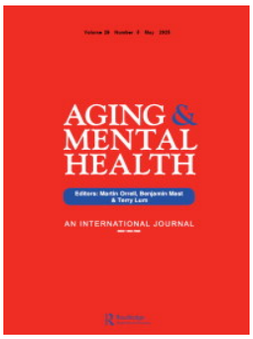

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Barriers to treatment seeking for depression among elderly service users at Butabika National Referral and Teaching hospital, Kampala- Uganda

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ABSTRACT

Objectives: Depression among the elderly is a significant public health concern in Uganda, where cultural, social, and healthcare-related barriers hinder access to treatment and support. This study examines the barriers to mental health service access faced by elderly service-users in Uganda.

Method: Using an interpretive phenomenological approach, in-depth interviews were conducted to capture the lived experiences of elderly Baganda service users receiving treatment at Butabika National Referral and Teaching hospital.

Results: The findings reveal an intricate interaction between cultural, social, economic, and healthcare system-related barriers. Key barriers include limited mental health awareness, financial constraints, fragmentation, drug shortage and geographical access. Social and cultural stigma further exacerbate these challenges contributing to delayed or avoided help-seeking behaviours among the elderly.

Conclusion: The study highlights the intersectionality of aging and mental health issues, underscoring the urgent need for a comprehensive, integrated approach to mental health care for the elderly. This research calls for targeted interventions to reduce stigma, increase mental health literacy, and improve the accessibility and affordability of care for vulnerable elderly populations in Uganda. Such services can improve mental health outcomes and quality of life for the elderly in Uganda.

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Depression; elderly; barriers; stigma; mental healthcare; Uganda

Introduction

Depression is a common mental health condition affecting millions globally and ranks as one of the leading cause of disability worldwide, including among older adults (Ganafa, 2024; Patel et al., 2016; WHO, 2021). Estimates indicate that about 5.7% of individuals aged 60 and above experience depression, underscoring its significant impact on their quality of life and overall health. This rate is notably higher than the 3.8% prevalence observed in the general population (WHO, 2023), highlighting the increased vulnerability of older adults. Globally, depression affects approximately 280 million people, with older adults representing about 5% of this demographic (Ganafa, 2024; WHO, 2023).

The aging process is often accompanied by both psychological and physiological changes, increasing susceptibility to mental health issues (Tiple et al., 2006; Zenebe et al., 2021). In sub-Saharan Africa, including Uganda, older adults face a depression prevalence rate of about 7% (Gureje et al., 2005). Unfortunately, many individuals remain undiagnosed and untreated, facing challenges such as stigma, mental health illiteracy, and inadequate resources (Sankoh et al., 2018). In severe cases, untreated depression may even lead to suicide attempts (Jörns-Presentati et al., 2021; Kaggwa et al., 2022; Nyundo et al., 2020).

In Uganda, research shows that about 13% of older adults are affected by depression, with factors like inadequate social support, chronic illness, and functional disability playing a significant role (Kinyanda et al., 2017; Opio et al., 2022). However, fewer than 10% of these individuals seek treatment, primarily due to stigma, cultural beliefs, and limited mental health awareness (Akimana et al., 2019; Kaggwa et al., 2021; Ongeri et al., 2019).

Uganda's rich cultural diversity, encompassing over 50 ethnic groups, deeply influences perceptions of mental health. The Baganda, often referred to as the 'Ganda' people, predominantly based in the central region, holds a significant position as the largest ethnic group constituting approximately 34% of the total country's population (Ahebwa et al., 2016; UBOS, 2024). This demographic prominence plays a significant role in shaping perceptions, particularly regarding community attitudes toward mental health and treatment-seeking (Ahebwa et al., 2016). These cultural attitudes, embedded in established traditions, significantly impact both informal support networks and formal treatment approaches.

While Uganda's mental health infrastructure is evolving, it continues to face challenges in adequately supporting older adults (Mugisha et al., 2019). Butabika Hospital, the main mental health facility, struggles with resource constraints, a lack of geriatric-specific services, and a shortage of trained professionals (Kigozi et al., 2023; Mugisha et al., 2022; Ongeri et al., 2019). Although studies on aging and treatment-seeking for depression in Uganda are limited, research from other low-income countries sheds light on key issues such as stigma, inadequate social support, cultural misconceptions, and poor access to mental health services as significant barriers to care (Gureje et al., 2005; Lund et al., 2010; Patel, 2007). These studies emphasize the interaction of socio-cultural norms, institutional gaps, and aging-related vulnerabilities in shaping treatment-seeking behaviour. In Uganda, while existing studies have largely

