

Viewing Uganda's mental health system through a human rights lens

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Abstract

There has been increased global concern about the human rights violations experienced by people with mental disorders. The aim of this study was to analyse Uganda's mental health care system through a human rights lens. A survey of the existing mental health system in Uganda was conducted using the WHO Assessment Instrument for Mental Health Systems. In addition, 62 interviews and six focus groups were conducted with a broad range of mental health stakeholders at the national and district levels. Despite possessing a draft mental health policy that is in line with many international human rights standards, Uganda's mental health system inadequately promotes and protects, and frequently violates the human rights of people with mental disorders. The mental health legislation is offensive and stigmatizing. It is common for people accessing mental health services to encounter physical and emotional abuse and an inadequate quality of care. Mental health services are inequitably distributed. Within Ugandan society, people with mental disorders also frequently experience widespread stigma and discrimination, and limited support. Promoting and protecting the rights of people with mental disorders has ethical and public health imperatives. A number of policy, legislative and service development initiatives are required.

Introduction

Over the last two decades, there has been a growing international concern about the risk of human rights abuses against people with mental disorders, as observed by international agencies and legislative decisions (Arboleda-Flórez, 2003; Maingay, Thornicroft, Huxley, Jenkins, & Szukler, 2002). Recent research has revealed that people with mental disorders are commonly exposed to some of the most harrowing forms of human rights violations, both within and outside the health care context (Dhanda & Narayan, 2007; Gostin, 2004). The lack of autonomy afforded to mental patients, and the restrictions placed on their freedom of movement have been well documented in the literature (WHO, 2001). Similarly, abuses in psychiatric institutions, through insufficient and harmful care and treatment as well as deplorable living conditions appear to be widespread in developing and developed countries (Kelly, 2006; WHO, 2005a). Studies in Europe, America and Africa have shown that psychiatric patients are frequently kept for long periods of isolation in filthy and unventilated spaces, and experience severe maltreatment such as being beaten, tied up and denied basic nutrition and

clothing (Gostin, 2004). Furthermore, consent for admission, detention and treatment are frequently neglected, and adequate assessments of capacity are not routinely undertaken (WHO, 2001).

Although there is a scarcity of research in Uganda, preliminary findings suggest that the mental health care system inadequately incorporates human rights concerns. It has been shown that people with mental disorders in Uganda frequently experience violations of their human rights in the community, such as physical abuse and violence, stigma, and labour exploitation (BasicNeeds, 2005). Furthermore, it has been revealed that people with mental illness are commonly not considered for employment and have no voting rights (Ssanyu, 2007).

Growing concern around the human rights of people with mental disorders globally is part of a more general trend that has developed over the last decade which has increasingly situated health concerns within human rights rhetoric. Indeed, human rights has emerged as a powerful discourse in many parts of the world for achieving conditions necessary for the attainment of improved health (Gruskin & Tarantola, 2002; London, Orner, & Myer, 2008).

With the increased attention being placed on human rights and health, various scholars have argued that there is a need to start focusing on positive rights, and not solely on 'negative' ones (Arboleda-Flórez, 2008; Kelly, 2006; Maingay *et al.*, 2002). 'Negative' rights are concerned primarily with the protection of classic individual freedoms and liberties, such as involuntary detention and improper or abusive treatment at psychiatric institutions (Kelly, 2006). 'Positive' rights are concerned with economic, social and cultural rights, with the broader, albeit more subtle ways in which the freedom and power of the mentally ill are defined and undermined by a range of social, structural and systemic societal issues (Kelly, 2006). There have thus been calls to consider mentally disabled people's rights to mental health services that are accessible and of adequate quality (Hunt, 2006); their rights to genuine rehabilitation and recovery-based support services (Dhanda & Narayan, 2007); their rights to live fulfilling lives in their community free from stigma, and social and economic discrimination (Corrigan & Watson, 2002); and their rights to increased opportunities to integrate and fully participate in society (WHO, 2001).

