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Recommendations for Global Livingston Institute's Mental Health Facilitator Program in Rural Lake Bunyonyi, Kabale, Uganda

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EXECUTIVE SUMMARY

The following brief will present two recommendations for GLI's Mental Health Facilitator program. Recommendations were conceptualized after analyzing statistical information collected on Lake Bunyonyi June-July 2022. Researchers executed interviews and focus groups with locals to learn about village services, perceptions, and belief systems surrounding mental health. Researchers discovered that a majority of the study participants have a narrow understanding of mental health diagnoses, expressed uncertainty about accessing support for mental health issues, and disagreed on best practices for treating mental health issues.

The last evaluation of this program was published in 2016. Since then, Uganda has undergone massive political change and resistance, legislative change, taken in millions of refugees, and muscled through a global pandemic. Although the results of this study are similar to the results of the last evaluation, this brief suggests emphasis on community characteristics related to information and training as opposed to tangible barriers which were suggested in the previous evaluation. An additional difference from the two studies concerns stigma around mental health disorders. The first evaluation cited stigma as a barrier to MHF program implementation and effectiveness. However, participants from this study did not routinely discuss stigma.

Mental health disorders impact communities broadly and at all levels. Mental health needs must be addressed to create a thriving community and support overall health and well-being. "Overall and with moderate level of certainty, the prevalence of any mental disorder in Uganda was 22.9%." (Opio, JN). Acute symptoms of mental health issues are more prevalent in low resourced, rural areas such as Lake Bunyonyi. These areas also require the most attention from NGOs as they are often disregarded by their own government. The MHF program is a critical service on Lake Bunyonyi. It must be evaluated regularly to ensure it performs to its greatest potential in order to expand the reach of mental health services and support to all rural Ugandans of Lake Bunyonyi.

This brief will proceed with two recommendations for the MHF program and conclude with acknowledgment of other actors which impact the success of the MHF program. Additional actors cited require systematic coordination with governing bodies to facilitate economic growth or financial assistance on Lake Bunyonyi.

INTRODUCTION

The Global Livingston Institute (GLI) is a United States based non-profit organization and has been in operation since 2009. GLI's mission is **"to educate students and community leaders to innovative approaches to international development and empower awareness, collaboration, conversation, and personal growth**." (*GLI*, n.d.) GLI achieves this mission by facilitating international development in rural communities in Rwanda and Uganda. GLI has been facilitating research, education, and immersion experiences since its conception. GLI takes on a variety of projects that help build economic and overall community capacity in these countries. This brief will focus on work that is currently being done in rural Ugandan communities which live on Lake Bunyonyi. More specifically, this brief will address program improvements, evaluation, and future considerations for GLI's Mental Health Facilitator (MHF) program. The MHF program deploys local GLI staff and community members into local rural villages to administer a Train the Trainer[1] model for mental health preparedness and response. The last Train the Trainer facilitation occurred in July 2020. Mental health needs in these areas are vast and low resourced. GLI provided this background information to support efforts made by current and future researchers for the MHF program:

> *In low-income countries with high rates of poverty, communicable disease, and maternal and child mortality, the importance of mental health is often disregarded (Lund, 2018). In Uganda, and sub-Saharan Africa at large, the need for mental health services is frequently overlooked or deprioritized given other issues such as HIV, which garner a higher level of attention through large scale events; annual music festivals in Uganda, focused around HIV/AIDS, reach mass international audiences, increase knowledge on the issue, and decrease stigma (Van Leeuwen et. al, 2018). A negative stigma associated with mental health issues stems from both a lacking availability of mental health services and low willingness of affected individuals to seek such services (Gellert, 2017). Cultural beliefs about mental illness being related to 'witchcraft', or similar causes, de-motivates individuals to seek formalized mental health services, and why 80% of patients interviewed in Uganda's mental hospitals have previously sought treatment from traditional healers (Van Leeuwen et. al, 2016 ; Molodynski & Cusack, 2017).*
>
> *As part of its mandate, the Mental Health section of the Ugandan Ministry of Health repealed the Mental Treatment Act of 1964 to the Mental Health Act of 2014, calling for a "population free of mental, neurological and substance abuse disorders" (Uganda Ministry of Health, 2019). In 2018, Uganda Parliament preliminarily passed the Mental Health Act, which brings hope for the country, broadening the definition of "Mental Health Conditions" to include depression, bipolar disorder, anxiety disorders, schizophrenia, and addictive behavior due to alcohol/substance abuse among several others (Bukuwa, 2019).*
>
> *A lack of strong mental health information systems and the presence of social stigma lead to a significant deficiency in the reporting of mental health disorders (Petersen, et. al., 2017; Ritchie & Roser, 2018). The actual number of Ugandans suffering from mental disorders is closer to 35%, and could be higher considering*

