How do you teach the young women with cognitive and intellectual disabilities at this organization about sexual health and menarche?

Can you explain the culture surrounding disabilities and mental health around this area of Lake Bunyoni (rural) and provide more information about the mental health training program you will be conducting next week?

Can you explain the culture surrounding mental health and disabilities in Uganda, and how the kindergarten you own along with other schools treat and incorporate these children?

Can you explain the culture surrounding cognitive and intellectual disabilities in Uganda, and how your daughter with dyslexia has moved through the school system?

Can you explain the culture surrounding mental health and disabilities in Uganda? Can you describe your own experience living with bipolar disorder, about access to medication, and the mental hospitals?

Can you elaborate on the culture surrounding people with mental and physical disabilities and explain how they interact with schools and the workplace?

Can you explain the culture surrounding mental health and disabilities in Uganda? Can you elaborate on the substance and drug abuse issues in Uganda?

Note: The terminology that was best understood was “mental disability”.
Is the person in a village with specially trained community mental health facilitator or a referral system?

- Yes: This is relatively rare. Can the family afford to send the person who is affected to a mental hospital hours away or pay for special services? Will the family choose to spend the money this way?
  - Yes: Money is likely to be spent elsewhere. Does the child/adult have a mental or physical disability?
    - Mental: Often kept away and at home. Child may not get formally educated or eventually work, may not go on outings with the family, and may be a source of shame to the family.
    - Physical: Child might integrate into the school system and eventually the workplace. The government currently runs a program to give people land to start small businesses. Special schools are very expensive, and a child at a normal school may be shamed and punished.
  - No: Mental disabilities: associated with demonism or curses, given bad diet, not allowed to attend school, hard to get employment. Physical disabilities may be treated well, may be allowed to attend school. In some locations: however, children have been abandoned or killed.

- No: Is the person affected live in an urban or rural region?
  - Rural: May be treated at a distant hospital if applicable. My be given medication from the hospital. Other services may be covered by the family to assist the person.
  - Urban: Does the person affected live in an urban or rural region?
    - Yes: Is the family wealthy?
      - No: Mental: There are tradeoffs, and money must be spent elsewhere. The person must cope without formal treatment
      - Yes: Physical: Why does context matter?

- No: Why does context matter?

Why does context matter?

A child may be spent to a special school that accommodates him or her or receive special services. However, it is unlikely the child will know his or her diagnoses or be around other people that understand it. Unlikely to receive medication, as it is rare to receive a diagnoses. Tend to be lumped into “disabled” and not differentiated

Adult suffering from addiction or other issues might have access to hospitals and potential medication.
DIVERSE INDIVIDUAL ACCOUNTS

➤ Even at schools who accept some students with mental disabilities and disorders, children are often viewed as “mad” or “dangerous”. One child observed at a school bangs his head on wall, and is considered “risky” because he occasionally harms himself or other children.

➤ After receiving the polio vaccine, a women can not longer walk. She is treated normally and integrated into the community.

➤ A child of an interviewee’s friend is born with a disability. The interviewee has never seen the child and the child does not go to school.

➤ A mother has a daughter with dyslexia, and realized her daughter had this after she repeated a grade four times. Her daughter had access to a specialist and now attends “Hidden Talent Children’s Center”.

➤ A man had to quit his job at a bank to visit a mental hospital to treat his bipolar disorder. The hospital staff was occasionally violent, but the man said the treatment helped and his medication was paid for.

➤ A man thinks main problem with “disabilities” is drug addition, specially marijuana and meth.

➤ A man in community had an abnormally large head and a very small body. He was left in his house and depended on others for movement.

➤ A women knows twin girls. One likely has cerebral palsy and does not attend school with the other twin. She stays at home., hidden away.

➤ A boy can not complete tasks and is highly emotionally reactive. He has been identified as special needs but is highly unlikely to receive a diagnoses or specialized care.
A GROWING RURAL APPROACH

In some rural areas, there has been a recent push to train influential people in communities about “mental health”, who then serve as “Mental Health Facilitators”. The intention is to change harmful ways of thinking, create a basic understanding of mental health and mental disorders, and connect people to services who need them. The initiative faces issues such as an extreme shortage of specialists and issues with the success of the referral systems. However, this initiative may be an interesting framework to further explore rural approaches.

Population-Based Mental Health Facilitation (MHF): A Grassroots Strategy That Works

J. Scott Hinkle

The World Health Organization (WHO) estimates that at least 450 million people worldwide live with unmet mental health problems. Additionally, one in four people will experience psychological distress and meet criteria for a diagnosable mental health disorder at some point in their lives. This data speaks to the need for accessible, effective and equitable global mental health care. Available mental health resources are inequitably distributed, with low- to middle-income countries showing significantly fewer mental health human resources than high-income countries. The need to proactively address this care-need gap has been identified by WHO and various national organizations, including NBCC International (NBCC-I). NBCC-I’s Mental Health Facilitator (MHF) program addresses the global need for community-based mental health training that can be adapted to reflect the social, cultural, economic and political climate of any population, nation or region.

Keywords: global, mental health, international, mental health facilitator, MHF, population, community, WHO
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