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MENTAL HEALTH AS A HUMAN RIGHT IN ESWATINI

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ABSTRACT

This study explored people's views towards mental health in Eswatini. It sought to examine the barriers that prevent people from seeking mental health care services in Eswatini. The study sought to understand the impacts of the COVID-19 pandemic on mental health. This study used the Human Rights Based Approach, Social Constructionism Theory, and the Functionalist Perspective to understand mental health in Eswatini. The study utilized in depth interviews and an online survey in order to strengthen the methodology heartiness of the study. A qualitative research methodology was used in to gain an in depth understanding of people's perceptions towards mental health. Convenient sampling was used to select participants to gather their views on mental health. In total there were 80 participants for the study, including forty Uneswa students, twenty-six members of Motshane community, thirteen mental health professionals from the National Psychiatric Referral Hospital, and the Principal Secretary of the Ministry of Health.

The study findings reveal that mental illness is still seen as a taboo in Eswatini. Mental illness in Eswatini is still viewed negatively often associated with witchcraft and demonic possession. These negative perceptions of mental illness often result in those people with mental illnesses not seeking for mental health care servicers because they fear being stigmatized and marginalized if it is known that they suffer from a mental illness. The National Psychiatric Referral Hospital which is the only mental health hospital in Eswatini suffers strong labelling, it is labelled as a place of "lunatics" and "crazy" people. The government also falls trap of these negative perceptions, which is evident in its consistent failure to adequately fund mental health in the country. With these negative perceptions, it is believed that a person with mental illness should seek help from traditional healers and religious leaders.

Conclusions from this study suggest that the current effort towards mental health is not adequate. There is still a lot that needs to be done to promote and raise awareness on mental health. The government needs to increase resources directed towards mental health, since it is evident from the study that there is a serious lack of resources towards mental health. The study proposed that the government use the Schools Health Program and Career Guidance and Counselling program to promote mental health in schools around Eswatini. The study also advocated for an improved funding for mental health and other programs that seek to promote mental health in Eswatini.

CHAPTER ONE

BACKGROUND OF THE STUDY

1.1 Introduction

Historically, an invisible divide-both in policies and practices- between mental and physical health has resulted in political, professional and geographical isolation and marginalization and stigmatization of mental health care (United Nations Human Rights Office of the High Commissioner, 2021). Mental health and emotional well-being are priority areas that need special attention especially with the onset of COVID-19. The Sustainable Development Goals (SDGs) are undoubtedly linked supportive instruments that support mental health and well-being of all individuals, families and communities.

Globally, mental health and mental illness have been overlooked. Nowhere in the world does mental health enjoy parity with physical health in national policies and budgets or in medical education and practice (United Nations (UN), 2017). Globally, 7 percent of health budgets in developed nations is allocated to addressing mental health. While funding for mental health in developing countries is evidently inadequate (Overseas Development Institute, 2016), millions of people are not receiving the treatment they need, despite the availability of cost-effective, evidence-based solutions (Mackenzie and Kesner, 2016). In low-income countries such as Eswatini, less than $2 (E31.54) per person is spent annually on it (PLOS Medicine, 2013). Even with limited budgets towards mental health, it remains unclear how these allocations are utilised due to lack of transparency in mental health reporting.

'The paradox of mental health: over-treatment and under-recognition' (PLOS Medicine, 2013). In most countries, the trend is that mental health budgets are often folded into general health budgets. The *modern public health* approach has emerged on a global scale at the end of the 21st century. It contained two key messages of the modern public mental-health are: 1) there is no health without mental health; 2) good mental health means much more than the absence of a mental impairment (UN, 2017). This approach still faces innumerable challenges on a global scale, such as fear surrounding mental health and stigma of people with mental illnesses.

Mental illness is a major health condition that affects individuals, families and communities in developed and developing nations (World Health Organization (WHO), 2017a). In 2016 mental disorders affected 1 billion people globally (Rehm and Shield, 2019). Globally, 7 percent of the global burden of disease is attributed to

mental illness and 19 percent of all years lived with disability (ibid). More than 80 percent of the people who have mental disorders are found in low-income countries, with mental illness and substance abuse presenting as an important cause of disease burden, accounting for 8.8 percent and 16.6 percent of the total burden of disease in low-income and lower-middle-income countries (Rathod, Pinninti, Irfan, Gorczynski, Rathod, Gega and Naeem, 2017). Consequently, the COVID-19 pandemic has increased the prevalence of mental illnesses, due to high morbidity and mortality rates associated with the epidemic. Mitigation measures, such as physical distancing, lockdown, and quarantine orders have exacerbated the severity of mental illness in the general population; most of which have not been clinically diagnosed (Czeiser, Lane, Petrosky, Wiley, Weaver, Robbins, Facer-Childs, Barger, Czeisier, Howard and Rajaratnam, 2020).

Globally, the history of mental health care has been clouded with controversies and human rights violations ranging from lobotomy, shock therapies and psychotropic medications all performed in the name of medicine (UN, 2013). The pendulum perceptions towards people with mental health illnesses have shifted from "chaining mad people and putting them in prisons or dungeons" to "brainless mind" and a "mindless brain."

> "*The biomedical model of mental health care can sometimes increase stigma for diagnosed individuals in the following four ways: 1) marking a clear dividing line between those with a diagnosis and without one, 2) stereotyping those with a diagnosis as inherently more dangerous, 3) position those with a diagnosis as part of a certain 'out-group', and 4) leading to discrimination and socioeconomic disadvantage for those so diagnosed*" (Beck, 2019).

The political abuse of psychiatry remains an issue of serious concern globally. While mental health services are starved of resources, any scaled-up investment must be shaped by the experiences of the past to ensure that history does not repeat itself.

In most African countries there is stigma attached to mental illness, communities are often not empathetic towards mental health patients. The mentally ill face discrimination, social ostracism and violation of basic human rights, all die to an on-going stigma associated with mental health problems (WHO, 2017a).

> "*Almost everywhere in the world, mental illnesses are taboo*" (Dombrowski, 2019).

For example, in Eswatini Autism is culturally attributed to witchcraft. Many people struggle to cope with mental illness yet the culture of silence around mental health problems is prevalent in the country.

> "*Social beliefs that include lack of knowledge, negative attitudes and perceived stigma about mental illness, may keep those who suffer from mental illness away from treatment*" (Monteiro, 2015, p. 85).

Developed countries have well documented researches on mental health and wellness, but in countries such as Eswatini there is little research on the subject. Often than not lack of assessment tools, positive interventions and weak or no legislative framework (WHO, 2017a). Mental health is a complex issue yet there is lack of support for mental health issues and changes in circumstances (WHO, 2018b). The stigma against mental illness is still powerful, and more people attach negative stigmas to mental illness at a far higher rate than to other diseases and disabilities (Holthaus, 2021). In low-income countries such as Eswatini, the belief of witchcraft and its relation

to mental illness and seeking of mental health treatments from traditional or spiritual leaders are common as traditional healers are regarded as part of the wider cultural belief system (Musyimi, Mutiso, Loeffen, Krumeich, and Ndetei, 2018).

People living with mental health issues face violence, disempowerment, social exclusion and isolation from their communities and/families. Though mental illness is widespread, its stigma often prevents people from seeking help or even talking about it with a co-worker, family member, or friend (Cecchini, 2018). Self-stigma leads to negative effects on recovery among people diagnosed with severe mental illnesses (American Psychiatric Association, 2020). These individuals face a series of systemic socio-economic disadvantage and harmful conditions in their families and at work (if they can get employment). It can happen when people or organizations specifically exclude people with mental or substance disorders in rental housing, employment or services, withhold benefits that are available to others, or impose extra burdens that are not imposed on others, without a legitimate reason (Ontario Human Rights Commission, 2016). Over the years mental health approaches ignore the social, economic and cultural obstacles, which prevent these individuals from living life free from stigma and discrimination. People living with mental illnesses should have access to the same opportunities as everyone else (Ponte, 2020a).

