic causes or conditions underlie mental and emotional symptoms (3). As evident in the testimony by Joseph Atukunda, because many patients associate mental health with spiritual peace, they are unable to achieve complete mental health without reconciliation with the spiritual world.

Tragic Choice in the implementation of mental health care

Thomas Pogge, in his diagnosis of injustice cautions against the strong tendency of international institutions to favor policies and interests of the more affluent states of the world (30). This is evident in the more Western leaning perception and treatment solution chosen by WHO to improve global mental health. While this approach has its strengths, its application in Uganda presents a couple of issues to the government of Uganda as well as health providers that advance mental health in Uganda. Firstly, since mental illnesses are perceived as having spiritual origins, then Western medication will not be sought for as the appropriate treatment. Therefore, while increasing the availability of medication and practitioners may have some positive impacts on mental health services, it barely affects the mental health of the majority population that holds a spiritual perception of the disease and would rather seek out a traditional healer. Secondly by advocating for a more scientific perception of mental disorders, the Western approach undermines the cultural beliefs on the role traditional medicine in Uganda. This makes the recommendations by WHO insensitive to the religious and cultural beliefs of the Ugandan community and thus imperialistic.

Even though the WHO Action Plan (2013-2020) was formed as an outcome of extensive consultations with the 135 member states including Uganda and demands that the approach for treatment allows for cultural considerations, the foundation of its treatment recommendation compromises traditional medicine. According to Nussbaum, this situation presents a tragic choice for the health providers in Uganda since in promoting the Central Capabilities explained above like health, affiliation, senses, thought and imagination, the approach set forth by WHO is culturally insensitive and limits individual's freedoms to practice culture and religion.

6) Suggested solution; A Hybrid Approach to Mental Health care

While Western medicine has advanced the understanding and treatment of mental illness, we must realize that it does not have all the answers. Joseph Atukunda, an activist for mental health care in Uganda maintains that one of the biggest problems for people with mental illnesses is that the disorders are not well understood even among the psychiatrists themselves (25). On the other hand we must also recognize that while some traditional healing practices are harmful, some may be as beneficial as those of Western medicine. As Ruth Macklin writes, the injunction to respect cultural diversity could rest on the premise that Western medicine sometimes causes harm without compensating benefits (which is true) or on the equally true premise that traditional practices such as acupuncture and herbal remedies once scorned by mainstream Western Medicine, have come to be accepted side-by-side with the precepts of Western medicine (35). Because of the importance of freedom of culture and religious expressions, mental health care needs to incorporate traditional and Western perceptions of medicine in order to fully promote the Central Capabilities of the mentally ill in Uganda. Therefore, rather than fully embracing the WHO recommendation as is and restricting traditional medicine, the Ugandan government ought to consider a hybrid system that will allow for traditional medicine to grow alongside Western medicine. Such a system would allow for better health outcomes without constraining religious and cultural beliefs.

The collaboration between traditional healers and psychiatrists may also have the advantages of being a more affordable and feasible means to bring health services nearer to the people. Since the traditional healers are more in numbers and are more accessible, a hybrid mental health care system can be a faster approach to extending mental health services to those in rural areas. Ovuga et al (1999) maintain that since a central concern for medical services is the man power implication of the large need relative to low resources, the integration of traditional healers into mainline services would be an inexpensive means of expanding the availability of efficacious services (36). Additionally, a hybrid approach may help Ugandans feel more comfortable visiting hospitals. Dr. Hebert Musinga, a social anthropologist at Makerere University mentions that, "When a traditional healer refers one to the hospital, people place a lot of confidence in that."

Two models of liaison have been proposed for this hybrid approach to mental health care. Because traditional healers are often turned to as the first option, it is reasonable to suggest that traditional healers be trained to refer certain cases of mental illness to psychiatrists. This model has been referred to as the sequential model of liaison (36). Another model of liaison that has been proposed is the simultaneous model whereby the traditional healers work side-by side, perhaps in the same premises with medical psychiatrists (36). In both instances, cultural and religious beliefs remain respected and both the traditional healer (for spiritual healing) and Western medicine practitioner (for bodily healing) would be retained. In fact, it is possible for both models of liaison to co-exist for much stronger integration of these medical services.