[1] Train the Trainer refers to a model in which the trainer or teacher trains others on information and in turn also trains them how to teach that same material to others

potential gaps in reporting (Molodynski & Cussak (2017). Uganda is said to rank "among the top six countries with the highest cases of mental illness in Africa" (UG Mirror, 2018). The two most common mental disorders, depression and anxiety, combine to represent 13.6% of the total number of years lived with disability (YLD) in Uganda (World Health Organization, 2017). Although as it stands, Uganda spends 9.8% of its gross domestic product on health care, but only 1% of this is allotted for mental health, and no substantial change in this area is outlined in the 2018 Mental Health Act (Molodynski & Cusack, 2017 ; Bukuwa, 2019).

Due to a limited number of mental health professionals, coupled with a lack of resources, 90% of individuals with mental illnesses do not receive any treatment (Molodynski & Cusack, 2017). Butabika Hospital is the only operating national mental hospital in Uganda, located in the capital city of Kampala. There are 28 inpatient psychiatric units throughout Uganda, 60% of which are located in Kampala, while 87.7% of Uganda's population lives in rural communities (Shah et. al., 2017). Quick dissemination of the 2018 Mental Health Act throughout Uganda is crucial, as most district level health plans still fail to even mention mental health (Mugisha, et. al., 2017). Decentralized, community-based care has proved to be a highly effective model in rural areas of Uganda (Shah, et. al., 2017). The utilization of community health workers allows for a larger population to be reached than traditional methods, and means that treatment can be adapted to fit existing community beliefs and needs (Shah, et. al., 2017).

To improve the MHF program and better deploy resources to local communities which live on Lake Bunyonyi, researchers conducted an extensive amount of qualitative research, travelling to and interviewing community members which might inform problem solving for mental health challenges on Lake Bunyonyi. The interviewees were carefully chosen from various groups of stakeholders in an effort to provide perspective variety and allow for comparison between the groups. The groups of people targeted for interviews were secondary school students, health care workers, traditional healers, religious leaders or practitioners, those who have been trained through the MHF program, and local leaders. Field work was conducted directly with locals. Interviews were recorded and sometimes required translation assistance. All interviews and recordings were conducted with verbal consent from the individuals participating, later transcribed, and then analyzed and coded for recurring themes. Incentives were not offered to participants. This brief will follow with two recommendations for GLI's MHF program. All demographic data can be found in the Appendix.

RECOMMENDATION 1

Narrow the knowledge gap by enhancing and adapting the MHF training

A consistent message from the interviews and focus groups indicated a narrow understanding of mental health. Throughout the interviews, variations of mental illness were described by the participants as "mentally disturbed" and often attributed to the behavior one might elicit when under the influence of drugs or alcohol. One student referred to mental health as "being silly when drunk." A narrow understanding of mental health issues and diagnoses came up on average 1.2 times per participant. Many participants spoke of alcoholism as the only mental health issue in their community. Some of the interviews and focus groups uncovered a community understanding that curing alcoholism was synonymous with curing an individual's mental health issues. When asked about mental health diagnoses outside of substance abuse such as anxiety, depression, mania, or ADHD, many interviewees asked the researchers to define those terms and explain symptoms. This was also the case with some participants who are also mental health facilitators. An understanding of how mental health issues might present outside of substance use was uncommon amongst the study participants. Additionally, no participants referred to mental health as part of a larger neurological system. No participants discussed emotional intelligence or emotional stability as indicators of mental health.