Many factors such as: social and economic environment, health behaviour, clinic care, and physical environment combine together to affect the health of individuals and communities (The Sycamore Institute, 2018). Whether people are healthy or not, is determined by their circumstances and environment (WHO), 2017b). To a large extent, factors such as the socioeconomic status, the physical environment, and genetics all have considerable impact on health (ibid). Higher income and social status are linked to better health (Wang and Gang, 2019). The greater the gap between the richest and poorest people, the greater the differences in health (ibid). Similarly, Raghupathi and Raghupathi (2020), report that adults with higher education attainment have better health and lifespans compared to their less educated peers. Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health (Office of Disease Prevention and Health Promotion, 2020). Human health is highly dependent on genetics, genetically inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses (Kovner, 2020). There is no health without mental health.

Holistic health is about caring for the whole person, providing for your physical, mental, spiritual, and social needs (Holland, 2018). Holistic health is an approach to life that considers multidimensional aspects of wellness (Western Connecticut State University, 2018). Holistic health does incorporate complementary therapies that have been scientifically proven to work, and like alternative medicine, it focuses on wellness and prevention, rather than just treating diseases (Wong, 2020). Holistic health is so important, because to truly achieve optimal wellness in the physical, mental, and spiritual sense we have to be viewing and supporting the body as the incredible system it is (Western Connecticut State University, 2018). According to the holistic health philosophy, one can achieve optimal health by gaining proper balance in life (WebMD, 2020a).

No one is immune to mental health problems. People at all levels of social, occupational or economic status can experience mental illness. Mental, physical and social wellbeing are virtually inseparable. Good mental health is an asset and is also linked to physical health, both of which support positive social and economic outcomes for individuals and society (Marshall, Bibby, and Abbs, 2020). There are multiple associations between mental health and chronic physical conditions that significantly impact people's quality of life, demands on health care and other publicly funded services, and generate consequences to society (Canadian Mental Health Association, 2017). Mental health plays a major role in people's ability to maintain good physical health. Poor mental health is a risk factor for chronic physical conditions (Rosado, 2017). Similarly, poor physical health can lead to increased risk of developing mental health problems (Mental Health Foundation, 2016). The social determinants of health impact both chronic physical conditions and mental health (Canadian Mental Health Association, 2017). These social determinants include: economic stability, neighbourhood and physical environment, education, food, community and social context, and health care system (Artiga and Hinton, 2018).

Mental health has an impact on every aspect of our lives and likewise it is intertwined with all SDGs (Devex, 2020). Mental health remains one of the most neglected global health issues, even though it is critical to the development of the 2030 Sustainable Development Goals (SDGs) (United Nations, 2018). Mental health is crucial in achieving the SDGs. The inclusion of mental health in the SDGs demonstrates recognition of this important global issues (Academy of Medical Sciences, UK, 2020). The SDGs are also relevant to the treatment and care of people with mental health problems (Lund, Brooke-Sumner, Baingana, Baron, Breuer, Chandra, Haushofer, Herrman, Jordans, Kieling, Medina-Mora, Morgan, Omigbodun, Tol, Patel and Shekhar, 2018). The SDGs are universal and mental health concern all, whether rich or poor (Dybdahl and Lien, 2018). The SDGs provide a framework for national and international interventions relevant to mental health (Herrman, 2019). Mental health is not just an issue for the health sector, but it is also related to equality and basic individual rights (United Nations, 2018).

1.2 Description of the study area (context)

Eswatini is a small landlocked country between South Africa and Mozambique (Dempsey, 2018). Eswatini system of governance is based on Tinkhundla democracy which is anchored on monarchical democracy (Shakantu, 2020). The country is divided into four administrative regions: Hhohho, Manzini, Shiselweni, and Lubombo). The country has an estimated surface area of 17,364 square kilometres (Dempsey, 2018). Eswatini is a lower-middle-income country, ranking 138th of 189 countries in the 2019 Human Development index, the country has the 10th highest income inequality in the world, at 49 percent (World Food Programme-Eswatini, 2020). The population of Eswatini is about 1.1 million (ibid). Although the country is considered a country with low-middle-income, about 58.9 % of the population live below the national poverty line (World Bank, 2019). With 20 percent of the population considered extremely poor (World Food Programme-Eswatini, 2020). About 91% of the urban population has access to safe water as compared to only 37% for the rural population (WHO-Eswatini, 2018). Adult literacy rate is 90% in urban areas compared to 78.3% in rural areas (ibid). Unemployment

is estimated at 23% of the economically active population, and much higher among the youth (ibid). These disparity in access to social services and gender distribution of wealth and social services is an important determinant of mental health. The Swati population faces major health issues, mainly HIV/AIDS. The HIV prevalence was estimated at 27.26% in 2018 of the adult population (National Emergency Response Council on HIV/AIDS (NERCHA), 2019). As of 2014 Eswatini had the 12th- lowest life expectancy in the world, at 58 years (Pacific Prime, 2020). The population of Eswatini is young with a median age of 20.5 years (ibid).

The country's health care system consists of the formal and informal sectors. The informal sector consists of traditional health practitioners and other unregulated service providers (Ncube, Knight, Bradley, Schneider and Laing, 2020). The formal sector is based on the concepts of primary health care and decentralization (ibid). Its infrastructure is made up of government, mission and private health facilities. These health facilities consist of: 14 hospitals of which 6 are private hospitals, 5 government health centres, 6 public health units, 215 clinics and outreach sites (WHO-ESWATINI, 2018). Government is also introducing the health post concept to increase access to healthcare at the community level (ibid). The country has only 1 psychiatric hospital that is in Manzini, making it difficult for someone people to access it, despite the formal sector's concepts of decentralization.

The National Development Strategy (NDS) 1997-2022 and the Poverty Reduction Strategy and Action Plan (PRSAP) 2006-2022 set a policy framework for Eswatini that envisions a first world country where all citizens are able to pursue their life goals and enjoy loves of value and dignity in a safe and secure environment by 2022 (WHO, 2018a). The National Health Policy 2007-2015 and the National Health Sector Strategic Plan 1 (NHSSP) 2008-2013 define the country's vision and goal for the improvement of the health status of the population (ibid). While the country is making efforts to increase access to universal health coverage (UHC) within the framework of the SDGs through inter-sectorial approach, little effort and attention is directed towards mental health. Maternal and child health continue to receive priority policy attention with guidelines for integrated sexual reproductive health strategy. Decentralized services for HIV prevention, treatment and care have been strengthened resulting in increased immunization coverage now standing at 90% and have maintained polio free certification (ibid).

The Ministry of Health in Eswatini (MoH) is responsible for ensuring that national health-related administrative and executive functions are performed adequately in the country. It also provides guidance on essential health care package delivery to all levels of health care countrywide (Ncube, Knight, Bradley, Schneider and Laing, 2020). The Ministry of Health decentralised its activities to regional health offices (RHO) in the four regions, and the RHOs are responsible for the implementation of national health plans and policies (ibid). At the regional level, the regional health management team (RHMT) provides technical leadership in the implementation processes (ibid). The RHMT comprises of the regional health administrative (overall in-charge), a senior matron from the regional health office, senior medical officers and matrons from hospitals and health centres, clinic sisters (senior nurses, based in the different clinics in the country), a pharmacist, and other health professionals stationed at the RHO depending on their availability (ibid).

According to WHO-Eswatini (2018), a number of key health development partners continue to support the country. These include United Nations agencies, the United States Government (PEPFAR), World Bank, European Union, and the Republic of China Taiwan. The main areas of focus for most partners are HIV/AIDS, TB, Malaria, and health systems strengthening. Other global health partnerships such as the Bill and Melinda Gates Foundation, Global Fund, Clinton Health Access Initiative (CHAI) and Medecins Sans Frontieress (MSF) continue to support in various aspects of health. Other stakeholders active in health include: civil society and non-governmental organizations, community groups, academic institutions. The National Health Partnership Consortium is the mechanism through which partners in health come together and coordinate their efforts (WHO-Eswatini, 2018).