However, since it has been identified that some traditional healers perform harmful rituals, the practices of traditional healers ought to be regulated in this integrated approach. The traditional healers will need to be trained to reinforce their good practices as well as limit the harmful practices/rituals. The official recognition of these healers may also reduce some of the prejudice that some members of the medical community might have against traditional medicine since the decision on integration would be achieved

through dialogue amongst parties with a vested interest. As Macklin notes, in medicine we ought to be able to respect cultural diversity without having to accept every single feature embedded in traditional beliefs and rituals (35).

Small projects have been implemented in Uganda that use this hybrid approach and have reported some success. One project using a Canadian grant trained nearly 500 traditional healers and village elders to recognize the signs of mental illness and soon reported that traditional healers had already referred hundreds of patients to hospitals (37). Another project was started in Northern Uganda seeking to aid the numerous individuals suffering from Post-Traumatic Stress Disorder (PTSD) as a result of the civil war (38). It was noted that patients sought out traditional healers because they believed that the spirits of the people they killed willingly or not willingly had come back to disturb them. Based on this knowledge, the hybrid approach was thought necessary to improve mental health in this area. Alex Okello, a traditional healer in this project believes that with such patients he purports to chase away those spirits but for conditions that are beyond his reach like epilepsy, he refers them to a psychiatrist (38). These projects demonstrate the willingness of traditional healers to partner with Western practitioners against mental illnesses. They also demonstrate the willingness of psychiatrists to work with traditional healers. Dr. Seddie Alibusa, the Ugandan psychiatrist participating in this project says that, “what we can do best is the psychiatric treatment—look for the best medication, apply it in the right dose, explain the illness. But when it comes to comforting the people, those traditional healers can do a really good job” (38).

This approach has also been implemented on a larger scale in South Africa where the government developed new legislation to regulate and promote systems of indigenous knowledge (39). A study on this system by Sorsdahl et al (2010) looking at traditional healer referral to Western care indicates that even though the traditional healers expressed willingness to collaborate with Western medicine and make referrals, they did not follow through with the referral of patients (39). In fact, while

the traditional healers acknowledged that there existed mental illnesses caused by witchcraft or by bewitchment and those that weren't, most reported that the main cause of mental illness was witchcraft (39). A possible explanation for this observation is that the traditional healers fear to compromise their legitimacy by embracing Western medicine. In addition to the issue of limited referrals, this study also highlighted the resulting delay in receipt of Western medicine as some traditional healers attempt to treat the illness and only refer the patient to the hospital when their treatment has failed. This delay compromises the effect of Western medicine which is time sensitive as well.

Along with the issues raised above, even more questions surround the application of this proposed hybrid approach such as; which model is most applicable in the Ugandan community given that it is not a monolith community? Are the traditional healers willing to end some of their rituals that are considered harmful to their patients or would they feel that these restrictions compromise their practice? Would members of the religious community who do not believe in some of the rituals performed by the traditional healers be comfortable with this integration, particularly the simultaneous model? While I cannot offer all the answers to these questions, I concur with Daniels (2008) and recommend the implementation of small scale projects that would be conducted as social experiments with adequate scientific and ethical review. With continuous evaluation by a tool like the Benchmarks (a tool with criteria that are fundamental for fairness of reform policy as shown in the Appendix) proposed by Daniels, such projects using different models would better guide the choice and application of a hybrid mental health care system that accounts for justice and health.

7) Conclusion

Culture and religious beliefs are attributes of a community that add to its identity and that ought to be respected. Since traditional medicine has always existed side by side with Western medicine, the government of Uganda and other health providers in this community must acknowledge its key role in

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the improvement of mental health care systems that are necessary for justice. A health care system that strengthens the provision of both traditional and Western medicine is required for the restoration of human dignity and a life worthy of for the mentally ill population in Uganda. More so, given the limited resources available in Uganda, this integrated approach seems to be a cost friendly way to equitably provide the basic mental health needs to this community. However, social experiments with continuous social and ethical evaluation are required to establish which hybrid model best serves the mental health needs of the Ugandan population that are required for social justice.

Appendix:

Daniels' Benchmarks of Fairness of Health Care reform

- Benchmark 1: Intersectoral public Health
- Benchmark 2. Financial barriers to equitable access
- Benchmark 3. Non-financial barriers to access
- Benchmark 4. Comprehensiveness of benefits and tiering
- Benchmark 5. Equitable financing
- Benchmark 6. Efficiency, Efficacy and quality of health care
- Benchmark 7. Administrative Efficiency
- Benchmark 8. Democratic Accountability and empowerment
- Benchmark 9. Patient and provider autonomy

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