There are three aspects to consider about closing this gap: 1) assumes a gap in knowledge, 2) assumes a gap in memory or practiced skills, and 3) assumes a gap in MHF implementation due to environmental factors in the communities it intends to serve. Upon review of the MHF program training modules, there is ample and comprehensive information on how to be a mental health first responder. The modules provide thorough information on how to help solve community problems through active listening, empathy, and other counseling skills. Module 1 provides introductory information about mental health symptoms and diagnosis, and eventually, in Module 9 the difference between stress, distress, and disorder is described. This is further detailed in Module 11. It isn't until Module 10 where the facilitators in training are introduced to problem solving methods for helping a community member. More specifically, Module 10 reviews the STPC[2] method previously mentioned in Module 2. Modules 11 and 12 specifically address a variety of mental health diagnoses. These modules are lengthy and presuppose a knowledge base which exceeds volunteer, community based mental health support. It is undeniable the information in these modules is relevant, crucial, and important to the success of community-based response. However, this brief asserts that the total 118 slides found in Modules 11 and 12 present an overwhelming amount of information to the prospective facilitators. In addition, many of the topics or diagnoses covered in these modules are the singular subject of some professions, research studies, or endemics, making them difficult to cover in an introductory way. It is important to consider what effect information overload can have on retention. It is the opinion of this brief that Modules 11 and 12 be broken down into additional smaller modules or cover less diagnoses for this introductory MHF training. There is undeniably a place for training on the more than 15 cited diagnoses in these modules. However, the performed interviews and focus groups suggest the amount of information covered is too vast which unintentionally asks learners to cherry pick diagnoses which are most easily digestible and more commonly recognized in their communities, such as alcoholism or other substance use disorders.

A secondary piece of the assumed knowledge gap is facilitators' memory retention from the initial training. Although learners' retention is in some way impacted by the amount of information

[2] STPC refers to helping the person assess the **S**ituation, review what has already been **T**ried, discuss future **P**ossibilities, and make a final **C**hoice

in the training modules, it is also impacted by the number of times the information is revisited. This is especially true for complex, high level information. The level of understanding regarding mental health diagnoses and support, both with facilitators and community members, will likely improve if the MHF program offers follow-up, refresher courses. Refresher courses should be shorter than the initial training and revisit key points from the initial training day. To maximize the potential of a refresher course, trainers should seek feedback from mental health facilitators on which topics they most want to review and learn more about. This feedback will also inform which mental health issues the facilitators are most commonly encountering in their communities.

The final piece to considering an adaptation to the MHF curriculum asks the curriculum to acknowledge the imperfect execution of services and support in these rural areas. Demonstrated by the logistical effort needed to perform interviews and focus groups, establishing an organized and consistent helping system in these communities is a lofty task. Although possible to set a consistent meeting time and place which allows follow up with suffering community members, as suggested in Module 2, there are numerous barriers village members face to being able to commit to such a process. Some barriers include inability to communicate consistently via telephone or lack of transportation to attend regular counseling meetings with a mental health facilitator. This not only requires more time from the individuals involved but also slows the facilitation process. This brief is not suggesting an organized system is impossible to achieve on Lake Bunyonyi. It is only asking the MHF training curriculum to acknowledge and discuss difficulties to its actual implementation in the communities. Mainly the pieces of the curriculum that ask for regular, consistent counseling.

RECOMMENDATION 2

Information campaign via WhatsApp or door to door outreach

During the interviews, researchers uncovered a common theme of community support and involvement. Nearly once per participant, interviewees referenced the support of their neighbors or community members as being a vital place to seek mental health support. In practice, this was also true. Researchers observed many ways which the communities on Lake Bunyonyi work and live as a collective society to achieve their goals.

