Clinical Review

Clinical Review identifies issues in the medical literature of interest to clinicians in Africa. Essential references are given at the end of each section

Mental Health Review

Mental health and human rights in Africa

'An emphasis should be placed on empowerment of people with mental health disorders so that they can be advocates for themselves and provide a voice to the voiceless.' From the front cover of the second *Lancet* Series on Global Mental Health October 2011.

Two events took place in Cape Town, South Africa in October 2011 that will have a long-lasting impact on the development of mental healthcare in Africa. The first of these was the Global Mental Health Summit and launching of the second *Lancet* Series on Global Mental Health (www.thelancet.com/series/global-mental-health-2011).

The second event was the formation of the Pan-African Network of People with Psychosocial Disability (PANPEP). 'Psychosocial disability' is a term preferred by people living with mental health problems as it emphasises that the distress and functional impairment of mental illness comes not only from the condition itself but also from the associated discrimination and stigmatisation by society.

The Global Mental Health Summit was organised by the Movement for Global Mental Health (www.globalmentalhealth.org). MGMH is a virtual network of academics, service providers, and user organisations from across the world, all of whom support the call to improve the care and rights of people with mental and neurological conditions particularly in low- and middle-income countries. The second *Lancet* Series is a collection of papers that review critical issues in global mental health including: the link between poverty and mental health, the scaling-up of mental health interventions, and the state of human resources in mental health.

Human rights violations and restrictions

In the final paper in the collection 'Human Rights violations of people with mental and psychosocial disabilities,' Drew and colleagues systematically describe the views and experiences of users of mental health services.[1] Contributors from Africa were from Ghana, Kenya, South Africa, and Zambia. The paper describes the key factors that restrict or violate the human rights of people with psychosocial disability, and identifies evidence-based strategies for countering these. There are four key areas of concern:

1. **Restriction of civil, cultural, economic, political and social rights.**
   People living with mental health problems are excluded from work and education opportunities thus exacerbating poverty. This in turn acts as a stressor for mental disorder. They may also be legally prevented from important personal and civil activities such as marrying and voting.
2. **Lack of access to metal health services**
   In many African countries, mental health services are absent, inaccessible due to distance or lack of affordability, or based only in large institutions where human rights abuses often occur.
3. **Abuses in residential facilities and places of detention**
   These abuses can take place not only in psychiatric hospitals, but in general hospitals, prisons, and in traditional or spiritual healing facilities. There may be direct ill-treatment but also problems of neglect including substandard accommodation and insufficient food.
4. **Lack of legal safeguards to protect rights**
   Many countries lack mental health legislation that aims to ensure that people who are detained in hospital have access to review and protection of their rights. Other laws and traditions can also restrict the rights of people with psychosocial disability to make their own decisions about their health and day-to-day life.

Strategies to tackle these concerns

After setting out these concerns, the paper then describes evidence-based strategies to improve human rights of people with psychosocial disability:

a. **Information, training and education campaigns**
   Anti-stigma campaigns have been shown to be effective at overcoming ignorance and false beliefs about mental health problems. Their effectiveness is improved by involving people with psychosocial disability in their design and execution. Specific targeting of education toward leaders at community and government level can be particularly effective.

b. **Provision of services in the community**
   Improving access to mental health services can be achieved through integrating mental health into primary healthcare, and through improving training of all cadres of health care workers. Provision of supported education and employment schemes can help people regain their dignity and place in society.

c. **Empowerment of people with mental and psychosocial disabilities.**
   Strategies to empower people with psychosocial disability include formation of independent advocacy groups and involving people with psychosocial disability in designing and delivering training of health workers.

d. **Legal and policy reforms**
   Countries should introduce or update mental health legislation to include key principles such as the right to independent review of detention and monitoring of conditions in psychiatric hospitals and other facilities. Other discriminatory laws should be abolished.

Launch of the Pan African Network of People with Psychosocial Disabilities

Mr Action Amos from the Federation of Disability Organisations of Malawi (FEDOMA) represented Malawi at a high-level meeting of mental health service users and carers groups from across Africa. He reported the event as follows: 'We had a successful Training seminar and General Assembly in Cape Town, South Africa, during which we adopted a name that clearly defines us. We are The Pan African Network of People with Psychosocial Disabilities.'