Despite significant international aid, the government of Eswatini fails to adequately fund the health sector, with only 10.1 % of the total expenditure spent on the health which falls far below the government commitment to scale up health spending and meet the Abuja Declaration of 2000, which provides that 15% of all resources generated to be allocated to health (United Nations Children's Emergency Fund-Eswatini (UNICEF-Eswatini, 2018). Subsequently, few funds are directed to mental health, making it difficult for mental health professionals to effectively deliver services. Sometimes there are no drugs and other equipment. Zwane (2020), reported that 42 hungry patients at the National Psychiatric Hospital escaped during riot over food. The government spends the majority of its resources on personnel and administrative. The majority of donor health resources are spent off budget. In line with OECD-DAC best principles, donor funding should increasingly flow through governments' own systems. This is a joint agenda. Moving forward, the government must prioritize strengthening their public finance systems to ensure a reduction in fiduciary risk for on budget donor funds, whilst donors can respond to these initiatives by moving away from proliferating off budget project support modalities, reducing transaction costs for both sides (UNICEF-Eswatini, 2018).

1.3 Statement of the Problem

With the prevalence of mental illness increasing worldwide, the violation of the right to mental health care has become a major public concern. In Eswatini there is no stand-alone mental health policy, moreover, mental health is excluded in the National Health Policy (2007-2015). As a result, mental health is poorly funded and this hinders progress in as far as mental health promotion is concerned. The non-existent of a mental health policy also contributes to the failure by government to decentralize mental health services. With the country having only one psychiatric hospital it makes it difficult for some people to access services provided there. There is high stigma associated with the psychiatric hospital in Eswatini. Yet the National Psychiatric Hospital is for everyone experiencing mental health problems from minor stress to schizophrenia. According to the WHO (2007) mental health policies define a vision for the future, which in turn helps establish benchmarks for the prevention, treatment and rehabilitation of mental disorders and the promotion of mental health in the community.

Mental illness is still seen as taboo, with a lot of people linking it to witchcraft (baloyiwe). People always think of mental illness in terms of the worst-case scenario (picking up litter on the streets). Equally people cannot come up openly when they start to show symptoms of mental disorders because they fear being labelled, so people suffer in silence because they fear being victims of stigma and stereotypes. These result to inefficient services towards mental health because government also fall trap of these stereotypes. Mental health in Eswatini does not get the same attention we gave to HIV/AIDS, mental health is not mainstreamed into the Swati society. Mental health is not mainstreamed into the education system, unlike HIV/AIDS.

1.4 Aim of the study

The aim of this study was to present a case for mental health to be seen as a human right in Eswatini.

1.5 Objectives of the study

1. To explore the views of people on mental health in Eswatini.
2. To examine the barriers that limit people from seeking mental health treatment Eswatini.
3. To understand impact of covid-19 on mental health in Eswatini.

1.6 Research Questions

a. How do people perceive people with mental illnesses?
b. Why are people reluctant to seek mental health services from the National Psychiatric Hospital in Manzini?
c. How has the COVID-19 pandemic affected people's mental health in Eswatini?

1.7 Significance of the study

The aim of this study was to make a contribution to the growing literature on mental health in Eswatini. As the country focuses on development and keeping in line with the United Nations Agenda 2030, mental health as a human right is a key determinant of development. There are few studies done on mental health in Eswatini. Most research on mental health focuses on how mental illness impacts on the youth. None of these studies focused on promoting mental health as human right and advocate for mental health policy. Therefore, this study advocates for the elevation of mental health to the status of physical health that is the main area of intervention. Furthermore, the study seeks to advocate for the development of a mental health policy in Eswatini, which will be a key mechanism in setting mental health to be at equilibrium with physical health. This study further utilizes the provisions, conventions and declaration by the United Nations (UN), African Union (AU) and Southern African Development Community (SADC), to which Eswatini is a signatory, in an effort to gain insight on mental health. Lastly, this mental health policy should be in line with these international treaties so that it will effectively promote the right to mental health.

1.8 Limitations of the study

Firstly, the COVID-19 pandemic has been a huge barrier in allowing the researcher to conduct face to face interviews for all participants. Focus Group Discussions which would have provided the researcher with more diverse perspectives, were not possible to facilitate because of COVID-19 regulations. Again, the COVID-19

pandemic did not allow for the generalizability of the study to cover all regions in Eswatini due to travel restrictions and other regulations relating to COVID-19. Limited resources prevented the researcher from engaging in a larger study. It would have been great to get views of people with mental illnesses, it would have boosted the researcher's advocacy. However, it was going to be not going to be easy for the researcher to identify them.

1.9 Definition of key terms

Mental health is the foundation for the well-being and effective functioning of individuals. It is more than the absence of a mental disorder; it is the ability to think, learn, and understand one's emotions and the reactions of others. According to Felman (2020), mental health refers to cognitive, behavioral, and emotional well-being. It is all about how people think, feel, and behave (ibid).

a. **Human rights** are the basic rights and freedoms that belong to every person in the world, from birth until death (Equality and Human Rights Commission, 2019). Human rights apply no matter where you are from, what you believe in, or how you choose to live your life (Amnesty International UK, 2018).

b. **Mental health stigma**

> "*Refers to societal disapproval, or when society places shame on people who live with a mental illness or seek help for emotional distress, such as anxiety, depression, bipolar disorder, or post-traumatic stress disorder*" (Zoppi, 2020).

Stigma is a mark of disgrace that sets people apart from others. When a person is labelled by their illness they no longer seen as an individual but as part of a stereotyped group.

c. **Mental illnesses (mental disorders)** are health conditions involving changes in emotion, thinking or behaviour (or a combination of these) (American Psychiatric Association, 2018). They are associated with distress and problems functioning in social, work or family activities (Srivastava, 2020). Examples of mental illness include depression, anxiety disorders, hallucination, dissociative disorders, multiple personalities, bipolar, schizophrenia, eating disorders and addictive behaviours (Mayo Clinic, 2019).

d. **Mental health policy** is an official statement by a government or health authority that provides the overall direction for mental health by defining a vision, values, principles and objectives, and by establishing a broad model for action to achieve that vision (WHO, 2007). The policy document constitutes the official government guidelines for the interrelated areas for action or directions that will be taken to improve mental health (ibid).

e. **Treatment** means all the different ways in which someone with a mental illness can get help to minimise the effects of the illness and promote recovery (SANE Australia, 2020a). It can involve psychological therapy, medication, and various supports in the community, as well as people with the mental illness helping themselves (ibid).

1.10 Organization of the study

Chapter One: This chapter lays the foundation of the study by providing a momentary valuation on mental health as a human right and a background of the study is provided. It also includes the description of the study area, problem statement, significance of the study, objectives of the study, research questions to be answered by the study, definition of key terms and is concluded by the organization of the study.

Chapter Two: This chapter presents literature and other important studies undertaken on mental health, mental health policy and human rights to mental health. It also presents international and regional instruments on mental health. Books, journal articles and internet sources were used to write this chapter.

Chapter Three: This chapter focuses on the theoretical frameworks guiding the study. The human rights-based approach and the functionalist perspective are assessed.

Chapter Four: This chapter consists of the research design and methodology used in the study. It comprises of the steps that are going to be taken by the researcher to collect, interpret and analyse the data. The chapter concludes by outlining the ethical consideration of the study.

Chapter Five: This chapter will focus on data analysis and presentation, data collected is analysed using the literature review and theoretical frameworks chapters.

Chapter Six: This chapter concludes and summarizes the study based on the findings. This is then followed by recommendations and suggestions for further research

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter outlines previous research and literature on mental health and challenges faced by those who are struggling with mental illness. The chapter begins with an overview of mental health and COVID-19. It gives an overview of the prevalence of mental disorders on adults. It also provides an overview of the most common mental disorders (brief information and early signs of mental disorders). The chapter further focuses on mental health in adolescents. Moreover, the chapter focuses on suicide due to mental disorders. The chapter also focuses on stigma and discrimination associated with mental disorders. Furthermore, the chapter focuses on the integration of mental health care into primary health care concepts that put mental illness as a human right issue. The chapter also focuses on the management of mental disorders. This chapter gives an overview of the role of traditional healers and spiritual leaders in the healing of mental illnesses. In addition, the chapter introduces the right to mental health. The chapter also focuses on investing on mental health internationally. The chapter also gives a synopsis of the barriers to accessing mental health care for people who suffer from mental illnesses. It further focuses on mental health promotion as well as the benefits of promoting mental health. The chapter also gives an overview of community care for people with mental illnesses as well international, regional and local legislative pieces on mental health. A conclusion is provided at the end of the chapter.