Nearly none of the community members who participated in this study had heard of the MHF program. Perhaps villagers have used the service but didn't know what it was called or strictly didn't know the service exists. To combat the latter possibility, the MHF program should organize a purposeful information campaign. Some village members cited the frequent use of WhatsApp to disseminate information quickly and/or achieve widespread outreach. The ease and quickness of sharing media through WhatsApp can achieve extensive outreach in a fraction of the time it might take the MHF program facilitators to execute.

For community members that cannot access WhatsApp, the MHF program should engage in door-to-door outreach to discuss the MHF program and its benefits with community members. Similar outreach is already being done by some medical staff who participated in this study. Research revealed the staff at the Kagunga Medical Center perform rigorous and time-consuming door-to-door outreach for vaccine administration. The MHF program can expand its reach to community members if (a) all medical professionals are also trained and/or (b) the MHF program deploys an outreach strategy that mirrors the Kagunga vaccine efforts.

Module 16 of the MHF curriculum highlights the importance of community and peer support. It is no doubt the curriculum and the trainers know how collective these communities truly are. This study reveals that information about the MHF program is not well understood. It is the recommendation of this brief that the MHF program, more specifically the trainers, include MHF program publicity to new facilitators during the initial Train the Trainer session. Providing social media content and specific language at the training will help the facilitators more aptly describe and promote the MHF program. In turn, communities will feel encouraged to use the MHF program more often.

ADDITIONAL CONSIDERSATIONS

It is critical this brief concedes additional factors not mentioned above which inevitably impact the success of the MHF program's deployment. Those additional factors are religious practices, external or tangible barriers, and government support. Uncovered in the research, a preference to treat mental health issues through various religious practices came up on average about 1.5 times per study participant. *Practices* refers to and encompasses a number of religious mentions in the interviews and focus groups. Some of those practices include mention of prayer, attending church for healing, performing an exorcism, and repeated mention of being possessed by demons. Religion is deeply ingrained in these communities. Religion serves a spiritual and communal purpose in these communities. Many village members receive support (financial, emotional, or otherwise) from their church communities and rely heavily on the impact of prayer to heal their ailment, mental health included.

Any change to the MHF program must consider the impact religion has on these communities. It was common in interviews to hear the preferred and first choice for mental health treatment involves a variation of the above-mentioned religious practices. Although participants who are medical professionals did not cite prayer as the most effective treatment for mental health issues or advocate for treatment through the church, many of them did include prayer as a secondary or concurrent option for treatment.

Secondarily, the MHF program cannot operate without understanding community barriers related to infrastructure, external resources, or material goods. This particular struggle came up on average 1.04 times per study participant. In defining this theme, researchers included any mention of cost to access services, geographical factors which made it difficult to access services, scarcity of trained professionals in mental health, inadequate training on mental health issues for existing professionals, inadequate supply of medication, and cost or accessibility issues related to transportation needed to move on and around Lake Bunyonyi.

Lake Bunyonyi is presented with the above-mentioned issues in part due to its remoteness in the wetlands. "Poor people, especially in rural areas, generally rely on ecosystem services directly for subsistence and income-generating activities or to obtain water and medicines because of lack of affordable alternatives." (*Poverty Rate in Uganda*, n.d.). It is one obstacle to properly educate the local Lake Bunyonyi population about mental health first aid. It is another, separate, obstacle to augment the infrastructure and material goods necessary to implement treatment. It is important that the MHF program and its training materials address this hurdle. Train the Trainer events should encompass strategies facilitators can use to creatively problem solve and assist their neighbors with minimal resources. Module 16 offers teaching on making referrals but does not address what to do when a community has minimal, if not zero, affordable referrals available, such as Lake Bunyonyi.

