Child and Adolescent Mental Health Care in Uganda

This report was developed by ICHAD (International Center for Child Health and Development), SMART Africa Center (Strengthening Mental health And Research Training in Sub-Saharan Africa), the Clark-Fox Policy Institute at the Brown School at Washington University in St. Louis and ChildFund Uganda.

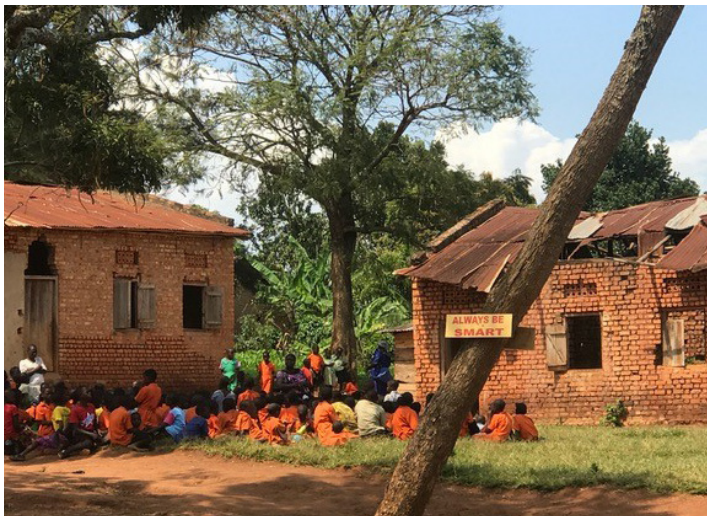
In Uganda, children make up about half (56%) of the total population, and they often present with multiple physical, mental health, and educational challenges.[1,2] Large numbers of Ugandan children live in communities with high rates of chronic poverty (38%), domestic violence (30%), physical violence toward children (80%), depression (33 to 39%), malaria (70 to 80%), and HIV or AIDS (6%).[3,4,5,6] All these factors require thoughtful policy interventions that will allow Ugandan children the opportunity to thrive and lead healthy and productive lives.

Mental Health: Prevention and Early Intervention

When screened in Ugandan primary care clinics, 12 to 29% of children present mental health symptoms.[7,8] More specifically, in a study of depression amongst adolescents in secondary schools in Uganda, Nalugya (2004)[8] found that 21% of youth presented depression symptoms. The prevalence of anxiety disorders has been found to be as high as 26.6%, with rates higher in females (29.7%) than in males (23.1%).[9] Adolescent suicidality in Uganda has also been high.[10]

Mental health challenges are associated with increased risk for poverty due to factors such as increased health expenses, compromised productivity, mental health stigma, and loss of employment.

Mental health challenges that emerge during childhood and adolescence may compromise healthy transition to adulthood and increase economic and social costs for families, governments, and society in general.[11,12] For instance, childhood disruptive behavior disorders, if not addressed, are associated with adverse outcomes, including academic problems (e.g., school dropout), social impairment, a higher incidence of chronic physical problems, unemployment and legal problems, substance abuse and violence as adults.[13,14] Moreover, studies show that a substantial proportion of mental health challenges in adults originate during childhood and adolescence.[15] Hence, addressing mental health challenges in early developmental stages has been set as a priority for the global child health agenda.[15]



RECOMMENDATION #1

Include language in the current Mental Health Bill that prioritizes children and adolescents.

The Mental Health Bill provides an opportunity to address the needs of children in Uganda. Specific language that identifies child and adolescent mental health as one of the key priority areas would highlight the critical need of all Ugandan children to have access to quality mental health care.

RECOMMENDATION #2

Early detection can ensure long-term health and socioeconomic benefits.

Policies must explicitly address strengthening capacity for addressing child and adolescent mental health care needs in non-stigmatizing settings, including families, schools, and primary health care clinics.[16] Government is best positioned to successfully embed early detection and care within existing child serving systems through the passage of the Mental Health Bill.

RECOMMENDATION #3

The Mental Health Bill should be renamed The Mental Health Care Bill.

The pending legislation should be renamed the Mental Health Care Bill to reflect Parliament's commitment to caring for the needs of our children, families, and communities. This will also allow to make the language less stigmatizing for people impacted by mental health challenges.

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In Uganda, children make up about half (56%) of the total population, and they often present with multiple physical, mental health, and educational challenges.[1,2] Large numbers of Ugandan children live in communities with high rates of chronic poverty (38%), domestic violence (30%), physical violence toward children (80%), depression (33 to 39%), malaria (70 to 80%), and HIV or AIDS (6%).[3,4,5,6] All these factors require thoughtful policy interventions that will allow Ugandan children the opportunity to thrive and lead healthy and productive lives.