2.1.1 Comprehensive and/or holistic health

The WHO (1946), refers to health as:

> "*A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*".

This is consistent with the bio-psychosocial model of health, which considers physiological, psychological and social factors in health and illness, and interactions between these factors (Martino, 2017). The WHO definition links health explicitly with wellbeing, and conceptualizes health as a human right requiring physical and social resources to achieve and maintain (ibid). Holistic health simply means caring for the whole person, providing for physical, mental, spiritual, and social needs (Holland, 2018).

2.1.2 Mental health and COVID-19

Globally, mental health is being challenged like never before by COVID-19. As attention has shifted to focus on people infected with COVID-19, marginalized populations are easily overlooked, such as patients with severe mental illness who are at high risk for medical comorbidities predisposing them to COVID-19 and whose psychiatric condition can worsen owning to COVID-19 infection (Kahl, 2020). People with severe mental illness may be among the most vulnerable populations affected by the COVID-19 pandemic (Druss, 2020). In addition,

the COVID-19 pandemic is acting as a stressor or trauma, which not only threats physical health status but also threats mental status and well-being of people (Mani, Estedlal, Kamali, Ghaemi, Zarei, Shokrpour, Heydari, and Lankarani, 2020). Similarly, the COVID-19 pandemic has disrupted or halted critical mental health services in 93% of countries worldwide while the demand for mental health is increasing (WHO, 2020a). Yet evidence obtained from the observations of mental health consequences and measures adopted during previous viral epidemics revealed that the psychological aspect of an infectious disease is as important as its treatment aspect (Wang, Horby, Hayden, and Gao, 2020).

The dire consequences of the global pandemic have been difficult to escape, let alone ignore (Malapani, 2020). The world was not set up to respond to the growing mental health crisis before COVID-19, and it is not now (United For Global Mental Health, 2020).

> "*The COVID-19 pandemic is not only attacking our physical health; it is also increasing psychological suffering; grief at the loss of loved ones, shock at the loss of jobs, isolation and restrictions on movement, difficult family dynamics, uncertainty and fear for the future*" (Malapani, 2020).

Added to this is the fear of contracting the virus and worry about people close to us who are particularly vulnerable (WHO, 2020a). The impact of the COVID-19 pandemic on mental health is complex, diverse and wide-ranging, affecting all parts of societies and populations. The extraordinary increase in mental health needs is taking its toll on already burdened mental health services which are underfunded and under-resourced in many countries on every continent affected by the COVID-19 pandemic. As the COVID-19 pandemic exposes the serious gaps in mental health care, and world leaders now more than ever world leaders need to prioritise and ensure quality mental health support is accessible to everyone, everywhere (United For Global Mental Health, 2020).

Those with existing poor mental health are facing a number of risks including increased risks of mental ill health and disruption to treatment, medications and the lifeline of support services. While mental health is determined by much broader factors than access to mental health services, these are critical for people experiencing mental illness (Marshall, Bibby, and Abbs, 2020). COVID-19 is likely to exacerbate existing mental health symptoms or trigger relapse among people with pre-existing mental health illness. In an online survey in South Africa, of those with a prior diagnosed mental health condition, about 12 % identified feelings of suicide as the main challenge, and 6% indicated substance use as a difficulty (The South African Depression And Anxiety Group, 2020).

Frontline workers are playing a crucial role in fighting the outbreak and saving lives. However frontline workers might be at risk of developing mental health problems (Khanal, Devkota, Minakshi, Paudel, and Joshi, 2020). They are under exceptional stress and while deaths of health workers are rising, the mental illness rates are rising faster still. Frontline workers, especially healthcare workers, are at particularly high risk of mental illness, including suicide attempts, and the risk of burnout (United For Global Mental Health, 2020). Without support they will be unable to fulfil their vital role in stopping the outbreak. Ensuring the good mental health of health workers is essential. A study among healthcare workers in China during the COVID-19 pandemic showed the frequency of depression to be 50.4%, anxiety at 44.6%, insomnia at 34%, and distress at 71.5% (ibid).

So, it is important not to neglect one part of health as seen with the COVID-19 pandemic, governments have turned all focus on physical health and have neglected mental health. Yet the COVID-19 virus is not only attacking our physical health; it is also increasing psychological suffering. Grief of the loss of loved ones, shock at the loss of jobs, isolation and restrictions on movement, difficult family dynamics, uncertainty and fear for the future all lead to mental distress. After decades of neglect and underinvestment in mental health services, the COVID-19 pandemic is now hitting families and communities with additional mental stress (WHO 2020b). Mental health services are an essential part of all government responses to COVID-19, and they must be expanded and fully funded (ibid). Credit must go to the Kenyan government for announcing plans to set up a tele-counselling and tele-psychiatry centre which will have a free toll number which will be operational day and night to assist even those who have been mentally affected by COVID-19 pandemic (Kihiu, 2020). Policies must support and care for those affected by mental rights and dignity (WHO, 2020b). Lockdowns and quarantines must not discriminate against those with poor mental health (ibid).

Mental health is a universal asset that we should all share. Good mental health supports us all to reach our potential, individually and collectively (Elliott, 2016). There are many reasons why people develop mental illness, some are genetic or biological; some are a result of childhood trauma or overwhelming stress at school, work or home; some stem from environmental injustice or violence. Mental illness is a global problem. It is estimated that 450 million people worldwide have a mental disorder and that 25% of the population will suffer from mental illness at some time in their lives (WHO, 2017a). More than 300 million people, 4.4% of the world's population, suffer from depression (Roberts, 2018). Data from the Health Management Information System (HMIS) shows that between 2017 and 2019, about 8229 people were affected by mental health related illnesses in Eswatini (Dlamini, Hlophe, and Mohammed, 2019). This figure represents only those individuals who accessed health facilities, which means it could be significantly higher (ibid).

Across the globe, people living in poverty are disproportionately affected by mental illnesses (Roberts, 2018). Similarly, those afflicted with depression and anxiety are more likely to face greater economic challenges due to a loss of employment and income, leading to poverty (American Association For the Advancement of Science, 2020). Moreover, refugees and asylum seekers are five times likely to experience mental health crisis or breakdown (Roberts, 2018). Mental disorders are on the rise in every country in the world and will cost the global economy $16 trillion by 2030 (Lancet Commission, 2018).

> "*The economic cost is primarily due to early onset of mental illness and lost productivity, with an estimated 12 billion working days lost due to mental illness every year*" (The Carter Center, 2018).

Despite the implications it has for global economy, mental health receives a fraction of the funding of other diseases, both in allocations from the Ministry of Health and development assistance.

The United Nations right to health expert, Mr Danius Puras, pointed out that despite evidence that there is no health without mental health, nowhere in the world does mental health enjoy parity with physical health in terms of budgeting, or medical education and practice (OHCHR, 2018). Countries spend on average only 2% of their

health budget on mental health, and international development assistance is estimated to be less than 1% of all development assistance for health (United Nations, 2020). Around 25% of countries today have no legislation on mental health and 40% have no healthcare policies in this area (Rathod, et al., Mental health service provosion in low-and-middle-income countries, 2017). An absence of planning and legislation and the development of inadequate public health policies are frequent and contribute to the stagnation of the system and make it difficult to access treatment (Azman, Jamir, and Sulaiman, 2019). This lack of will and commitment on the part of the government also affects budget allocations, resulting in the system being underfunded and services not being provided (Malik and Khan, 2016).

In Eswatini mental health is does not form part of the government's agenda on health, such that mental health was omitted from the National Health Policy 2007-2015. The government is mostly focused on HIV/AIDS and Malaria. Similarly the health sector is underfunded with a budget of E2.2 billion for the year 2019 (Budget Speech, 2019), and E2.3 billion for the year 2020 (Budget Speech, 2020), so one can imagine how much goes towards mental health from such a low budget and the fact that mental health is of less interest to government. The health system in Eswatini is mostly focused on HIV/AIDS and Malaria, and of most recent diabetes and cancer, not mental health.