The final point which deserves notice calls attention to the Ugandan government. According to Freedom House, Uganda is labeled as "Not Free" (*Explore the Map*, n.d.). The last assessment of Uganda occurred in 2021. Freedom House cites numerous instances of corruption within the government and surrounding political elections. Uganda currently sits at a political freedom score of 11/40 (*Countries and territories*). Corruption in Uganda reaches beyond the capital city. In August 2021, "the government ordered the closure of 54 nongovernmental organizations (NGOs), accusing of them of failing to comply with legal requirements. Groups affected included the Citizens' Coalition for Electoral Democracy in Uganda (CCEDU) and human rights NGO Chapter Four." (*Countries and territories*). These actions suggest the government is unlikely to provide or support existing social safety nets for its citizens and signal the government is willing to actively create barriers for NGO operation, possibly impacting mental health provisions in the country.

Uganda's government participation is crucial to the success of mental health services. The MHF program is capable of filling gaps within the rural communities which need mental health first aid. However, the MHF program cannot, as it stands now, fill the gaps caused by lack of funding, nonexistent facilities, and minimally trained professionals. Without governmental support, medical centers remain barren of critical medication, beds, or staffing. Certain geographical areas lack mental health services and facilities in general. Four of the four medical professionals interviewed in this study believed the government could do more to help rural Uganda as a whole, more specifically, suggesting an injection of money to their specific facilities would better support the people of Lake Bunyonyi. It is vital the MHF program take into consideration what it means to provide service provisions in a non-democratic country which does not provide substantial support or assistance to its people. Inevitably, the cost of providing services increases in areas with less government support, as does the complexity of the problems.

LIMITATIONS

Lake Bunyonyi is surround by nine major villages. Due to the geographical remoteness of Lake Bunyonyi, efforts to collect accurate census data in the region require a great deal of time and resources not yet available. With that, it is unlikely to know a precise population of those nine villages, even less likely to know a population that includes the smaller communities surrounding those nine. With this challenge, it should be noted the data presented in the appendix should not be considered representative of Lake Bunyonyi, rather a small sample size that provides a snapshot of information to shine light on a much greater issue.

Research efforts were also limited by unreliable communication. Lake Bunyonyi lacks major electrical and cellular infrastructure. As a result, community members are often unreachable for days. Often, interviews and focus groups were arranged over the course of multiple days only through “word of mouth” on one’s whereabouts. Because of these communication limitations, researchers were unable to target participants by demographic information. The research presented lacks significant age and gender diversity and all participants in the study represent the same race and similar socioeconomic status.

CONCLUSION

This study uncovered unexpected gaps in knowledge about the MHF program and defining mental health disorders. Lake Bunyonyi, though resilient, suffers from many acute symptoms of poverty. One substantial, under resourced symptom is that of untreated and undiagnosed mental health disorders. This study aimed to understand how the people of Lake Bunyonyi address mental health disorders in their community and how those communities can best be served. This study uncovered critical information necessary to the success of GLI's MHF program.

Research showed a need for bolstering information and understanding around mental health issues alongside massive tangible resource gaps. It is the opinion of this brief that knowledge and understanding of mental health must first be achieved before asking individuals to access a service. Identification of such disorder will inform what type of service someone might need and in turn support a linear process of care. This brief offers solutions to achieving the knowledge gap by launching an information campaign about the MHF program via WhatsApp, asking medical professionals to engage in door-to-door outreach, and amending the current MHF program curriculum.

However, it is also the opinion of this brief that knowledge and understanding of mental health issues should be addressed concurrently with resource gaps. Mental health issues on Lake Bunyonyi are complex, as are the ways people must seek services. This brief acknowledges the challenges of execution on Lake Bunyonyi, especially challenges related to poverty, geographical remoteness, and operation in a non-democratic country.

The importance of community based mental health services on Lake Bunyonyi cannot be underscored enough. Local community members routinely struggle with undiagnosed and untreated mental health disorders. GLI's MHF program is a strong and vigorous service which must continue operation and adapt to the changing needs of the communities. The MHF program has and will continue to make positive change in these communities through intrapersonal relationships, informal counseling services, and mental health education.