Workforce Training

Uganda, like many other developing countries, has scarce mental health workforce resources (e.g., psychiatrists, psychologists, social workers and nurses). Moreover, very few of these professionals are trained specifically in child and adolescent mental health care.[7] Given the limited number of mental health care professionals in Uganda (and most SSA countries), it is not feasible to rely solely on such professionals to deliver mental health prevention and care services. Although primary health care professionals can provide the bulk of care, mental health professionals, namely psychiatrists, nurses and experts in psychosocial health, are also needed to provide adequate services to those children and adolescents who require intensive intervention. Additionally, the mental health care workforce plays a key role in delivering training, support and supervision to non-specialists. Without these mental health care professionals, Uganda will not have enough human resources to meet their populations' mental health treatment requirements, including children and adolescents. This is even more urgent given that Ugandan population primarily comprises of children and adolescents (56%).

RECOMMENDATION #1

Primary health care workers must be trained in child and adolescent mental health.

Research evaluating the effectiveness of mental health training for various groups, including general practitioners and nurses found that the trainings were especially successful in improving diagnostic skills and sensitivity of trainees as well as their attitudes towards mental health challenges.[8]

RECOMMENDATION #2

Additional training is needed for mental health care workers.

Given the unique needs of children and adolescents with mental health challenges, supplemental training programs, (e.g., certificate programs, advanced degree programs) for the primary mental health care workforce can add to the pool of individuals trained in child and adolescent mental health.[9] Training in the delivery of brief, low-burden, evidence-based interventions adapted to the Ugandan context has been found effective, feasible, and acceptable.[8]

RECOMMENDATION #3

Support and train lay workers and peers that already exist in health and education systems to implement evidence-based mental health interventions.

Task-shifting (also referred to as task sharing), endorsed by the World Health Organization, is a cost-efficient and feasible model that involves redistributing tasks from professionally trained workers to those with less training and fewer qualifications.[9] Research has demonstrated that mental health interventions provided by local lay counselors with little to no previous mental health training or experience have demonstrated positive findings in the area of mental health, health, and overall psychosocial outcomes.[9] Community health workers, village health teams, expert clients -and others who may fall in that category- who work directly with children and families at Health Center 1 and LC 1 levels could constitute this workforce in the Ugandan context.

Endnotes

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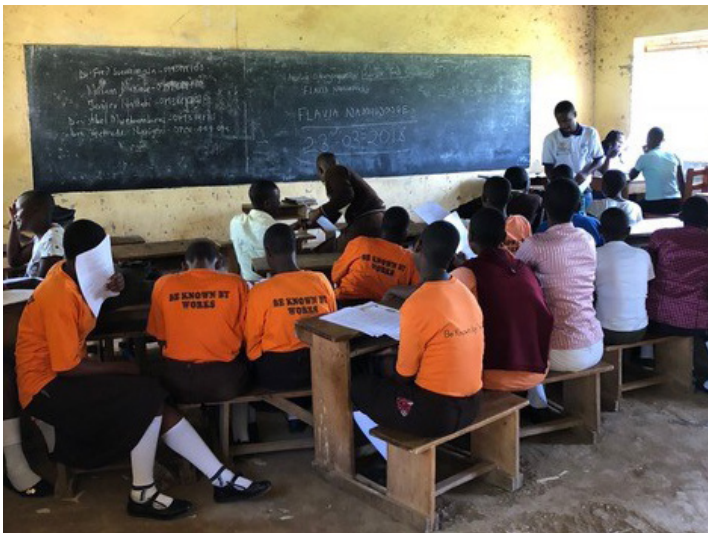

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Asset-Based Economic Development Aimed at Addressing Poverty

According to the World Bank, Uganda reduced monetary poverty from 31.1% in 2006 to 19.7% in 2013.[7] However, the proportion of the Ugandan children and adolescents living below the national poverty has reached 38% for children under five and 55% for children ages six to 17. Of those children, 18% live in extreme poverty and face serious challenges to healthy development and transition to adulthood.[1] Poverty during childhood also increases the risk for intergenerational poverty.[8]

Research has pointed to the bidirectional relationship between poverty and mental health, with poverty increasing the probability of mental health challenges through heightened stress, social exclusion, decreased social capital, malnutrition, and increased obstetric risks, violence, and trauma.[9] In turn, mental health challenges are associated with increased risk for poverty due to factors such as increased health expenses, compromised productivity, mental health stigma, and loss of employment/unemployment.[10]

Children and adolescents in communities assaulted by persistent poverty and disease are more likely to suffer from a range of chronic mental health challenges, which in turn, undermine their ability to become functional members of the society. Poverty has also been found to negatively impact children's brain/cognitive development.[11]

Studies have pointed to the bidirectional relationship between poverty and mental health, with poverty increasing the probability of mental illness.

RECOMMENDATION #1

Asset-based interventions can play a critical role in reducing risks associated with mental health challenges.

Economic empowerment interventions, including family and child savings accounts, need to be offered to poverty-impacted adolescents and families in Uganda. Research has demonstrated that poor families in low-resource communities can effectively benefit economically from these interventions. Additionally, the interventions can minimize risk taking behaviors and address mental health stressors among children and adolescents.[12, 13, 14, 15, 16, 17]

RECOMMENDATION #2

Providing financial literacy training to children and adolescents can promote saving behavior.

Integrating financial management trainings into school curriculum can contribute to teaching and promoting saving behavior among children and adolescents, which in turn, may reduce poverty and its associated risks.[12, 13, 14, 15, 16, 17]

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