Taking heed of this call, this study used data from a situational analysis of current mental health policy, legislation and services in Uganda to analyse the mental health system in the country through a human rights lens. A human rights framework uses international human rights norms and standards to assess and address the direct and indirect human rights implications of any health care policy, programme or legislation (Braveman & Gostin, 2003; De Cock, Mbori-Ngacha, & Marum, 2002). This study thus sought to shed light on how the human rights, both civil and political freedoms, as well as the more social and economic rights subsumed within the scope of positive rights, of people with mental disorders in Uganda are being violated. While past studies have reported human rights violations against the mentally ill in Uganda (BasicNeeds, 2005; Ssanyu, 2007), no study has yet been conducted that examines human rights and the Ugandan mental health system within this broader framework. The findings from this study will offer opportunities to identify ways in which policy, legislative and programme developments can better protect, respect and promote the rights of the mentally ill in Uganda and other low-income African countries.

It is important to mention at the outset of this paper that various assertions have been made that human rights is a western construct, and is thus inappropriate and has limited applicability to non-western countries (Nyazema, 2000). For example, it is argued that rights talks 'legitimize pressures on indigenous communities to adopt ways more

consonant with the sensibilities of elites, pressures which would have been dismissed as Eurocentric only a few decades ago' (Nhlapo, 2000 as cited in London, 2002, p. 679). Furthermore, it is postulated that the notion of human rights as propounded within international organizations is largely founded on European concepts of individualism and individual entitlements. It is asserted that this is incompatible in many African societies where the emphasis is on the collective, relationships of reciprocity and responsibility and the sociality of human beings (Holdstock, 2000; Mkhize, 2004). These are important assertions that need to be engaged with in any human rights analysis within an African context. The discussion section will thus return to this issue, indicating how the results from this study may be illuminating for these debates.

Methods

This paper used both qualitative and quantitative data from a situation analysis of the status of Uganda's mental health system which was conducted as part of the first phase of the Mental Health and Poverty Project (MHaPP). The MHaPP, which is being conducted in four African countries: Ghana, South Africa, Uganda and Zambia, aims to investigate the interventions required to break the vicious cycle of human poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries (Flisher *et al.*, 2007).

Quantitative data were collected using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 (WHO, 2005b). The WHO-AIMS tool has been developed to assess key components of a mental health system and thereby provide essential information to strengthen mental health systems. The instrument consists of six domains, 28 facets and 156 items (covering the ten World Health Report 2001 recommendations). The six domains are interdependent, conceptually interlinked, and somewhat overlapping. Shorter questionnaires seeking specific information were generated from the 156 items in the WHO-AIMS document. These questionnaires were developed and distributed to respondents from the following settings:

- Department of Psychiatry, Makerere University Medical School
- Makerere University Institute of Psychology
- Mental health professionals and the records office at the National Mental Hospital
- Uganda Nurses and Midwives Council

- Mental health non-governmental organisations (NGOs) and user associations
- Mental Health Division, Ministry of Health headquarters

The data were collected in 2006, based on the calendar year 2005. The data were entered into the excel data entry programme where numeric data were aggregated. Descriptive statistical analyses of relevant items were conducted.

The qualitative data for this study were obtained through semi-structured interviews (SSIs) and focus group discussions (FGDs) at both national and district levels. At the national level, a total of 42 stakeholders were interviewed, and eight others took part in a focus group discussion. At the district level a total of 20 semi-structured interviews and five focus group discussions were held with various stakeholders. Two districts were chosen as representative samples for the study, one being an urban district in the central region and neighbouring the capital city, and the other a rural district in the eastern part of Uganda.

The sampling of respondents for the SSIs and FGDs was purposive. The participants were selected based on the principle of maximum variation, in order to provide as wide a range of perspectives as possible on mental health policy development and implementation in Uganda. The participants who were interviewed included stakeholders from various sectors including health, education, law and justice, housing, gender and social welfare, legislators/politicians, media, NGOs in mental health, user support organizations, research institutions, private sector, religious and traditional healers and mental health service users. Respondents were also selected because they were resourceful people who had experience that was particularly relevant to the study.

The six FGDs were conducted with homogenous groups, consisting of people of the same background including mental health nurses, general health nurses, a mix of general nurses and mental health nurses at the National Mental Hospital, as well as secondary and primary school teachers.