REFERENCES

1. Bukuwa, C. (2019). *New law protects rights of persons with mental illness*.
2. Countries and territories. Freedom House. (n.d.). Retrieved August 1, 2022, from https://freedomhouse.org/countries/freedom-world/scores
3. Gellert, F. (2017). Mental Illness Stigma, Socially Acceptable Treatment, and Barriers to Health. *Independent Study Project (ISP) Collection*. 2709.
4. Gli. GLI. (n.d.). Retrieved May 25, 2022, from https://www.globallivingston.org/
5. Lund, C. (2018). Mental Health In Africa: A Neglected Link In The Development Chain. *Africa Policy Review*. pp. 86-88.
6. Molodynski, A., Cusack, C., & Nixon, J. (2017). Mental healthcare in Uganda: desperate challenges but real opportunities. *BJPsych international*, *Vol 14*(4). pp. 98-100.
7. Mugisha, J., Abdulmalik, J., Hanlon, C., Petersen, I., Lund, C.D., Upadhaya, N., Ahuja, S., Shidhaye, R., Mntambo, N., Alem, A., Gureje, O., & Kigozi, F.N. (2017). Health systems context(s) for integrating mental health into primary health care in six Emerald countries: a situation analysis. *International journal of mental health systems*.
8. Men Petersen, I., Marais, D., Abdulmalik, J., Ahuja, S., Alem, A., Chisholm, D., Egbe, C., Gureje, O., Hanlon, C., Lund, C., Shidhaye, R., Jordans, M., Kigozi, F., Mugisha, J., Upadhaya, N., ... Thornicroft, G. (2017). Strengthening mental health system governance in six low- and middle-income countries in Africa and South Asia: challenges, needs and potential strategies. *Health policy and planning*, *Vol 32*(5). pp. 699-709.
9. Opio JN, Munn Z, Aromataris E. Prevalence of mental disorders in Uganda: a systematic review and meta-analysis. *Psychiatr Q*. *Vol 93*(1). pp. 199-226. doi: 10.1007/s11126-021-09941-8.

10. *Poverty Rate in Uganda: Percentage of Rural Subcounty Population Below the Poverty Line*, 2005. (n.d.). World Resources Institute. Retrieved August 9, 2022, from https://www.wri.org/data/poverty-rate-uganda-percentage-rural-subcounty-population-below-poverty-line-2005
11. Ritchie, H., Roser, M. (2018) "*Mental Health*". Our World in Data.
12. *Rising cases of mental health, stigma worries MPs*. (2018). Uganda "UG" Mirror Newspaper.
13. Shah, A., Wheeler, L., Sessions, K., Kuule, Y., Agaba, E., & Merry, S. P. (2017). Community perceptions of mental illness in rural Uganda: An analysis of existing challenges facing the Bwindi Mental Health Programme. *African journal of primary health care & family medicine, Vol 9*(1). pp. e1-e9. doi:10.4102/phcfm.v9i1.1404.
14. Van Leeuwen, J., Adkins, S., Mirassou-Wolf, T., Schweiger, W. & Grundy, R. (2016). An evaluation of the Mental Health Facilitator programme in rural Uganda: Successes and recommendations for future implementation. *Journal of Psychology in Africa, Vol 26*(3). pp. 288-299. Doi: 10.1080/14330237.2016.1185919.
15. Van Leeuwen, J., Nabimanya, H., Ward, A., Grundy, R., & Thrun, M. (2018). Music Festivals Serving as a Catalyst for Collaborative HIV Prevention Education and Expanded HIV Testing in Rural Uganda. *International Journal of Community Development, Vol 6*(1). pp. 1. doi: 10.11634/233028791503915.
16. World Health Organization. (2017). Depression and Other Mental Health Disorders. In WHO Press (Eds.), Global Health Estimates (pp. 17). Geneva, Switzerland: WHO Presstal Health Facilitator (MHF) Program. (2018). National Board of Certified Counselors – International.