The 65th World Health Assembly adopted Resolution 4 on the global burden of mental disorders and the need for a comprehensive coordinated response from the health and social sectors at country level (WHO, 2013). Subsequently, during the 66th World Health Assembly, Resolution 8 was adopted. It called on member states to develop comprehensive mental health action in line with the Global Comprehensive Mental Health Action Plan 2013-2020 (ibid). The principal purpose of the Mental Health Action Plan 2013-2020 is:

> "*To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability of people with mental disorders*" (Mental Health Action Plan 2013-2020).

Mental health services must be incorporated as a core component of health systems and must be clear in calls for comprehensive primary health care. Most fundamentally, any response to the global challenges of mental health will only succeed if it addresses the multiple social, political and economic determinants of the problem. Mental health is at the core of our humanity. According to WHO (2020b), mental health enables us to lead rich and fulfilling lives and to participate in our communities. Mental health is a human right, the Universal Declaration of Human Rights (UDHR) of 1948 Article 25 states that:

> "*Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*" (UDHR, 1948).

Equally mental health may be subject to the Convention on the Rights of Persons with Disabilities (CRPD) of 2006, in that Article 1 of the convention states that:

> "*Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*" (CRPD, 2006).

Viewing mental illness as a disability then subjects us to all the provisions enriched in this convention. As such Article 25, spells the right to health as such:

> "*State parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation*" (CRPD, 2006).

This means people with mental illnesses have a right to mental health care.

We are facing a global human rights emergency in mental health (WHO, 2020b). People with mental health problems experience a wide range of human rights violations. In many countries people do not have access to basic mental health care and treatment they require (ibid). The United Nations High Office of the Commissioner for Human Rights (OHCHR) (2018), reports that in some countries, the only care available for mentally ill individuals is in psychiatric institutions, and many of them are associated with significant human rights violations reflected in inhumane treatment and living conditions such as shackling or locking up in confinement for extended periods of time. Even outside the health care they are excluded from community life and denied basic rights such as shelter, food and clothing, and are discriminated against in the fields of employment, housing, and education (WHO, 2020b).

Mental healthcare systems all over the world are characterised by deficiencies and weaknesses, especially in low-and-middle income countries (Carbonell, Navarro-Perez, and Mestre, 2020). The underfunding and austerity measures affecting healthcare management models place limits on the professional interventions carried out in the area of mental health and resources allocated to it, thereby forcing the family to become more involved in caring for the person with mental illness (Carbonell and Navaro-Perez, 2019). Actions that prevent mental disorders and promote mental health are an essential part of efforts to improve the health of the world's population and to reduce health inequalities. According to Gil-Rivas, Handrup, Tanner, and Walker (2019), mental health must move to the top of the political agenda so as to guarantee adequate funding for tte planning, development and evaluation of the services and to reduce the stigma and discrimination suffered by people with mental illness.

> "*Ensuring good mental health for all means guaranteeing the fundamental right to mental health support, not only through equitable access to mental health services through health systems, but by the promotion of good mental health throughout society and the environments we live in*" (Devex, 2020).

It is important to support governments to adopt mental health policies and to integrate mental health policy into public health policy and general social policy. One country that has a good stand-alone mental health policy is Kenya, the Kenya Mental Health Policy (2015-2030) provides for a framework on interventions for securing mental health systems reforms in Kenya. This is in line with the Constitution of Kenya 2010, Vision 2030, the Kenya Health Policy (2014-2030) and the global commitments. The policy acknowledges that mental health is a human right and makes provision that government shall ensure that the mental health system for service delivery

is affordable, equitable, accessible, sustainable and of good quality. The policy also recognizes the need for advocacy and partnerships, it calls for everyone to be involved to ensure parity for mental health at all levels in both public and private sectors. Like we need the same energy we gave to HIV/AIDS to be given to mental health. Mental health should be mainstreamed into all parts of society.

Even though many people suffer from mental illness, you often will not know someone has a mental illness if they tell you directly. Unlike a broken arm or leg, it is often difficult to understand what that person may be experiencing and how you can help. Sometimes their mental illness will make them act in unusual ways, which may make mental health professionals feel uncomfortable.

2.1.3 Prevalence of mental disorders in adults

The burden of chronic non-communicable disease is emerging as a major public health challenge worldwide, especially in developing countries where these diseases have been thought to be less common (Hunduma, Girma, Digaffe, Weldegebreal, and Tola, 2017). In South Africa, neuropsychiatric disorders are ranked third in their contribution to the burden of disease after HIV/AIDS and other infectious diseases (National Mental Health Policy Framework and Strategic Plan 2013-2020). Mental health and wellbeing are as important in older age as at any other stage of life (WHO, 2017d). "The world's population is ageing rapidly. Between 2-15 and 2050, the proportion of the world's older adults is estimated to almost double from about 12% t0 22%. However, while there is population ageing, over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders) and 6.6% of all disability among people over 60 years is attributed to mental and neurological disorders. The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively" (WHO, 2017d).

The prevalence of mental disorders is the highest in low-and –middle income countries such as South Africa, attributed to conflict and trauma, hunger and poverty, poor access to health and social care, and social inequality (Meyer, Matlala, and Chigome, 2019). In Eswatini, mental illness is most common among people between the ages of 25 to 45 years old (Nxumalo-Ngubane, 2016).

2.1.4 Brief overview of the most common disorders (brief information on early signs of mental disorders)

Many people have mental health concerns from time to time, but a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function (Mayo Clinic, 2019). Sometimes symptoms of a mental health disorder appear as physical problems, such as stomach pain, back pain, headaches, or other unexplained aches and pains (ibid). Annual reporting from the National Psychiatric Hospital shows that the leading mental disorders for both admissions and readmissions in Eswatini include: epilepsy without psychosis, schizophrenia, bipolar effective disorder, depression, substance induced psychosis, and being epileptic with psychosis (Dlamini and Shongwe, 2019).

> "*The burden of mental disorders continues to grow with significant impacts on health and major social, human rights and economic consequences in all countries worldwide"* (WHO, 2019).

The common disorders include: depression, anxiety disorder, eating disorder, stress-related disorder, schizophrenia, and bipolar disorder (Cherry, 2020a). Depression is a common mental disorder and one of the main causes of disability worldwide (WHO, 2019).

> "*Globally it is estimated that 264 million people are affected by depression*" (Disease and Injury Incidence and Prevalence Collaborators, 2018).

More women are affected than men (WHO, 2019). Depression is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration. People with depression may also have multiple physical complaints with no apparent physical cause. Depression can be long-lasting or recurrent, substantially impairing people's ability to function at work or school and to cope with daily life. At its most severe, depression can lead to suicide.

Anxiety disorders are those that are characterized by excessive and persistent fear, worry, anxiety and related behaviour disturbances (Cherry, 2020a). People with anxiety disorder respond to certain objects or situations with fear and dread, as well as with physical signs of anxiety or panic, such as rapid heartbeat and sweating (WebMD, 2019). An anxiety disorder is diagnosed if the person's response is not appropriate for the situation, if the person cannot control the response or if the anxiety interferes with normal functioning (ibid). Anxiety involves the anticipation that a future threat may arise (Cherry, 2020a). Anxiety disorders include generalized anxiety disorders, panic disorder, social anxiety disorder, separation anxiety and specific phobias (ibid).

Eating disorders are characterized by obsessive concerns with weight and disruptive patterns that negatively impact physical and mental health (American Psychiatric Association, 2013). Anorexia nervosa, bulimia nervosa, and binge eating disorder are the most common eating disorders (Cherry, 2020a). Other eating disorders include: rumination disorder, and pica (American Psychiatric Association, 2013). Trauma and stress-related disorders involve exposure to a stressful or traumatic event. These were previously grouped with anxiety disorders but are now considered a distinct category of disorders (Cherry, 2020a). Disorders included in this category include: acute stress disorder, adjustment disorders, post-traumatic stress disorder (PTSD), reactive attachment disorder (American Psychiatric Association, 2013).

Schizophrenia is a severe mental disorder, affecting 20 million people worldwide (Disease and Injury Incidence and Prevalence Collaborators, 2018). Psychoses, including schizophrenia are characterized by distortions in thinking, perception, emotions, language, sense of self and behaviour (WHO, 2019). Common psychotic experiences include hallucinations (hearing, seeing or feeling things that are not there) and delusions (fixed false beliefs or suspicions that are firmly held even when there is evidence to the contrary) (Holland, 2018). These can potentially put them in a dangerous situation if left untreated (ibid). The disorder can make it difficult for people to work or study normally (WHO, 2019). Schizophrenia typically begins in late adolescence or early adulthood (ibid).