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focused on depression prevalence among specific groups, such as women, HIV-positive individuals, and conflict-affected populations (Akimana et al., 2019; Opio et al., 2022), the barriers specific to older adults remain underexplored. This study aims to address this gap by investigating the socio-cultural and structural barriers influencing treatment-seeking for depression among the elderly, particularly the Baganda community. By doing so, it seeks to contribute to the development of culturally sensitive mental health interventions tailored to the unique needs of Uganda's aging population. The central research question guiding this study is: *What are the socio-cultural and institutional barriers that affect treatment-seeking for depression among elderly Baganda service users at Butabika National Referral and Teaching Hospital, Kampala?*

Methods

Study design

This qualitative study was conducted at Butabika National Referral and Teaching Hospital (https://www.butabikahospital.go.ug/) to explore treatment-seeking barriers for depression among Baganda elderly service users. An interpretive phenomenological research approach, as described by Hesse-Biber and Leavy (2006) and Merriam and Tisdell (2015), was employed to capture the lived experiences and perceptions of these individuals. Phenomenology, as explained by Leavy (2014), focuses on interpreting individuals' experiences within their world, which aligns with the study's aim to understand the subjective barriers to depression treatment.

Participants

A purposive sample of 08 service users, five males and three females, were recruited from Butabika National Referral and Teaching hospital. The Hospital is located in Nakawa Division, Kampala city. Participants were selected from several hospital wards (in-patient) based: elderly (aged 60 and above), diagnosed with depression, being of Ganda ethnicity, and receiving treatment at the hospital and in the recovery phase with the ability to express themselves as identified by psychiatric nurses to ensure they could provide in-depth insights. The selection criteria is in line with what Higginbottom (2004) and Staller (2021) propose with a focus on age, diagnosis and cultural background. The gender imbalance was due to the limited number of eligible female service users at the hospital during the study period. Initially, twelve service users were approached; four were excluded due to having active symptoms.

Data collection methods, ethics, and procedure

In-depth interviews were conducted with each participant to gather detailed narratives of their perceived barriers to accessing treatment. The interviews, lasted between 45–60 min, were conducted by the primary researcher, with support from a psychiatric nurse to ensure ethical and cultural considerations were met. This approach, based on Patton et al. (2015), enabled the researcher to remain responsive to participants' needs by allowing short breaks during the interviews and permitting a family member to be present if desired. The interview process was flexible, allowing for additional questions to be posed based on the conversation flow and the lived experiences of the service users.

Participants were informed of the study's purpose, and consent was obtained without incentives. The criteria for inclusion were strictly followed, with only individuals meeting psychiatric recommendations for age, ethnicity, and diagnosis included. Ethical considerations were maintained throughout, including anonymity, voluntary participation, and the right to withdraw at any point. This research was part of the Master's degree thesis. Permission was obtained from the hospital administration, and although ethical clearance was not mandated by Makerere University for student's research, the study followed rigorous ethical standards.

Analysis

Thematic analysis was guided by Hycner's (1999) Data Explication Process (Clarke & Braun, 2017), as detailed by Groenewald (2004). The analysis began with familiarization with the recordings, followed by transcription and translation from Luganda to English by the researcher who is familiar with both languages. Transcriptions were reviewed for accuracy and further familiarization, a process Groenewald (2004) describes as 'bracketing and phenomenological reduction.'

For coding and theme identification (Crowe et al., 2015), a consensus approach was followed. Codes and themes were refined iteratively, with similar excerpts extracted, labelled, and organized into sub-themes. Three broad themes were categorised: (i) individual barriers, (ii) family and social barriers, and (iii) health systems and institutional barriers. Each transcription was carefully analysed to ensure that sub-themes captured the lived experiences effectively. These themes were organized in a data analysis matrix, clustering similar statements to provide a comprehensive understanding of the participants' perspectives.

Study findings

The presentation of findings began with a description of the socio-demographic characteristics of the study participants. The study findings have been categorized into three overarching themes, namely: (i) The individual barriers, (ii) The family and socio barriers and (iii) The health systems and institutional barriers. The themes and sub-themes presented in this section have been identified and supported with direct quotations from the interviews.

Socio-demographic characteristics of the participants

The socio-demographic characteristics of the research participants are shown in the table below.

Characteristics	The proportion of elderly (f)
Sex	**No**
Females	03
Males	05
Age group	
60–64	04
65–69	03
70+	01
Marital Status	
Widowed	05
Separated/ divorced	02
Single	01

Characteristics	The proportion of elderly (f)
Educational Level	
No education	01
Primary	04
Secondary	03
Tertiary and above	01
Religious affiliation	
Catholic	02
Protestant	01
Born again	03
Moslem	01
Others	01
Duration on treatment	
0–4 year	03
5–9 years	04
10 years and above	01

Eight (08) participants took part in the study: five (05) were males, while only three (03) were females. Although depression prevalence is generally higher among females, the number of eligible female participants aged 60 and above from relevant tribal backgrounds admitted to the hospital during the study period was low. This demographic limitation contributed to the smaller representation of females in the study. Participants in the study were between 60 and 71 years old. In terms of marital status, five (5) were widowed, two (2) were separated or divorced, and one (1) was single.