APPENDIX

GLI Work Outline
Public Health and Community Development, Summer 2022

Purpose: To better understand the resources available to individuals facing mental health struggles and document the opinions of those living in Lake Bunyonyi communities. By **listen**ing to the local needs, the GLI will be able to **think** about how to respond appropriately and then **act** in the best interest of the Lake Bunyonyi people. This original human subject research will inform the GLI's approach to implementation and program evaluation of the MHF program.
Method: In person interviews, individual and small group
Resources needed: Recording device, translator, transportation
Target groups: Secondary school students, healthcare workers, political leaders, traditional healers, religious leaders, peer educators
Procedure: To begin each interview, the interviewer(s) will introduce themselves and objectives. The interviewer(s) will ask the interviewee(s) (further referred to as participants) to write down their name and profession. Contact information is welcomed but optional. Interview questions are meant to guide Q&A. Each interview will be treated as an open conversation, and the interviewers will flexibly conduct the conversation to suit the needs and desires of the participants. All interviews and recordings were conducted with verbal consent from the individuals participating. Incentives were not offered to participants.

Interview Questions (General)

1. How would you define mental health?
2. Have you ever felt like you've struggled with your own mental health? If yes, did you know how to seek treatment/were you comfortable doing so?
3. What resources are available to those struggling with mental health?
4. Has the community adapted to meet mental health needs?
5. Are you aware of mental health resources in Uganda? What about the Mental Health Facilitator program?
6. Do you feel like your community does a good job at addressing mental health concerns?

Interview Questions (Students)

1. Does your school provide resources to help you with mental health?
2. Do you feel supported by your parents and community to address your mental health?
3. Would you rather seek help from a traditional healer, religious leader, or a doctor?
4. What do you think about mental health in your community?

Interview Questions (Healthcare workers)

1. What training/certification do you have in the medical field?
2. What is your experience treating mental health problems?
3. How do you typically help those struggling with mental health?
4. What can be done better to help those who are struggling?
5. How do you feel about religious leaders or traditional healers and the way they address mental health?

Interview Questions (Religious Leaders)

1. Do people come to you seeking help with mental health related concerns?
2. What is your advice/solution to those who are struggling with mental health concerns?
3. How do you feel about mental health and the people who are struggling with it?
4. How do you feel about traditional healers or doctors and the way they address mental health?

Interview Questions (Political Leaders)

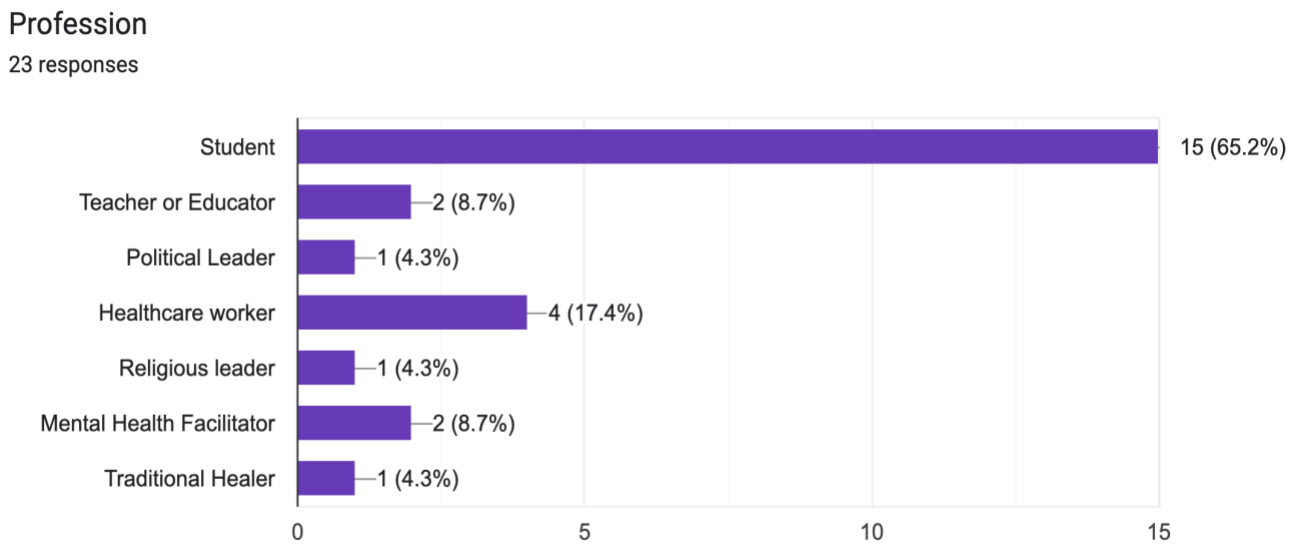
1. What resources are available to your community members who are struggling with mental health?
2. Do you have suggestions on how to improve mental health availability in the community?
3. How do you feel treating mental health through religious leaders or traditional healers?
4. Do you work with other local government or the federal government to better understand and treat mental health in Uganda?