According to the Lancet (2018):

> "*Bipolar disorder affects about 45 million people worldwide*".

Bipolar disorder is characterized by shifts in mood as well as changes in activity and energy levels (Cherry, 2020a). The disorder often involves experiencing shifts between elevated moods and periods of depression. It typically consists of both manic and depressive episodes separated by periods of normal mood (WHO, 2019). Manic episodes involve elevated or irritable mood, over-activity, rapid speech, inflated self-esteem and decreased need to sleep (Cherry, 2020a)). People who have manic attacks but do not experience depressive episodes are also classified as having bipolar disorder (WHO, 2019).

Worldwide, approximately 50 million people have dementia with nearly 60% living in low-and middle-income countries (WHO, 2019). Dementia is usually of a chronic or progressive nature in which there is deterioration in cognitive function beyond what might be expected from normal ageing (ibid). It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement (American Psychiatric Association, 2013). The impairment in cognitive function is commonly accompanied, and occasionally preceded by deterioration in emotional control, social behaviour, or motivation (American Psychiatric Association, 2013). Dementia is caused by a variety of diseases and injuries that affect the brain, such as Alzheimer's disease or stroke.

2.1.5 Mental health disorders in adolescents

Adolescence (10-19 years) is a unique and formative time (WHO, 2020d). Going through adolescence, a time during which many psychosocial and physiological changes take place, often results in huge stress levels and subsequent mental health disorders (Karim, 2016). Mental health in adolescence is a significant problem, relatively common and amenable to treatment or intervention (American College of Obstetricians and Gynecologists, 2017).

> "*Data from the Eswatini Health Management Information System (HMIS) recorded that between 2015 and 2019, 40% of mental illness patients in public clinics and healthcare centres were young people between the ages of 15 to 35 years*" (Dlamini, Hlophe, and Mohammed, 2019).

Multiple physical, emotional and social changes, including exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems (WHO, 2020d). Adolescents with mental illness often engage in acting-out behaviour or substance use, which increases their risk of unsafe sexual behaviour that may result in pregnancy or sexually transmitted infections (American College of Obstetricians and Gynecologists, 2017). Thus, promoting psychological well-being and protecting adolescents from adverse experiences and risk factors that may impact their potential to thrive, are critical for their well-being during adolescence and for their physical and mental health in adulthood (WHO, 2020d).

"*The prevalence of mental health problems in young children is estimated to be between 17% and 20% globally, with the first symptomatic manifestations observed before age 14 on average*" (Caqueo-Urizar, Flores, Escobar, Urzua, and Irarrazaval, 2020).

In addition, it has been found that the highest prevalence rates are in developing countries (ibid). Globally, depression is the fourth leading cause of illness and disability among adolescents aged 15-19 years and fifteenth for those aged 10-14 years.

"*The prevalence of depressive disorders in children and adolescents is estimated to be increasing, and the average age at which the first signs or symptoms appear is decreasing*" (WHO, 2020d).

"*Globally, the prevalence ranges from 2 to 5% in children and 4 to 8% in adolescents*" (Caqueo-Urizar, Flores, Escobar, Urzua, and Irarrazaval, 2020).

Learning and emotional difficulties are also prevalent, and these have been shown to contribute to the development of depressive symptoms (Cummings, Caporino, and Kendall, 2014).

On the other hand, anxiety disorders are the most common mental health disorders in adolescents (American College of Obstetricians and Gynecologists, 2017).

"*The prevalence of anxiety disorders in children and adolescents significantly surpasses that other mental health problems usually diagnosed in this population (4 to 32% worldwide), not including those cases in which anxiety manifests itself as a symptom of other clinical conditions*" (Caqueo-Urizar, Flores, Escobar, Urzua, and Irarrazaval, 2020).

At any given time, one in eight adolescents meets clinical criteria for an anxiety disorder (ibid). Anxiety also shows comorbidity with social phobia and obsessive-compulsive disorders, and it impacts not only the effective domain but also cognitive function.

"*Globally an estimated 62000 adolescents died in 2016 as a result of self-term. Suicide is the third leading cause of death in older adolescents (15-19 years). Nearly 90% of the world's adolescents live in low-or-middle income countries and more than 90% of adolescents' suicides are among adolescents living in those countries. Risk factors for suicide are multifaceted including harmful use of alcohol, abuse in childhood, stigma against help-seeking barriers to accessing care and access to means*" (WHO, 2020d).

Diagnosis of mental illness in adolescents can be more challenging, as compared to adults, despite fairly similar diagnostic criteria for both groups (Paruk and Karim, 2016). Common emotional and behavioural changes as part of normal development, could make it difficult to distinguish from the mental illness (ibid). Most adolescents are not able to access health services independently and are accompanied by a caregiver (Meyer, Matlala, and Chigome, 2019). This could result in reluctance to engage with the practitioner, fear of disclosing personal information to the caregiver, or fear of stigmatisation by others (Paruk and Karim, 2016).

2.1.6 Suicide due to mental disorders

"*Suicide is a major health problem, and the global suicide mortality rate amounts to 1.4% of all deaths worldwide*" (Bradvik, 2018).

It is estimated that there are 800000 suicides per year (Beurs, Have, Cuijpers, and Graaf, 2019). The suicide burden is highest in low- to middle-income countries, despite underreporting of suicide cases, due to cultural, social and religious stigma (WHO, 2014). Although difficult to access, it is estimated that for every person who died by suicide, there are around 20 people who attempted suicide (Beurs, Have, Cuijpers, and Graaf, 2019). In Eswatini reports from the National Psychiatric Hospital recorded that 125 people between the ages of 13 and 25 committed suicide in 2017, with most cases stemming from depression (Dlamini, Hlophe, and Mohammed, 2019). Most suicides are related to psychiatric disease, with depression, substance use disorders and psychosis being the most relevant risk factors (Bachmann, 2018).

Although mental illness is generally linked to premature deaths, certain mental illnesses carry with them remarkably high lifetime instances of suicide (Soreff, 2019). In fact,

> "*95% of people who commit suicide have a mental illness*" (Soreff, 2019).

People with a diagnosed mental health problem have been found to be at higher risk of suicidal thoughts and behaviour (Bradvik, 2018). Self-harm behaviour has also been found to be a risk factor (Mental Health Foundation, 2019). Suicide prevention interventions should be comprehensive, collaborative and take into consideration the complexity of mental conditions (Carpiniello and Pinna, 2017).

2.1.7 Stigma and discrimination associated with mental disorders

Stigma and discrimination exist worldwide relating to both mental health and substance use (Corrigan, et al., 2017). People with mental health conditions commonly face stigma and discrimination, which impact negatively on their lives and are associated with poor mental health prognosis and increased premature mortality (Oexle, et al, 2017). Stigma associated with mental illness and consequent discrimination is considered the cause of worse outcomes than the actual mental illnesses (or barriers to improvement) (Seeman, Tang, Brown, and Ing, 2016). In a study done by Nxumalo-Ngubane, McAndrew, and Collier (2019), it was found that Swazi women diagnosed with schizophrenia experience stigma from family, community and care providers, thus compromising their recovery process.

More than half of people with mental illness do not seek help for their disorders (Seeman, Tang, Brown, and Ing, 2016). Often, people avoid or delay seeking treatment due to concerns about being treated differently or fears of losing their jobs and livelihood (ibid). That is because stigma, prejudice and discrimination against people with mental illness is still very much a problem (American Psychiatric Association, 2020). Stigma and discrimination against people with mental illnesses are significant contributors to self-harm and suicide attempts (Oexle, et al., 2017). Stigma and discrimination do not only affect people with mental disorders, but also their families and caregivers (Seeman, Tang, and Brown, 2016). Stigma often comes from lack of understanding or fear (American Psychiatric Association, 2020). Inaccurate or misleading media representations of mental illness contribute to both those factors (ibid).