Regarding educational background, one (1) participant had no formal education, four (4) had completed primary education, three (3) had attended secondary school, and one (1) had attained tertiary education.

Participants also represented a range of religious affiliations: two (2) were Catholic, one (1) was Protestant, three (3) identified with the Born Again faith, one (1) was Muslim, and one (1) reported no religious affiliation.

Regarding the time on treatment, three (03) service users had been receiving treatment for less than five years, four (04) had been on treatment for five to ten years and one (01) had lived on treatment for ten (10) years and above.

The individual barriers

At an individual level, the following barriers emerged.

Ageism and perception of aging

This study found that ageism significantly hinders elderly service-users from seeking treatment for depression. Symptoms of depression are often dismissed or overlooked, viewed as a normal part of aging rather than conditions warranting treatment. This perception appears to be shared by the service users, as shown below.

> […] it is (depression) always common for us (elderly) to suffer from such illness. I believe that once a person has aged like me, it is normal to feel the way I feel and much attention should be given to the young ones. […] at my age, I believe I have seen it all and little is left for me. I am here (hospital) because doctors forced me to stay. I want to go back to my home and even if I die now, I have nothing much to lose. (03, 63 female participant)

For such and several other participants, their age constituted a notable obstacle to accessing mental health services. Both her and other service users expressed the belief that they were too old to seek help, viewing mental health services as more suitable for younger individuals. They perceived aging as synonymous with experiencing various conditions and found solace in the notion that their needs required less attention compared to relatively younger people.

These sentiments are further echoed by other service users;

> The society has nothing much to do with an old person like me. I mean […] you haven't got much longer to live[…]the life experience of being old coupled with depression makes the whole issue complex. I also believe at this age you aren't going to be here that much longer… I wonder why they want to waste their time on older people when they could use it on young ones who still got more to offer. (01, 71male participant)

Based on the aforementioned findings, participants held the belief that depression is an expected aspect of aging, often perceived as a natural occurrence that does not necessitate formal treatment.

Limited knowledge and awareness of depression

The lack of knowledge and understanding of depression and mental health conditions emerged as another significant barrier. This lack of awareness is partly linked to the strong cultural beliefs on depression since some participants linked their depressive symptoms to supernatural powers. Participants revealed that them and several community members, especially older adults, may not recognize or acknowledge the symptoms of depression as a treatable medical condition as expressed below.

> I didn't even know there was treatment for depression, I knew my disease needed spiritual healing. I was never aware that one could get treated for my disease and we first went to several traditional healers but there was no difference. […] at some point, I thought if you had what I am suffering from, you just keep it to yourself […] I didn't know you could get formal help. (04, 60 male participant)

Other service users attest to this, expressing uncertainty regarding where to seek treatment and acknowledging the persistently low levels of mental health literacy within their communities, which subsequently delayed their access to care.

> Due to limited awareness, many elderly service users with depression end up dying at home due to their lack of access to information about hospitals for care. There is consistently a lack of sensitization and information sharing on mental health conditions, especially concerning depression and its management. (05, 62 female participant)

Owing to the limited understanding of depression, participants reported seeking alternative sources of assistance. They revealed that their initial recourse was traditional healing. Both service users and their family members held the belief that the condition stemmed from spiritual or supernatural origins, therefore necessitating spiritual healing for a successful recovery.

> When my condition got worse, we didn't know how to handle and what to do next. I was told that what I was suffering from was connected to super natural powers brought by evil spirits which should be taken to a traditional healer. We moved to several traditional healers unfortunately there was no significant improvements after spending a lot of money there. (01, 71 male participant)

As seen from the voices above, limited awareness about depression and mental health services among elderly individuals and the lack of information about the possible treatment centres contributes to a scenario where service users are unable to seek timely and appropriate treatment. Furthermore, the lack of sensitization and information sharing exacerbates the problem, as it prevents individuals and their families from recognizing the signs of depression and understanding how to manage the condition effectively.

Delayed recognition of depressive symptoms

Related to limited knowledge and awareness is the delay in recognizing depressive symptoms among elderly individuals. Given their age, participants in the study tended to perceive depressive symptoms as inherent to the natural aging process and, consequently, were unlikely to pursue medical care. Furthermore, it is plausible that some of these symptoms progress gradually in severity and are perceived as acceptable over time;

> You seem not to recognize that you are depressed…Some of us thought that it was a normal thing that comes with age and it's okay to live with thoughts because you have gone through a lot of good and bad experiences; a condition that may not necessarily require professional help. (04, 60 male participant)

Other participants underestimated their condition;

> It took me some time to recognize that this condition was big and that it required medical intervention…you know for us men, we are strong and when you get many issues around you, you take it to be a normal thing even with worrying symptoms […] I knew these are mere thoughts because I had lost my job but I never thought I needed help from anyone. (08, 65 male participant)

From such voices, the implication is that there is a lack of recognition and understanding of depression at the individual level, particularly among the elderly. This can lead to underestimating the severity of depressive symptoms and overlooking the need for proper treatment and support.