The following countries were present: South Africa, Uganda, Malawi, Kenya, Zambia, Nigeria, Rwanda, Ghana, and Cameroon. Representatives were also present from Open Society International (OSI), UN Special Rapporteur on Disability, and the Committee member on the UN Committee on Disability. The UN has a particular focus on this issue at present since the ratification of the UN Convention on the Rights of Persons with Disabilities the aim of which is: *'To promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'* (http://www.un.org/disabilities/).

A new approach was adopted by all members to refocus on the human rights of those affected by psychosocial disabilities. Equally important was the issue of balancing the power relationship on mental health sectors with the intent of involving people with psychosocial disabilities as key stakeholders. Though there is uniformity of problems affecting all people with psychosocial disabilities globally, there is need to focus on the African continent as our needs are unique i.e.

a) Need to have law reform;
b) Ignorance of stakeholders on international human rights instruments;
c) A tendency to regard people with psychosocial disabilities as objects of mental healthcare (rather than active participants).

A strategy for the next 2 years was put in place with the major highlight being training, advocacy, and fundraising for member organisations.

The new Board of Directors was elected and, as its first resolution, came up with The Cape Town Declaration of 16th Oct 2011. We got a golden opportunity to participate in the Second Summit of the Movement for Global Mental Health on the 17th October 2011 and the new Chairperson, Robinah Nakanwagi Alambuya from Uganda, read the Declaration with dignity. It was such a moving moment.

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Reference

1. Drew N, Funk M, Tang S, et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis, *Lancet* 2011, Oct 14. [Epub ahead of print].

The Cape Town Declaration of 16 October 2011

'We recognise that people with psychosocial disabilities have been viewed in bad ways, with derogatory words being used to describe us such as mentally disturbed, having unsound minds, idiots, lunatics, imbeciles and many other hurtful labels.

We are people first! We have potentials, abilities, talents and each of us can make a great contribution to the world. We in the past, presently, and in the future, have, do and will continue to make great contributions if barriers are removed.

We believe in an Africa in which all people are free to be themselves and to be treated with dignity. We are all different, unique, and our differences should be appreciated as an issue of diversity. We need all people to embrace this diversity. Diversity is beautiful.

There can be no mental health without our expertise. We are the knowers and yet we remain the untapped resource in mental healthcare. We are the experts. We want to be listened to and to fully participate in our life decisions. We must be the masters of our life journeys.

We want, like everyone else, to vote. We want to marry, form relationships, have fulfilled family lives, raise children, and be treated as others in the workplace with equal remuneration for equal work.

For as long as others decide for us, we do not have rights. No one can speak for us. We want to speak for ourselves.

We want to be embraced with respect and love.

We are deeply concerned about the extent of suffering experienced by our brothers and sisters on our vast continent. Poverty, human rights violations, and psychosocial disability go hand in hand. We know that there can be no dignity where poverty exists. No medicines or sophisticated western technology can eradicate poverty and restore dignity.

The history of psychiatry haunts our present. Our people remain chained and shackled in institutions and by ideas which our colonisers brought to our continent.

We want everyone to acknowledge their participation in calling us names and treating us as lesser beings. These are the barriers to our full enjoyment of life. These barriers are disabling us and these prevent us from fully participating in society.

We wish for a better world in which all people are treated equally, a world where human rights belong to everyone. We invite you to walk beside us. We know where we want to go.'

Public Health Review

The United Nations' major focus this year on non-communicable diseases (NCDs) has dovetailed appropriately into consideration of the social determinants of health. Of course communicable and infectious diseases are not immune to social influences. Rasanathana and Krech point out that, '80% of non-communicable diseases could be prevented through primary prevention – through modifying behaviours such as reducing tobacco consumption and fat, alcohol and salt intake, preventing obesity, and promoting physical activity.[1] But as they also note, it is not just a matter of individual behaviour, but the social and planned environments that enable or discourage such behaviours.