2.1.8 Social determinants of mental health

It is well documented that social factors affect risk for mental illness and substance use disorder, as well as health outcomes of persons with these disorders (Compton and Shim, 2015).

> "*Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk*" (Allen, Balfour, Bell, and Marmot, 2014).

The most at risk are the poor and vulnerable, but also those in the middle of the social gradient suffer (ibid). These social determinants include: socioeconomic status, neighbourhood and physical environment, education, food, community and social context, and health care system (Artiga and Hinton, 2018).

2.1.8.1 Education

Insufficient information leads in most cases to situations where family or close friends do not take any measures when they notice certain misbehaviours in the person's attitude (Gabriela and Gavrila-Ardelean, 2016).

While Jiang and Xie (2020) say that "*education significantly improve health, both physical and mentally*" a lot of people still believe signs of mental disorders for moodiness, temporary hysterical moods, which often cause inappropriate behaviour. After concluding their study Gabriela and Gavrila-Ardelean (2016) state that the distorted interpretations of mental disorders and mentally distorted people are the consequences of insufficient information and educational gaps.

2.1.8.2 Food

Food insecurity has been linked to adverse mental health outcomes (Polsky and Gilmour, 2020). More especially in the context of developing countries (Jones, 2017). A study by Fang, Thomsen, and Nayga (2021), suggest that becoming food insecure during the COVID-19 pandemic is highly associated with mental health problems related to anxiety and depression. Worth noting though is that the effect of food insecurity is three times that of the effect of losing a job during the pandemic (ibid).

2.1.8.3 Health system

People with severe mental illnesses routinely have no access to adequate medication and psychological counselling (Frannces, 2020). The COVID-19 pandemic has exposed the disparities in the mental health system all over the world, leaving many people without accessible and affordable care as policymakers fail to adequately address the crisis (Altiraifi and Rapfogel, 2020). As the pandemic continue to wreak havoc on communities, the need for accessible, culturally affirming mental health support services has never been more acute (ibid).

> "*Many people with complex or chronic mental health problems do not receive the full scope of care they need and end up cycling through the acute care system*" (Canadian Mental Health Association, 2018).

2.1.8.4 Socioeconomic status

A clear link exists between socioeconomic inequality and poor mental health (Macintyre, Ferris, Goncalves, and Quinn, 2018).

> "*There is a social gradient in mental health, and higher levels of income inequality are linked to higher prevalence of mental illness*" (Macintyre, Ferris, Goncalves, and Quinn, 2018).

Socioeconomic inequality may be the enemy between us, increasing status competition, undermining the quality of social relations, increasing stress and impacting on health and wellbeing (Wilkinson and Pickett, 2017). It is important to note that low income does not necessarily lead to higher rates of mental health problems, but that social factors associated with lower income and socioeconomic status, such as debt, can adversely affect mental health (Mental Health Foundation, 2016).

2.1.8.5 Neighbourhood and physical environment

The built environment has direct and indirect effects on mental health. A clean and healthy environment is essential for human health and well-being (Filipova, et al., 2020). Everything from the house, city, and the state you live in to the weather in your area, and your work environment can affect your mental health (Lindberg, 2021).

2.1.8.6 Community and social context

These include neighbourhood trust and safety, community-based participation, violence or crime, attributes of the natural and built environment, neighbourhood deprivation (WHO and Calouste Gulbenkian Foundation, 2014). A healthy community can be essential to good mental health; community can provide a sense of belonging and a source of support, which both benefit mental health (Ponte, 2020b).

2.1.9 Integration of mental health care into primary health care

Mental health is an integral part of health; however, health systems have not been able to adequately respond to the burden of mental health (Wakida, Talib, Akena, Okello, Kinengyere, Mindra, Obua, 2018). Up to 85% of people with severe mental illness in low-and middle-income countries (LMIC) receive no treatment for their disorder (WHO Mental Health Plan 2013-2020). Psychiatric services alone can neither meet the demand for care, nor provide it cost-effectively, hence general practitioners are increasingly called upon to provide appropriate care (Meyer, Matlala, and Chigome, 2019). Mental health care can be delivered effectively in *primary health care* (PHC) settings and that once identified, most mental illness can be treated using cost-effective means (McGough, Bauer, Collins, and Dugdale, 2016). PHC practitioners can play a vital role in mental health awareness and reducing stigma associated with mental health disorders (National Mental Health Policy Framework and Strategic Plan 2013-2020).

> "*The integration of mental health services into PHC provides a number of advantages including: 1) reduced stigma; 2) improved prevention and detection of mental health problems; 3) reduced chronicity and improved social integration; 4) human rights protection; 5) better health outcomes; and 6) improved human resources capacity for mental health care*" (Sunderji, Kurdyak, Sockalingam, and Mulsant, 2018).

The integration of mental health into PHC has been carried out in various countries and in different forms (Barraclough, Longman, and Barclay, 2016).

In 2017, the Communicable Diseases Health Services Delivery-Research Policy Scale-Up (COMDIS-HSD) in collaboration with the Eswatini Ministry of Health, the National Psychiatric Hospital and other regional stakeholders, developed a brief psychological intervention for people living with depression to be delivered by nurses in primary care in Eswatini (Communicable Diseases Health Services Delivery-Research Policy Scale-Up, 2018). Similarly,

> "*the South African Mental Health Policy aims to integrate mental health care into PHC by introducing several strategies such as scaling up decentralised primary mental health services, increasing public awareness regarding mental health, promoting mental in the South African population, empowering local communities to participate in promoting mental well-being and recovery within the community, and ensuring that the planning and provision of health services are evidence-based*" (Schneider, Baron, Breuer, and Docrat, 2016).

2.1.10 Management of mental disorders

Extraordinary advances have been made in the treatment of mental illness (First, 2020). As a result, many mental disorders can now be treated nearly as successfully as physical disorders (ibid). Treatment for mental health disorders is not one size fits all, and it does not offer a cure (Holland, 2018). Instead, treatment aims to reduce symptoms, address underlying causes, and make the condition manageable (ibid). Treatment depends on the type of mental illness, its severity and what works best for the patient. In many cases, a combination of treatments works best (Mayo Clinic, 2019). Management of mental disorders can include: psychotherapy, medication and community support groups (SANE Australia, 2020b).

Psychotherapy: Psychotherapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist or other mental health professional (Mayo Clinic, 2016). There are several different types of psychotherapy which include: cognitive behavioural therapy (CBT), dialectical behaviour therapy, acceptance and commitment therapy, psychodynamic and psychoanalysis therapies, interpersonal psychotherapy, and supportive psychotherapy (ibid). Psychotherapy helps people with a mental disorder to understand the behaviours, emotions, and ideas that contribute to their illness and learn how to modify them (WebMD, 2020b).

> "*Problems helped by psychotherapy include difficulties in coping with daily life; the impact of trauma, medical illness or loss, like the death of loved one; and specific mental disorders, like depression or anxiety*" (American Psychiatric Association, 2019).

Medications: Psychiatric medication include all drugs which can be prescribed to treat different types of mental illnesses, or reduce the symptoms (Mind, 2016). Medication is often a key part for the treatment or management plan for people with mental illnesses, such as schizophrenia, psychosis, bipolar disorder, severe depression and/or anxiety (British Columbia Schizophrenia Society, 2018). Even though psychiatric medications do not cure mental illness as aforementioned, they often significantly improve symptoms or help you cope with them better (Mayo

Clinic, 2019). Psychiatric medications can also help make other treatment, such as psychotherapy, more effective (ibid). The four main categories of medications used to treat mental disorders, and these include: antidepressants, anti-anxiety medications, mood-stabilizing medications, antipsychotic medications; the type that is best will depend on the symptoms and other health issues the person may face (Holland, 2018).

Community support: Community support is any care or support you need to carry out daily tasks which you are finding difficult (Mind, 2017). Community support programs are especially important for the people with recurrent symptoms or who have a psychiatric disability (SANE Australia, 2020b). Having people, you can rely on when you need to talk or need help with something can help you through difficult situations that might feel insurmountable alone (Gilbert, 2019). This support may include help with managing money or improving relationships, transport to attend appointments or services, or assistance with benefits and housing applications accommodation, help with finding suitable work, training and education, psychosocial rehabilitation and mental support groups (Mind, 2017). Understanding and acceptance by the community is also very important.