Interviews were recorded with the permission of respondents and transcribed verbatim. The analysis was undertaken using a grounded theory approach. As the name implies, grounded theory refers to generating theory and understandings which are 'grounded' or which emerge from the data that is systematically gathered and analysed (Strauss & Corbin, 1998). The objective is to build and expand, rather than test theory, allowing for the discovery of new insights and enhanced understandings that are derived from the coded categories, themes and patterns. Grounded theory is useful in undertaking local research where it may not be wise

to transfer theory generated in more western settings into an African context (Pidgeon & Henwood, 1997).

The fieldwork for the qualitative component was conducted between August 2006 and March 2007. Ethical approval for the study was obtained from the National Council for Research, and the Director General of Health Services in Uganda. Respondents in the SSIs and FGDs gave informed consent to participate in the study. The identities of interviewees have been kept confidential.

Results

Mental health legislation

The WHO-AIMS data revealed that the Mental Health Act, passed in 1964, is outdated and inadequately promotes and protects the human rights of those with mental disorders. This legislation was found to have a number of shortcomings. These include:

- Failure to distinguish between voluntary and involuntary admission and treatment
- A strong focus on detention of the mentally ill
- The use of derogatory and stigmatizing language to refer to the mentally ill. For example it refers to people with mental disorders as 'lunatics' and possessing 'unsound minds'
- Immense power given to magistrates and police officers for the handling of people with mental disorders
- No provision for equitable mental health care
- No special protection of vulnerable groups such as minors, women and the mentally retarded
- No provision for promoting and protecting the rights of people with mental disorders, including:
 - The right to humane treatment
 - The right to privacy, autonomy and confidentiality
 - The right to non-discrimination in areas such as employment, housing, financial assistance
 - The right to psychotropic medications
 - The right to informed consent on admission
 - The right to protection outside of the hospital

Ultimately, the results revealed that the main focus of the Act is to remove persons with mental disorders from the community and to keep them in confinement without serious consideration for clinical care.

Many stakeholders were unaware of mental health law. Those that were aware of its existence and content were particularly vocal about its incompatibility with contemporary international human rights standards. There were ubiquitous comments that the

current law is 'obsolete', 'offensive' and 'prejudiced', 'criminalizing' people with mental problems, and referring to them as 'dangerous' and 'mad'. Many stakeholders emphasized that the frequent human rights abuses and violations that people with mental health disorders experience is attributable to the problematic nature of the current mental health legislation. This was clearly articulated by one mental health service user:

When you read the Act of 1964 and analyse it critically, you will see that it is safeguarding the public from mental health patients and not safeguarding the patient himself. That is why they [people with mental disorders] are beaten to death, that is why they are looked at as a danger, that is why they are mistreated; because that Act is very wrong.

Many respondents shared this view that the current legislation 'is mainly trying to protect and help the community get rid of those with mental illness' rather than 'safeguarding the rights of those who actually suffer from mental problems'.

Mental health care services

Physical and emotional abuse. Qualitative interviews with a range of stakeholders revealed that patients had experienced various forms of direct human rights abuses within the mental health facilities and units in the country, particularly in psychiatric units in general hospitals. In discussions of the mental health service facilities, many stakeholders from different groups spoke about how it is fairly common for mental health professionals to infringe on the rights of patients. Numerous respondents, particularly mental health care service users themselves, spoke about the stigma and verbal abuse patients experience from mental health professionals. As one service user lamented:

Sorry to comment on psychiatrists but when you are in hospital, instead of calling you by name, they call you 'case', 'this case here', 'this mental case'... That is not a proper way to address people. Why do you call me case? I have a name. I am not a case and I have a right to be called my name. But because they have an attitude of labeling... you are being turned into an object by them.

Other users spoke about the physical abuse professionals sometimes inflict upon patients with remarks that 'patients are not treated well', they are sometimes 'admitted in inhumane ways', 'tied-up and all kinds of things like that' or 'locked away for no reason at all'. A mental health nurse commented

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when talking about a mental health unit in a general hospital in the country:

The patients are still secluded, sometimes they are beaten up, they are starved as punishment, sometimes they are left in the room for hours with no-one attending to them, and things like that.