Social determinants embrace a wide range of factors related to human interactions and institutions. In its 2008 report, 'Closing the gap in a generation: health equity through action on the social determinants of health,' the World Health Organization (WHO) identified such factors as employment, housing, neighbourhoods, access to social and health services, social networks and group membership, access to social protection mechanisms, gender, markets and economic opportunity, and finally governance and political participation.[2] The WHO report not only distinguishes differences among countries where social circumstances may dictate lifespans up to 75 or as low as 48, but also makes distinctions within countries. The report aims at optimism – indicating that circumstances that result in excess morbidity and early mortality are amenable to change.

Clearly, the health system cannot work alone to redress the imbalances, though it can do its fair share in ensuring equitable access to services. Simply put, social determinants result in 'substantial health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally,' according to Marmot and colleagues.[3] They also stress that it is not only equal access to services like education regardless of social class or gender, but trace the ability to benefit from education back further to equity issues involving nutrition and maternal health as seen below.

'Brain development is highly sensitive to external influences in early childhood that can have lifelong effects. Good nutrition is crucial and begins before birth with adequate nourishment of mothers. Mothers and children need a continuum of care from before pregnancy, through pregnancy and childbirth, to the early days and years of life.'

Marmot provides examples of the cross- or inter-sectoral interventions that are needed to address the social determinants of health including, 'rural employment guarantees, food security, universal healthcare, social security for informal workers, education, housing, and rights of tribal and forest dwellers.'[4] Specific country examples follow.

Brazil, which hosted the World Conference on Social Determinants of Health in October 2011 provides several examples of specific policies and programmes aimed at social determinants and improving equity.[5] These include:

- decentralisation of health systems and the creation of the Sistema Único de Saúde (Unified Health System);
- cash transfer policies, such as the Programa Bolsa Família (Family Stipend Programme;)
- increase in the national minimum wage;
- creation of the Special Secretariat on Human Rights Initiatives that recognise regional culture, with the creation of the so-called Pontos de Cultura (Culture Spots) that aim to bridge historical discrepancies by linking social development with education, culture and healthy lifestyles;
- antidiscrimination policies related to gender, race, sexual orientation, and ethnicity have been expanded.

These efforts again stress the multi-sectoral approaches needed to improve health by addressing economic, political, social and cultural inequities. No one agency, institution or policy framework can address the challenge.

The example of cholera outbreaks in Zimbabwe demonstrates the need for multi-sector collaboration in solving a problem that disproportionately attacks the poor.[6] While the health sector took the lead, there was need to involve professionals from the water, sanitation, communications, and education sectors as well as social networks and organisations within affected communities. Enhanced surveillance and readiness have been an immediate outcome, while longer-term improvements in access to water and sanitation are planned.

Children who suffer from intestinal worm infections live in poor communities with inadequate access to basic services. Not only do these poor and unsanitary conditions lead to infection but worm infection in turn is associated with increased school absenteeism, lower literacy levels, and lower future earnings. In Kenya an integrated school health programme addressed water, sanitation and hygiene, health education, and school meals with intersectoral collaboration from international donors, local NGOs, and government agencies as well as involvement of community organisations like the Parent Teacher Association. The programme covered 45 districts and 3.5 million children were dewormed.[7]

Tanzania's national malaria programme achieved a steady growth in net ownership from 1995–2008 and covered 65% of households with at least one insecti-

The poor often lack access to safe water supplies

Congested urban neighbourhoods hold health risks

cide-treated net (ITN). 'However, the lowest socioeconomic groups and the rural population lagged behind in uptake and utilisation of ITNs. Furthermore, the gap between net ownership and sleeping under the nets remained high,' according to Koot and co-workers.[8]

The forgoing examples provide a focus on national policy making and large scale programmes. We also need to ensure that at the district and local levels intersectoral planning, coordination, and implementation actually occurs. Local level intersectoral development committees are needed and involvement of community organisations is essential if we are to overcome the social determinants of both communicable and non-communicable diseases and achieve our Millennium Development Goals.

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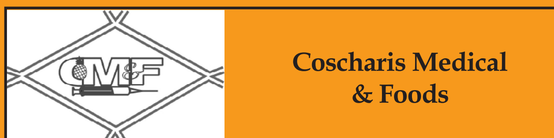

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