High cost of treatment and lack of financial support

The findings of the research revealed that the substantial expenses associated with mental health care services, combined with inadequate financial assistance, pose a significant barrier to accessing treatment for depression. The situation worsens for elderly individuals burdened by financial constraints, especially considering that most lack a stable source of income or familial support. Consequently, they struggle to navigate daily life and often struggle to fulfil their basic needs.

> It is difficult to access treatment if you do not have money or anyone to support you financially. It is very costly for me to always come here (butabika) for drugs since I spend a lot of money on transport, feeding and of course buying some drugs. It is so difficult for us who barely get income from any sources but only rely on hand-outs from either the family or well wishers, so occasionally I choose not to come. (05, 62 female participant)

Findings also revealed that many people grapple with poverty besides the daily demands and hence the choice for treatment is foregone in pursuance of other basic needs;

> Poverty is the root cause of everything […] one may desire treatment, but without money, accessing necessary help becomes impossible. You are forced to choose between meeting basic needs and seeking treatment. Even getting to a facility like Butabika requires money for transportation, and, of course, medications necessitate adequate nutrition. (01, 71male participant)

As seen above, the elderly age in the context of poverty and individual capacity to contribute to the cost of treatment is a significant barrier to effective mental health care utilisation. For those with limited income and reliance on sporadic financial assistance from family or others, attending treatment sessions regularly becomes unsustainable.

Family and social barriers to treatment seeking for depression

At the family level, the following barriers to treatment seeking among the elderly emerged;

Stigma and cultural perceptions

Studies on HIV/AIDS (Kakaire et al., 2016; Turan et al., 2017) have elaborated on the role of stigma in treatment seeking. In this study, experiences of social stigma were identified as a significant barrier to seeking mental health treatment among elderly patients.

> Here (Buganda), being depressed is associated with witchcraft or evil spirits. […] when dealing with any mental health condition, it's essential to carefully consider whether or not to disclose it. It's highly stigmatized in our society, and individuals are hesitant to be associated with it. (03, 67 male participant)

Another participant mentioned that the sociological association of mental disorders with evil spirits induces panic and fosters negative narratives about individuals with such illnesses;

> I could not look for help because I knew the society had a poor perception towards people like me. I was not ready to face discrimination due to my condition and I decided to keep it to myself. I thought that if the people around don't like me, even the doctors will not help because they are part of the society. (01, 71 male participant)

Participants reported that stigma stems from perceived causes and strong beliefs in supernatural explanations. This led them to feel ashamed, take it personally, and conceal their condition from others

> Being with depression makes me live a shameful life. I feel that I should be blamed of my condition because I never planned well for my life and sold everything I had […] an old man like me could have lived a better life but see how my life is a misery! Sometime I don't want to come out to the public and decide to hide myself and not coming for treatment but when I do this, the situation gets worse. (07, 69 male participant)

From such voices, the social stigma and discrimination surrounding mental health conditions deter individuals from seeking help. This fear extends to healthcare professionals, because they are believed to be influenced by the same societal attitudes (Magaard et al., 2017). As a result, individuals may choose to keep their mental health struggles hidden, sacrificing their well-being to avoid potential discrimination.

Patriarchal norms and masculinity in care seeking

The findings found patriarchy and masculinity to be another barrier to treatment seeking for depressed elderly patients. The societal construct of masculinity, which categorize men as the stronger gender and women as the weaker, was recognized as a significant barrier to seeking treatment. For men, seeking medical assistance challenges the social expectation of strength. Several participants noted that men adhere to this concept of masculinity when seeking healthcare and this is particularly evident among elderly individuals with depression. As presented below, male elderly participants are confronted by this notion.

> The primary obstacle to men's health-seeking behaviour is the mentality of **'I am strong'** because this aligns with societal expectations. Men often exhibit overconfidence compared to women.

> Our society views us (men) as stronger than women, expecting us to independently tackle and overcome challenges instead of showing vulnerability in public. […] when you attempt to open up about your struggles, you are often met with the dismissive phrase '**be a man**'. (04, 60 male participant)

Men often harbour resentment towards being perceived as sick by other family members due to patriarchal norms. This reluctance stems from the expectation that certain topics should not be discussed with women and children.