Other users spoke about the deplorable living conditions of the mental health facilities, which have poor air ventilation, inadequate mosquito nets and insufficient food supplies. For example, when talking about a mental health unit within a general clinic, a member of a mental health NGO explained:

The thing has only ventilators. Don't these people need fresh air? They can even contract communicable diseases because of that. They should build them well like other wards for other patients. So, they should change their units, with proper aeration and whatever needs to be done so that the patients can live like normal human beings.

Another respondent, a mental health service user, spoke about the lack of mosquito nets available in mental health units, and the dire consequences this has for patients:

We know it is difficult for government to give nets, but having no nets in the wards is terrible. It is not right. I think the psychiatrists think patients can't get malaria. So, when a patient cries 'I am having malaria', the psychiatrist thinks that is a delusion; neglecting something important. By the time they discover, they have either lost the patient or it is very severe.

Many respondents also spoke about the 'poor food supply in the mental health units', which is 'never enough for everyone', and is often 'old' or 'so bad you wouldn't wish it upon anyone'. Poor dietary supplies were seen to impact especially badly on those patients who are also physically ill, such as HIV-positive patients:

Those patients with HIV, we are feeding them on posho [cornmeal or cassava porridge] and beans and they are taking ARVs. It is actually not healthy. We need to get a fund to cater for those physically sick patients. Else they won't get better... So the service is still not up to standard.

Such comments were made about all other mental health facilities besides Butabika, the main mental hospital. No respondents spoke about the possible human rights abuses at Butabika, with many stakeholders talking about the fairly good conditions that exist within this facility.

WHO-AIMS data revealed that these human rights abuses remain largely unchecked, as there is no national or regional human rights review body for assessing the human rights protection of users in mental health services. Neither the national mental hospital nor the psychiatric units in general hospitals receive any review/inspection of human rights protection of patients. Similarly, the mental hospital and psychiatric units do not have specific staff training on human rights protection of patients. Some of the health workers, however, have had some general training on human rights issues among the mentally ill as part of their overall training.

Inadequate quality of care. There was unanimous agreement amongst all stakeholders that there are insufficient mental health care personnel in Uganda, including those in the professions of psychology, social work and occupational therapy. There were phrases scattered throughout the interviews that 'there are not enough workers' the 'workforce is insufficient', and that there are 'major human resource problems'. This medical doctor summed up the situation when talking about mental health:

The major challenge is inadequate human resources. You find that most of the health facilities don't have adequate staff. That is a big problem. You find...like Butabika...how many doctors are there to attend to the patients? And it is even worse at other health facilities.

Similarly, a mental health nurse explained:

The moment you enter a clinical room, you look at the patients waiting and you are already worried of 'when will I finish?'...you have 200 patients waiting, whom you are supposed to attend to...and there might be three practitioners around. So, you are already stressed even before starting the work.

The low numbers of mental health professionals was seen to compromise the quality of care afforded to patients. It was emphasized that the professionals that are available 'cannot spend much time with each patient', and are thus frequently forced to make diagnoses and prescribe treatment without having time to do a full assessment. Many mental health care providers, such as this mental health nurse, spoke about the dire consequences of such rushed consultation:

Often we don't have time to fully assess the patient, and also often the doctors just aren't there. So you find that for us, we just rush with our treatment without a thorough investigation. That is why you find that we get patients collapsing, or you give a patient medication

and then the next day you find the patient in a coma. You don't know why. It is because of rushing with these drugs.

It was emphasized further that the inadequate numbers of mental health care professionals means that mental health care remains purely curative and biomedical. Many respondents mentioned that understaffing means that providers do not have time to 'tell them [patients] about their condition', 'give them education and information' or look into the 'psychosocial problems that might be affecting their well-being'. Indeed, WHO-AIMS data revealed that only a few mental health service users (1–20%) had received one or more psychosocial interventions in the previous year. The biomedical and curative focus of mental health care was most aptly revealed by this mental health nurse:

We are providing treatment...after diagnosis, we are giving the treatment, but in most cases we are not handling the aetiological part of it. We don't have time. You are giving the drugs to treat...you are removing the symptomatology, but what brought the symptomatology you are not removing.