Interview Questions (Traditional Healers)

1. How often do people come to you with mental health related illness?
2. What is your main form of treatment?
3. What influences your beliefs about mental health?
4. What do you think about other modalities to treat mental health?

This work outline has been adapted, with permission, from an original version written by Ethan Gutterman, fellow MHF program researcher.

Participant Demographics

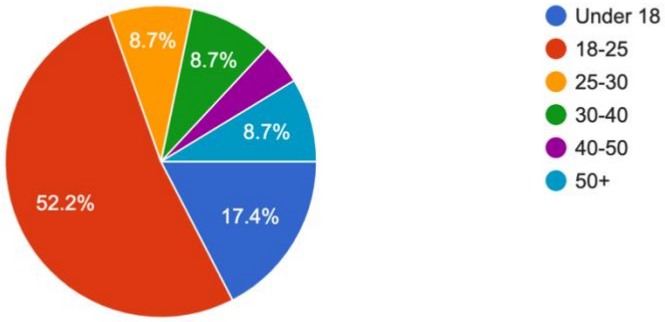


Some study participants occupy multiple roles in their community, holding more than one profession.

Participant Demographics continued

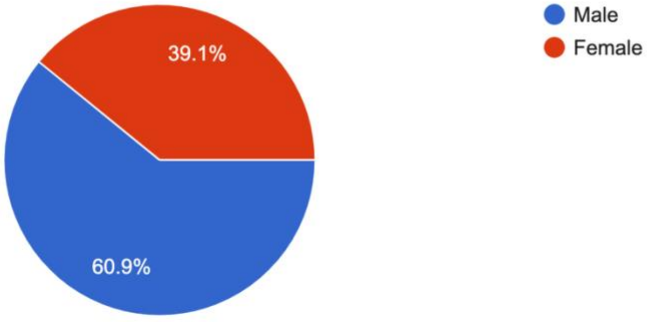
Age

23 responses



Gender

23 responses



Recurring Themes

Recurring Theme in interviews and focus groups	Number of times theme was mentioned (All participants)	Ratio of amount of times mentioned:per person	Ratio expressed per participant, on average
Preference to treat MH with religious practices	33	33:23	Came up nearly 1.5 (1.43) times per participant
Narrow understanding of defining MH issues or diagnoses	28	28:23	Came up 1.2 times per participant
Tangible resources as a barrier (no facility nearby, lack of transportation, money, meds, etc.)	24	24:23	Came up 1.04 times per participant
Reference to support/care from neighbors or fellow community members	22	22:23	Came up about once per participant (.95x)
Narrow understanding of the causes of MH issues	13	13:23	Came up .57x per participant

Special thanks to those who made the research possible and those who opened their homes and workspaces for collaborative conversation in an effort to serve the people of Lake Bunyonyi.

Participants

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Clinton Muhwezi
Aggrey Kabagambe
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