> The culture here (Buganda) puts us in a vulnerable position as heads of the family and any other institutions. There are certain things we believe people should not know us for […] most of the time if you are not feeling well, you pretend to be strong because your wife and children considers you to be the source of strength in the family. […] you may not want to present yourself as sick because the whole family would be agitated. It is not a thing of pride for the head of the family to be going to the hospital or complaining. It is a sign of weakness […] so we pretend as if nothing is happening. (06, 60 female participant)

From such voices, societal expectations of masculinity create significant barriers to men seeking healthcare. Men are socialized to believe that showing vulnerability is a sign of weakness and goes against the expectation of being strong and self-reliant. This societal pressure leads men to suppress their health concerns and avoid seeking medical help, even when needed.

Limited family and social support

While family and kinship networks are often expected to provide crucial support for ill family members, the study revealed a different reality for elderly individuals with mental health conditions. Over time, the once-strong bonds of family support appear to weaken, leaving elderly service users with little or no assistance. This erosion of support is exacerbated by both poverty and the stigma associated with mental health issues among the elderly, which further isolates them within their communities.

One participant shared,

> I don't have any of my family or even a friend who has ever come to see me. Those are some of the reasons why I wanted to kill myself. When you get a mental problem, you are no longer considered a person, you are like useless to people […] nobody, not even my own son. So am on my own…Other young people here are being visited and they are given things to eat, use and sometimes left with money but me am here alone. (010, 71-year-old male participant)

Participants observed that some relatives and friends are hesitant to provide support during the process of seeking help. For instance, another participant noted,

> I don't get much support from my family. When you get old and depressed, the family seem to care less because you are not taken to be much valuable to them. With friends, once people age, everyone takes their own path and there is nothing you can do about that. Friends and family shun you because of your condition […]I think so because am useless, no money and am like a burden and they don't really need me. (06, 60 female participant)

These experiences illustrate that society often places diminished value on the elderly, viewing them as less important compared to other age groups. The narratives reflect how both family and broader social structures may fail to provide adequate support to elderly individuals, especially those with stigmatized conditions like mental illness, further isolating them in times of need (Xu et al., 2018).

Health system and institutional barriers

The findings here were guided by an analytical framework focusing on health systems highlights key building blocks that impact healthcare delivery. These factors pertinent in examining the barriers elderly individuals face in seeking mental health care;

Distance and access barriers

Geographical accessibility to mental health treatment centres is a significant barrier for elderly patients seeking care for depression. Many elderly individuals face physical limitations that restrict their mobility, making travel to distant facilities challenging. Additionally, participants noted that the financial burden of regular transportation costs further impedes their ability to attend appointments and access care.

> It's challenging for me to adhere to the doctors' appointments due to the distance. There are times when I'm unable to come for two or three months, or even longer, especially when my family lacks the financial means to bring me here. As a result, my illness may worsen without access to medication, which I am determined to avoid. (05, 62 female participant)

Another participant further reveals;

> The long distance makes it challenging for some of us to receive regular treatment. I reside far from here, and attending treatment sessions is always difficult for me. There are times when I am physically weak and require assistance to move […] when I consider the distance to the hospital, I wait until I gather enough energy to make the journey. It is not just me alone, several others too lack access to the services provided here at Butabika, the only facility for mental illness treatment. (02, 63 female participant)

The study findings revealed that long travel distances significantly hinder access to mental health services, particularly for rural residents facing transportation challenges.

Drug stock outs

The availability of medication significantly impacts the facilitation of treatment, thereby making it easier for service users to access care. According to the findings, participants noted that public health facilities in Uganda frequently experience shortages of medications to effectively manage the conditions of the elderly and mental health issues overall. They specifically highlighted the absence of drugs tailored to the needs of elderly patients as a significant barrier in public health facilities.

> There are frequently no medications available in hospitals. Upon arrival, doctors often inform patients how the medications have run out and request them to purchase them elsewhere. […] remember, I am alone in this situation, yet I am required to seek out a private pharmacy to purchase medication at a higher cost. In my experience, I often require two or more types of medication. (03, 67 male participant)

Other participants add that the availability of mental health medications is unpredictable, creating unnecessary anxiety among service users;

> There is insufficient medication, and at times, patients become angry, resorting to using abusive language towards the health workers. In some instances, certain drugs may be available, but essential medicines can be out of stock for extended periods, sometimes lasting two or three months. (08, 65 male participant)

The shortage of sufficient depression medications in public health facilities in Uganda discourages elderly service users with depression from accessing appropriate treatment for their conditions.

Service fragmentation

Due to the lack of service integration, service users are required to seek services at multiple service centres. Participants revealed that as elderly individuals, they encounter difficulties accessing mental health treatment due to the fragmented services commonly practiced in public facilities. They highlighted that service segmentation and fragmentation in Uganda's healthcare systems create significant barriers for the aging population with depression to fully access care and treatment.