Inequitable distribution

WHO-AIMS data indicated that there is inequitable distribution of mental health care services, personnel and supplies across the country. Most of the psychiatric beds in the country (62%) were located in or near the largest city. The distribution of human resources between the urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city was 11 times greater than the density of psychiatrists in the entire country. The density of nurses was 13.4 times greater in the largest city than the entire country. Furthermore, of all the expenditures spent on mental health, 55% is directed towards the National Mental Hospital in Kampala, the country's capital city. Approximately 88% of the Ugandan population is based in rural areas.

Many respondents spoke about how this inequitable distribution, with most resources being skewed to the urban city centres, severely limits access to mental health care for rural users. It was highlighted that people in rural areas frequently have to travel far in order to access care, and that the time incurred and high transport costs deterred them from seeking care:

Many people in more remote areas are forced to take the patient to Butabika [psychiatric hospital]...it is a long journey...you reach there and it takes time for the patient to be admitted...And also to take a patient to

Butabika, you need to hire a special transport, and that person must charge you highly because of the risks involved. So it is not worth it for many people. (FGD, mental health nurse 3).

Ugandan society

Stigma and discrimination. Respondents from all of the different stakeholder groups emphasized that apart from the mental health system, people with mental disorders experience some of the most harrowing forms of stigma and discrimination in Ugandan society. There were ubiquitous comments throughout the interviews that people with mental illnesses are ‘highly stigmatized’, and are frequently ‘given derogatory labels’. Many stakeholders highlighted how people perceive mentally ill patients as incapable and stupid, as reflected in this housing officer’s remark:

Unfortunately, people with mental illness are taken to be those who cannot think for themselves; whatever they say they are mad, even if they improve . . . whatever they give . . . even if it’s good, we say they are mad . . . there is that ideology that if you are mental, then you don’t have any idea.

Similarly, a member of a mental health NGO sadly explained:

There is so much prejudice. You see people in towns abusing people with mental illness, neglecting people with mental illness, condemning them.

Many respondents explained how besides frequently experiencing insults, abuse and neglect within the community, people with mental disorders were also commonly subjected to discrimination and exploitation. There were numerous accounts describing how people with mental disorders are regularly denied employment. Comments such as ‘they don’t employ people with a mental label’ and ‘people with mental problems can’t get employment’ were commonplace. This was most aptly revealed by this service user’s narrative:

In public service they hold the question, ‘Have you ever suffered from mental illness?’ . . . it would be a good question if they are going to help you on job. But it was a bad question used negatively because they will never call you for an interview however much capability you had. Once you declare that you have ever suffered from mental illness, automatically you would be disqualified.

This user went on to describe how he has continued to struggle to find a job, despite his recovery from a mental illness. Other respondents indicated that if people with mental disorders do manage to find employment, they are frequently exploited, being under-paid or not paid at all, and forced to work under terrible conditions. As one nurse said:

You find that people with mental illness, they are exploited . . . They dig an acre and they are paid 3000, they fetch 10 jerry cans of water and they are paid 200. Others are not even paid.

Besides employment discrimination and labour exploitation, respondents also indicated that people with mental disorders are frequently denied other forms of social and economic opportunities, such as grants, loans, housing and legal protection. This was clearly revealed by one service user’s description of mental illness as a ‘legal death’:

Why do I call it a legal death? This person [mental patient] can never access microfinance legally, this person cannot get what we call supported decision making, like powers of attorney. Everybody needs supported decision making, but not substituted decision making . . . this business of guardianship, thinking you will decide for me the best. That is an abuse of my right. Why do you think you know what I need more than myself? When am okay, you should ask me ‘what do you think about this?’, ‘In case you are sick, who do you give powers of attorney?’ And legally it can be accepted. But it has not been in the legal framework.

Ultimately, the pernicious stigma and discrimination was most succinctly captured by this mental health service user’s comment:

The stigma which these people face is the most disabling part. Because once you are labelled that you are mentally sick then you lose your job, you lose access to opportunities, you lose your integrity in society, people have negative attitudes towards you; however much you can deliver, people don’t believe you can. So you are treated as if you do not even exist.