> The services provided here and in other public hospitals are scattered, requiring patients to spend a significant amount of time to see a doctor […] upon entering the hospital, patients are directed through a cumbersome system and procedure before receiving treatment. One must navigate from the reception to the registry, and often to a counsellor before finally seeing the doctor. Someone who came in the morning may end up spending the entire day in the hospital for a simple drug refill. (06, 60 female participant)

Similarly, another participant reported that;

> With this poor coordination, obtaining all necessary services from a single point becomes challenging. One might expect all services to be available at a centralized station, but unfortunately, this is not the case. Patients may be examined at one location and then instructed to travel long distances to access another service […] when you consider the hassle involved in navigating from the reception, you may feel discouraged. For those of us who arrive alone, moving from one service point to another presents a significant difficulty. (07, 69 male participant)

Based on the study findings outlined above, the bureaucratic nature of service delivery within the public health system presents an additional barrier for elderly service users already grappling with mobility challenges in accessing essential mental health treatment.

Understaffing and limited human resources

Study participants highlighted the shortage of mental health professionals in Uganda, noting that those available are often not well-trained specifically in elderly mental health care. Participants observed that even in facilities such as regional referral hospitals, there is a critical shortage of well-trained personnel capable of addressing the unique mental health needs of older adults.

One participant expressed this concern, stating,

> There are no specialized doctors who knows what to do when it comes to people with mental problems. You go to public hospitals; you will hardly get a specialized doctor who can handle mental health issues or even issues of the elderly. Even where there psychiatric nurses, health unit managers tend to allocate them to other duties, not just mental health (05, 62 female participant).

Another participant echoed this, emphasizing the disparity between the needs and available resources:

> Another challenge has to do with shortages in staffing that exist in health sector. There are few staff in public facilities, and it becomes even harder to find those specialized in mental health services. […] many young scientists choose to go abroad to do their specialty, thereby avoiding rural areas. As a result, populations in different parts of the country overwhelm the few existing psychiatrists (08, 65 male participant).

As these participants indicated, the shortage of specialized mental health staff creates a substantial gap in the provision of mental health services for the elderly, placing an immense burden on patients.

Discussions of findings

This study provide insights into the complex barriers elderly service users face when seeking treatment for depression at Butabika National Referral and Teaching Hospital in Uganda. Findings reveal obstacles across micro and macro levels, highlighting the need for comprehensive support systems and targeted interventions to improve mental health service accessibility for elderly individuals with depression as discussed below.

Individual barriers

Ageism and perception of aging

The study revealed that elderly service users perceive depression as an inevitable part of aging, shaped by societal expectations that prioritize the mental and physical health needs of younger populations. This view reflects deeply ingrained ageist attitudes, which lead older adults to undervalue their mental illness as a natural consequence of aging. Such perceptions are consistent with recent findings, which highlights the tendency among older adults to normalize depressive symptoms, reinforcing hesitance to seek treatment (Carpenter et al., 2022; Hossain et al., 2022). This societal devaluation of aging, particularly in Ganda culture, exacerbate these issues, as age-based stigma discourages older adults from accessing mental health support (Holt-Lunstad, 2020; Ramirez et al., 2022). Addressing this issue requires initiatives to combat ageism and promoting awareness that mental health care is essential across all life stages.

Limited knowledge and awareness

A key barrier to mental health care for older adults in this study was a lack of awareness about depression and its treatment options. Participants often attributed depressive symptoms such as sadness, fatigue, and social withdrawal to cultural or spiritual factors such as curses or punishment from ancestors, rather than recognizing them as mental health issues. Such cultural interpretations, while significant, delayed formal help-seeking and shaped their assumptions about depression and its treatment. This lack of awareness was not universal but varied depending on individual exposure to health education and cultural norms.

This reflects broader trends in international research, where older adults may fail to recognize depression as a mental health issue or doubt the efficacy of biomedical interventions (Patel et al., 2021; Skurla et al., 2022; Vahia et al., 2020). The variability in participants' mental health literacy highlights the importance of culturally sensitive health education initiatives to improve understanding, reduce stigma, and encourage timely treatment-seeking behaviour.

Cost of treatment and lack of financial support

The cost of treatment and limited financial support are significant barriers to mental health care for elderly service users with depression in Uganda. Many elderly individuals live below the poverty line, struggling to prioritize healthcare

expenses over basic needs such as food and shelter (Uganda Bureau of Statistics (UBOS), 2022; Wakida et al., 2019). This financial dependency on family members or community well-wishers often leaves the elderly vulnerable, with healthcare costs deprioritized in favour of immediate necessities. When faced with competing priorities, elderly patients typically prioritize essentials over healthcare expenses, which they may perceive as less urgent compared to food and housing. These challenges align with broader research emphasizing the economic constraints faced by elderly populations in low-resource settings, where poverty intersects with inadequate access to healthcare (Patel et al., 2024; Ssebunnya et al., 2024; von Gaudecker et al., 2022).

Furthermore, Uganda's lack of affordable mental health insurance exacerbates these barriers. The absence of formalized health coverage for mental healthcare including the costs of medication, consultations, and travel renders treatment inaccessible to many elderly individuals. Other studies similarly highlight the critical role of financial autonomy and insurance coverage in improving mental health outcomes among older populations (Wanjiku et al., 2024). These findings suggest the need for policy interventions that prioritize subsidized mental health services and expand insurance coverage for vulnerable groups.

Family and social barriers

Stigma and cultural perceptions

The stigma surrounding both mental illness and aging emerged as a pervasive barrier to care, deeply rooted in societal and cultural norms. Participants reported fears of shame and discrimination, consistent with studies that identify stigma as a primary obstacle to mental health access in low-resource settings (Rathod et al., 2023; Roberts et al., 2020). The intersectionality of mental illness and aging intensifies this stigma, with elderly individuals often excluded from mental health discourse and public health initiatives. Research from various African contexts corroborates with these findings, highlighting how cultural beliefs perpetuate stigma and hinder care for elderly populations with depression (Banerjee et al., 2022; Borelli et al., 2022; Zamorano et al., 2023).

Global mental health initiatives have aimed to address such stigma, yet awareness remains low, particularly among older adults in culturally conservative societies (Anyebe et al., 2021; Jana et al., 2023). For Uganda, these dynamics point to the urgent need for culturally sensitive public health campaigns that challenge stigma and promote inclusive mental health services. Addressing stigma at both individual and community levels can foster a more supportive environment for elderly individuals seeking mental health care.

Patriarchal norms and masculinity in care seeking

The study highlights how patriarchal norms hinder elderly individuals, particularly men, from seeking mental health care. In patriarchal societies, cultural expectations associate masculinity with resilience and strength, discouraging men from expressing vulnerability or seeking help. This aligns with findings by Chrisler et al. (2016) and Sharma (2021), who emphasize that rigid gender norms discourage men from admitting mental health struggles for fear of losing social status. Similarly, patriarchal structures restrict women's autonomy over healthcare decisions, often limiting their access to necessary resources (Heise et al., 2019; Shahvisi, 2019).

For men in Buganda, cultural expectations amplify this dynamic, as their roles as heads of families and institutions position them as symbols of strength. Admitting illness or seeking help is often perceived as a weakness, further complicating their willingness to engage with healthcare systems. Conversely, societal norms provide some degree of acceptance for women to express emotions and seek support, but women remain constrained by power dynamics that undermine their autonomy in accessing care. These findings resonate with global evidence that patriarchal norms and gender inequalities reduce healthcare access for both men and women, albeit through different mechanisms (Sharma, 2021).

Addressing these barriers requires gender-sensitive mental health interventions that challenge harmful stereotypes and promote equitable healthcare access. Programs should prioritize community engagement to shift attitudes, fostering an environment where seeking mental health care is normalized for all genders.

Limited family and social support

The study also reveals that limited family and social support significantly impedes treatment-seeking among elderly individuals with mental health conditions. While family networks traditionally play a vital role in providing care, these structures are increasingly strained due to economic hardship, shifting priorities, and the stigma surrounding mental illness. This mirrors findings from Katugume et al. (2024), Okello et al. (2020), and Wakida et al. (2019), who note that economic constraints exacerbate social isolation, making it harder for families to prioritize the mental health needs of elderly relatives. Research in low- and middle-income countries supports this trend. Studies indicate that financial strain and changing family dynamics reduce the capacity of families to support elderly members, leading to neglect of chronic conditions such as depression (GYASI, 2018; Lee et al., 2020; Sarker et al., 2023). Without robust family or community support, elderly individuals face increased barriers to accessing mental healthcare, further exacerbating their isolation. These findings underline the importance of strengthening social support systems to complement family care. Community-driven programs and policies aimed at addressing economic hardship and reducing stigma are critical to enhancing care-seeking behaviours among elderly populations.

Health systems and institutional barriers distance and access barriers

The study highlights that long distances to mental health facilities are significant barriers to treatment-seeking for elderly individuals in Uganda. Mental health services are disproportionately concentrated in urban centres, with rural areas often lacking specialized facilities for the elderly. This geographical imbalance reflects broader challenges in low-resource settings, where limited investment in rural healthcare infrastructure exacerbates inequities in access (Agyei et al., 2020; Shidhaye 2023). Elderly individuals, especially those with mobility challenges, face compounded difficulties due to unreliable transportation and financial constraints.

Studies indicate that, geographical proximity significantly influences healthcare utilization among vulnerable populations

(Kwiringira et al., 2021; Lin et al., 2024). However, as Bostock (2001) notes, distance alone is insufficient to explain barriers to access; it often intersects with socioeconomic and infrastructural challenges. Addressing these gaps requires targeted government investment in decentralized and community-based mental health services to ensure accessibility for rural elderly populations.