Limited structural support. WHO-AIMS data revealed that very few laws and policies outside the Ministry of Health appear to take cognisance of the human rights of people with mental disorders. There are no legislative provisions to provide support for users in the following areas:

- a legal obligation for employers to hire a certain percentage of employees that are mentally disabled;

- provisions concerning protection from discrimination at work (dismissal, lower wages, etc.) solely on account of mental disorder; or
- financial provision concerning protection from discrimination in allocation of housing and subsidized housing schemes for people with severe mental disorder.

During a focus group discussion with mental health nurses, one nurse wondered:

For us what we do, we play our part this way, we give medicine. But how are we helping them in the community... we as nurses... but I suppose also society in general?

In answer to this woman's question, many respondents reported that very little is being done in the community to support the needs of people with mental disorders. It was highlighted that very few services and structures are in place to help people with mental disorders integrate and participate in society as independent people. This was clearly revealed by a member of a mental health NGO:

Most mental health services are curative. When somebody gets depressed, then we give them anti-depressants, when they are psychotic we give them anti-psychotics. But there's barely anything being done to meet the more general needs of the mentally ill people: the need for livelihood, the need for improved skills through capacity building, their housing needs and their need for information.

Indeed, many stakeholders shared this view, indicating that there are very few genuine rehabilitation and recovery-based support services for people with mental disorders in the country. As one mental health service user explained:

Patients with mental illness are trained to think that they are dependent. They should be empowered to think, to work for the good of their life so that they become independent. But, we are not rehabilitated, not given any skills and later, we are just thrown into society... They become the poorest of the poor... We are not asking for a Porsche, but a sustainable livelihood, some skills of livelihood.

A few respondents indicated that in addition to the lack of rehabilitative services, many policies outside of the Ministry of Health, those in labour and housing for example, do not adequately address, protect and promote the needs of mentally ill people. This was seen to limit the opportunities of such people. As one member of a mental health NGO explained:

There are some policies, in for example the labour or housing sector, that are not mental

health friendly... that don't promote mental health, are not supportive of people with mental illnesses. For instance the environment might not be supporting mental health. It might be encouraging accidents, or exploitation.

Discussion

Utilizing both quantitative and qualitative data, this study examined Uganda's mental health care system through a human rights lens. The voices of a number of specific population groups were heard, including general and mental health care professionals, academics, NGO members, teachers, as well as government officials. This study also gives agency to the views and lived experiences of those actually suffering from mental disorders, voices which are frequently neglected in research.

Most studies in Africa that have considered mental health issues from a human rights perspective have explored the nature of traditional healers' practices, shedding light on the possible abuses that may occur within these domains (Ensink & Robertson, 1999; Vinorkor, 2004; WHO, 2002). Very few studies, and to the authors' knowledge none in Uganda, have placed the more broad mental health system under a critical human rights gaze.

A promising aspect of Uganda's mental health care system, not the focus of this paper, is its draft mental health policy, developed in 2000, which is in line with many international human rights standards (Ndyabangi, Basangwa, Lutakome, & Mubiru, 2004). It makes special mention of the need to protect and promote the human rights of users of mental health care services. Uganda's mental health care policy is somewhat evolved compared to many other low- and middle-income countries, where it is estimated that over 40% of developing countries do not have a mental health care policy, and many that do are not in line with global international norms (WHO, 2005c).

Despite this rather progressive policy in Uganda, the results from this study revealed that there is a weak interface between policy as intended, and policy as practised. In reality, the lives of people with mental disorders within the Ugandan mental health system and society in general seem to be characterized by widespread violation of their human rights, and limited structures protecting and promoting their entitlements. The results of this study will now be discussed within the context of the Constitution of Uganda (Ugandan Government, 1995), as well as the Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2007) which is signed and ratified by the Ugandan government.

Both the Constitution of Uganda, as well as the CRPD indicate that society and the State are obliged to recognize the rights of people with disabilities, including those with mental and/or intellectual disabilities, to respect, dignity and integrity. Through its derogatory and offensive language the mental health legislation fails to uphold this obligation. Furthermore, the findings from this study, and corroborating findings from other studies in Uganda (BasicNeeds, 2005; Ssanyu, 2007; Ssebunnya *et al.*, 2009) and other African countries (Gureje, Lasebikan, Ephrain-Oluwanuga, Olley, & Kola, 2005) reveal that people with mental disorders frequently experience harrowing forms of stigma, condemnation and harassment in the community. This clearly violates their rights to dignity and respect.

The findings from this study revealed that patients are frequently subjected to inhumane and degrading care within government mental health facilities. It seems that many patients in psychiatric units outside of the main mental hospital are subjected to physical and verbal abuse and violence, poor living conditions (such as the inadequate provision of mosquito nets) and insufficient food supplies. The CRPD clearly states that people with mental disorders shall not be subjected to cruel, inhuman or degrading treatment. In addition, the Constitution of Uganda stipulates that 'No person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment' (Clause 24). These rights are unmistakably not being respected, as evidenced by the above mentioned examples.

It is interesting that such issues were not raised in connection with Butabika, the main mental hospital, with many respondents actually praising the conditions at this facility. It is possible that the respondents associated the interviewers with Butabika Hospital, and were thus reluctant to be critical of facilities at this hospital. Alternatively, it is possible that the treatment at Butabika is of a different standard, something that is plausible given the amount of finances that have been put into improving the conditions at this hospital.

The CRPD also emphasizes that people with mental disabilities have the right to enjoy the highest attainable standard of health, and health care that is of optimal quality and ethical standards. The results from this study revealed, however, that partly as a result of resource constraints, patients are frequently provided with inappropriate and incorrect treatment, which often has dire consequences for the patient. This fundamentally violates their rights to optimal health and health care. Such violations are only exacerbated by the failure to provide adequate psychosocial support. The CRPD also states that mental health care services should be as close as

possible to people's own communities, including in rural areas. This concurs with Uganda's Constitution, which specifies that the State will take necessary measures to bring about balanced development of the different areas of Uganda and between the rural and urban areas. Both quantitative and qualitative results from this study revealed that there is an inequitable geographical spread of mental health services, with the availability of psychiatric care being significantly skewed in favour of the urban city centres and mental hospitals in these centres. Indeed, this appears to be a widespread problem in other low-income African countries (Kohn, Saxena, Levav, & Saraceno, 2004; Saxena, Thornicroft, Knapp, & Whiteford, 2007).

Some of the main principles in the CRPD are that people with disabilities should experience non-discrimination, full and effective participation and inclusion in society and equality of opportunity. The findings from this study indicated that these rights are not enjoyed by many people with mental disorders. Labour exploitation and employment discrimination, together with the denial of other forms of social and economic opportunities, such as grants, loans, housing and legal representation, appear to be commonplace. Furthermore, the results revealed that rehabilitation, capacity-building and recovery-based support services are scarce in Uganda. All of these factors infringe on the rights of people with mental disorders to lead fulfilling and integrated lives in society, that are free from social and economic discrimination. Indeed, these more 'positive' social and economic entitlements are the exact rights that scholars assert are all too frequently neglected and abused amongst the mentally ill (Dhanda & Narayan, 2007; Hunt, 2006; WHO, 2001).

All of these violations may be, in part, symptomatic of the lack of legal support and protection afforded to such people in Uganda. This study revealed that the current mental health legislation in Uganda inadequately promotes and protects the human rights of the mentally ill, and even perpetuates the very rights abuses it is supposed to protect against. Furthermore, the study found that there is no national or regional human rights review body for assessing the human rights protection of users in mental health services, and limited training in human rights for mental health care professionals. It appears that laws in sectors outside of health, such as education, justice, employment and housing, are not necessarily 'healthy' for people with mental disorders. They inadequately promote an enabling social and economic environment for people with mental disorders to realize many of their rights.