Drug shortage

Participants reported frequent shortages of essential medications for depression, a systemic issue reflecting Uganda's limited mental health funding. Such shortages are common across sub-Saharan Africa, where mental health services are often deprioritized in national budgets (Lugada et al., 2022; WHO, 2023). For elderly patients with comorbidities, these shortages result in delayed treatment and increased reliance on alternative remedies that may not meet clinical standards (Adjei-Banuah et al., 2024). Not only are patients unable to access critical medications for mental health, but they may also experience delays in receiving drugs for other conditions, as these shortages create bottlenecks in the supply chain.

Additionally, drug shortages can exacerbate the financial burden on elderly patients, as they may need to buy medications out-of-pocket from private pharmacies, where costs are higher. These challenges align with findings from Nigeria, Ethiopia, and South Africa, where drug shortages have been cited as major barriers to effective care (Iseselo et al., 2024; Abebe Moges et al., 2020). The financial burden of sourcing medications privately further marginalizes elderly service-users, highlighting the need for sustained investment in medication procurement and distribution systems to support comprehensive care for the elderly.

Service fragmentation

The study reveals that fragmented healthcare services discourage elderly patients from seeking on-going treatment. In Uganda, public health facilities often operate as separate service points for outpatient, mental health, and chronic care, requiring elderly patients to navigate complex systems. This fragmentation increases wait times, causes fatigue, and disproportionately affects elderly individuals with mobility limitations (Chen & Cheng, 2023; Makhubele et al., 2024).

Consistent with other findings, fragmented service delivery has been linked to reduced healthcare utilization among elderly populations (Kokorelias et al., 2021; Wiktorowicz et al., 2020; Yang et al., 2023). Improved intra-facility communication and holistic care approaches would mitigate the physical and emotional toll on elderly patients and promote retention in care.

Understaffing and limited Human resources

A critical shortage of trained mental health professionals in Uganda further restricts access to care for the elderly. Even in regional hospitals, the lack of specialized personnel limits the availability of tailored services, exacerbating treatment delays. This reflects a global trend in low- and middle-income countries, where mental health systems face workforce deficits and high workloads (Chowdhury et al., 2022; Makhubele et al., 2024).

Efforts to address understaffing should prioritize training programs focused on geriatric mental health, alongside strategies to retain healthcare workers in underserved areas. Increased workforce capacity is essential to meet the growing demand for mental health services among elderly populations.

Clinical implications for elderly care in Uganda

This study has several clinical implications for improving mental health services for elderly populations in Uganda. Clinicians should prioritize culturally sensitive interventions that respect traditional beliefs surrounding mental health. Training healthcare providers on the specific mental health needs of the elderly, along with enhanced patient education, can improve communication and reduce stigma. A family-cantered approach could also address family-level stigma and increase social support. To tackle financial and geographic barriers, policies to subsidize mental health costs for the elderly are crucial. Finally, public health campaigns focused on mental health literacy and combating ageism could help shift societal attitudes, promoting the understanding that depression is treatable, not a natural part of aging.

In conclusion, the findings emphasize the urgent need for an integrated approach to mental health care for the elderly in Uganda. Elderly individuals face a double burden in seeking mental health care, as they experience the intersectionality of aging and mental health issues, yet resources to address their increasing needs are limited. As highlighted by the different levels of social reality, the barriers to mental health care becomes more complex and entrenched as we move from individual to macro-level factors, involving multisectoral issues. Through addressing the individual, social, and systemic barriers at various levels, health practitioners and policymakers can create a more supportive environment for elderly individuals seeking mental health services in Uganda.

Strengths and limitations of the study

A key strength of this study lies in its focus on a neglected population of elderly Ugandans with depression whose unique barriers to mental healthcare are rarely addressed in the literature. The inclusion of various perspectives, gender considerations, and patient-centric factors add to the robustness of the findings. Additionally, conducting the study within a national referral hospital enabled direct engagement with individuals actively seeking mental health care, which strengthened the validity of the findings.

However, limitations include the omission of key informants, factors such as age, tribe, and location acted as inherent filters, which may not fully represent the experiences of elderly individuals across other regions and other cultural groups in Uganda. Future research could expand to include key informants, larger and more culturally diverse samples across rural and urban regions. This expansion would provide a more comprehensive understanding of elderly individuals' mental health needs in Uganda, enabling policymakers to design more inclusive mental health programs.

Authors' reflexivity

The authors were motivated to undertake this research to address the critical knowledge gap surrounding the barriers elderly individuals face when seeking treatment for depression, particularly in low-resource settings like Uganda. As researchers,

our positionality as empathetic to mental health challenges and committed to social justice influenced the way we engaged with participants, approached data collection, and interpreted findings. Our awareness of power dynamics and cultural sensitivities shaped an ethical and participatory research process, ensuring the voices of the elderly were authentically represented. This perspective also informed our interpretation of the data, emphasizing the systemic and personal challenges these individuals navigate in care seeking.

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Data availability statement

All relevant data used are within the paper.

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