It is thus clear from the results of this study that both the negative and positive human rights of people with mental disorders are inadequately protected and

promoted, and frequently violated. The fact that people with mental disorders in Uganda continue to experience degradation and human rights abuses on a daily basis, abuses that are directly at odds with the principles and obligations set out in both Uganda's Constitution, as well as the Convention on the Rights of Persons with Disabilities, is morally inexcusable. Over and above intrinsic ethical imperatives, evidence suggests that neglecting the human rights of people with mental disorders also has a range of negative public health repercussions, given the reciprocal relationship between health and human rights (Gruskin & Tarantola, 2002; Hunt, 2006; Mann *et al.*, 1999). Human rights violations can lead directly and indirectly to adverse health impacts. For example, there is much evidence to suggest that stigma and discrimination of people with mental disorders can have deleterious effects on their willingness to make use of appropriate care, adhere to treatment regimes, and ultimately recover from their illness (Arboleda-Flórez, 2003). This in turn poses major barriers to alleviating the already significant public health burden of mental illness (Horton, 2007; Jacob *et al.*, 2007).

At the outset of this paper, the arguments made against human rights discourses, asserting that they are western constructs and not applicable within African countries, were touched upon. Most certainly, as London (2002) argues, the notion of human rights in its philosophical origins and its contemporary embodiment under the declarations of the United Nations are profoundly rooted in western traditions. This, however, does not necessarily make them irrelevant to non-western societies. It depends on what the focus and underlying intention is, and whether it is compatible with the social, cultural and economic structures of the particular setting. As London argues, 'If "rights talk" also speaks to concentric circles of privilege that extend beyond groups and countries to questions of global privilege, rights-based strategies can become tools to promote respect for cultural difference, while recognizing equality and fairness' (2002, p. 679). In this current study, the human rights framework overtly incorporated broader issues of social justice and social patterning subsumed in more positive rights. It thus has the potential to illuminate inequitable conditions and structures of power, control and dominance. Similar approaches have been adopted in other African countries where they have been able to shed light on how social and economic power unfairly distributes resources for health (Braveman & Gruskin, 2003). Furthermore, the human rights framework appeared to be one which many Ugandan respondents embraced. This was evidenced by the concern expressed by a range of respondents from various sectors, regarding human rights abuses.

Ultimately, this study sought to expose the reality of the lives of many mentally ill people in Uganda, highlighting the abuse they experience on a regular basis, the poor living conditions in which they frequently reside, and the exploitation and discrimination they commonly endure. This study was thus not underpinned by notions of individualism and individual entitlements, concepts for which human rights discourses are frequently criticized. It was concerned with unveiling the vulnerability of this social group, who lack the power in society to redress their social and economic conditions.

Conclusion

Despite having a mental health policy that is in line with international human rights standards, Uganda's mental health care system still inadequately promotes and protects the human rights of people with mental disorders. In this light, a number of policy, legislative and service development initiatives are required. Firstly, there is an urgent need to review the outdated mental health legislation to bring it up to date with current international standards (WHO, 2003; WHO, 2005a).

Secondly, the training of health-care providers in the rights of people with mental disorders needs to be scaled up, so that their practices do not infringe on the rights of their patients. At the same time, there is a need to develop national and regional human rights review bodies for assessing the practices and conditions within psychiatric services, particularly in regional general hospitals.

Thirdly, more awareness-raising and anti-stigma campaigns need to be executed in order to reduce the prevailing stigmatization of mental illness and those affected. These need to be accompanied by more comprehensive social and structural interventions aimed at improving people with mental disorders' status and position in society.

Finally, and related to this last point, it is also important that laws and policies outside of health, those pertaining to education, labour, housing and so forth take cognisance of the rights of people with mental disorders, ensuring that they adequately address, protect and promote the rights of people with mental disorders.

These recommendations will enable the Ugandan government to meet many of its rights obligations set out in the Constitution and the Convention on the Rights of Persons with Disabilities. Transforming human rights discourses into practical application is not always easy in the context of high poverty, gross income disparities, and an extremely high burden of disease, as in Uganda and other low-income African countries. The crux of the matter may lie in the notion of 'progressive realization' as referred to in

Uganda's constitution, the Convention on the Rights of Persons with Disabilities and many other human rights declarations. Although it is unlikely that the above-mentioned recommendations can be realized immediately, it is a State obligation to increase, over time, its legislative and financial commitments to meeting the socio-economic entitlements of those who live with mental illness.

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