2.1.11 The role of spiritual leaders and traditional healers in healing of mental illnesses

The WHO's Mental Health Action Plan 2013-2020 acknowledges the value of traditional medical systems and spiritual healing only subsidiarity qualifying them as 'informal' (Bouso and Aviles, 2020). The Mental Health Action Plan 2013-2020 states that:

> *"Greater collaboration with 'informal' mental health care providers, including families, as well as religious leaders, faith healers, traditional healers, school teachers, police officers and local non-governmental organizations, is also needed"* (WHO Mental Health Plan 2013-2020).

Mental disorders are often believed to be attributable to culturally accepted ideas and beliefs about divinity, witchcraft, medicine, disease and the influence of ancestral spirits, and social misconduct (Drury, 2020). These culturally specific beliefs have an impact on care-seeking behaviour and expectations about treatment outcome (ibid). Therefore, people rely on traditional healers for healing for mental illnesses. A study done by Dlamini & Shongwe (2019), revealed that relatives of some patients in Eswatini believe that the patient is demon-possessed and thus seek other alternatives (usually taditonal medicines) in the process disregarding all prescriptions and instructions from health providers.

Surprisingly, in most parts of the Global South, traditional healers are more numerous than mental health workers, and they constitute the main health resources that local populations use and believe in (Bouso and Aviles, 2020). For example, Eswatini has only one psychiatric hospital serving the mental health needs of the entire 1.1 million population (Dlamini and Shongwe, 2019) and 0.08 psychiatrist per 100 000 population (WHO, 2018), while there are a lot of traditional healers and they are geographically placed all over the country, making it easier for people with mental illness to access their services. Kajawu (2017), adds that traditional medicine is more accessible and affordable than contemporary medicines. People with mental illnesses find it easier to accept and this can be seen as a solution for governments in low-and-middle income countries that are not able to provide other types of care (ibid).

Similarly,

> "*Healing is generally a central component of all religious systems and aims to restore health and wholeness and alleviating suffering*" (Dein, 2020).

As religion and spirituality often play a vital role in healing, people experiencing mental health concerns often turn first to a faith leader (Kajawu, 2017).

> "*From a public health perspective, faith community leaders are gatekeepers or first responders when individuals and families face mental health or substance use problems*" (Kajawu, 2017).

2.1.12 The right to mental health

Human rights are not only entitlements that have a legal and ethical force but also fundamental pillars of justice and civilization (Puras, 2019). Over the last two decades, mental health has become recognized as a critical component of the right to health and one that must be addresses for this right to be realized (Cogrove and Shaughnessy, 2020). The United Nations Human Rights Council which is responsible for the promotion and protection of all human rights around the globe, views physical and mental health as a central tenet of its work (Asambe, Gaba, and Yang, 2018).

> "*Mental health and wellbeing cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychological, political, economic and physical environment that enables individuals and populations to live a life of dignity, with enjoyment of their rights and in the equitable pursuit of their potential"* (Puras, 2019).

People living with mental health conditions are people, as people they deserve to be treated with dignity, and under the law they have rights and projections. Human rights to mental health are universal standards that protect and promote not only healthcare but the right to a standard of living that supports mental health and well-being (Marks, Verdeli, and Willis, 2019).

2.1.13 Perceptions on mental illness

Discrimination against people with mental illness is widespread. The stigma and discrimination associated with mental and psychosocial disabilities often marginalize people from their community, thereby affecting their ability to secure employment and livelihood, and exercise basic civil, political, social, economic and cultural rights (Marks, Verdeli, and Willis, 2019). While employment holds many benefits for people living with mental illnesses, stigma and discrimination act as significant barrier for them to get employment (Hampson, Watt, and Hicks, 2020). Similarly, the impacts of workplace stigma and discrimination on people with mental illness leads to work avoidance, reluctance to disclose mental health conditions to employers and reduced to longevity of employment (ibid). Access to adequate housing is another critical component of recovery in which people with mental illness may experience discrimination (Ponte, 2020a). Landlords may refuse to lease out their houses to people with illnesses. In prisons, inmates with mental illnesses experience discrimination and cruel treatment, including the use of confinement and restraint chairs (Petras, 2020).

The human rights violations in the mental health context remain significant throughout the world (Puras and Gooding, 2019). The prevalence of rights abuse cannot be explained by amere lack of resources (ibid). The fear and social exclusion that surrounds untreated mental illness can lead to different types of abuse and even torture, exploitation and humiliation that designate the person as "less of a human" (Marks, Verdeli, and Willis, 2019). Men, women, and children are chained or locked in confined spaces in 60 countries across Asia, Africa, Europe, The Middle East, and the Americas (Human Rights Watch, 2020).

Specific rights of persons with mental illnesses are violated as a result of lack of access to appropriate care, including psychosocial interventions, rehabilitation and essential medicines, because they are unavailable, infeasible, or unaffordable (Marks, Verdeli, and Willis, 2019).

> "*In 2017, community-based residential care facilities still remain sparse in low and middle-income countries (LMICs) while the average number of mental health inpatient beds is 1.9 per 100000 population. In contrast, in high-income countries, there are 25 residential care beds and 52.6 mental health inpatient beds per 100000 population. In terms of mental health workforce, there were 0.1 psychiatrists per 100000 in LMICs whereas 120 times more in high income countries*" (Mental Health Atlas, 2017).

2.1.14 Investing in mental health in Africa

The estimates of people receiving mental health care in sub-Saharan Africa is jarring; only 15 % of South Africans with mental health conditions receive treatment. In Ghana and Ethiopia the estimates are than 10% (Weobong, Lund, and Nonvignon, 2020). As the mental health gap continues to widen, significant investment is needed to increase access to care for the most vulnerable worldwide (Harvard Global Health Institute, 2020). Investment must be about more than just money if mental health services are to be made fit to address the challenges of the COVID-19 pandemic and post COVID-19 era and to become resilient against future public health crises (The Lancet, 2020). Investing in mental health today is not just the right thing to do; it will have multiple social and economic benefits, too (World Economic Forum, 2020). Addressing the large and growing burden of mental, neurological and substance use (MNS) disorders at the population level via scaled-up implementation of evidence-based treatment and prevention has been repeatedly called for over the past decade, and can be expected to place new resource demands on the health systems of low-and middle-income countries (LMICs) (Chisholm, Sweeny, Sheehan, Rasmusse, Smit, Cuijpers, and Saxena, 2016). Financing the budgetary implications of these extra claims on the health system is therefore a pressing policy concern for countries desiring to move towards universal health coverage for their populations in a manner that includes MNS disorders (Chisholm, Kangere, Kigozi, Mugisha, Muke, Olayiwola, Shidhaye, Thormicroft, and Lund, 2019).

2.1.15 Barriers to mental health care globally

Mental health treatment can make a huge difference in a person's life (NAMI Chicago, 2020). But many people who might benefit from mental health treatment are not taking part in it (ibid). While we hear a lot of reports about the lack of access to physical health care during this era of COVID-19, the situation is even worse when it comes to mental health care (Rodrigo, 2020). Mental health is not recognized as a human right, much less an

essential aspect of wellness, especially in countries with limited resources (ibid). While most people do not hesitate to seek medical attention when suffering from a physical illness, however for mental illnesses there are some barriers that prevent people with mental illnesses from accessing mental health care services (Valera Health, 2017). These barriers include:

a. **Lack of policy**

Mental health is often underfunded and there are not always options for mental health treatments available as part of primary care (Marchildon, 2020). There is a crisis of inaction on mental health (ibid). Comprehensive mental health policies and plans are needed to coordinate action and to ensure resources are available, especially in localities that need them most (Rodrigo, 2020). These reduce the inequalities and inequities in access to mental health care (ibid).

b. **Accessibility**

A large obstacle for people seeking mental health care is access to mental health providers, especially in underserved communities (Ringer, 2020). Many people seeking treatment struggle to find a provider that is relatively close and accepting new patients (Valera Health, 2017). Transportation issues can also make mental care less accessible (NAMI Chicago, 2020).

c. **The cost of mental health care**

Mental health care can be expensive, leaving many people unable to afford the cost of services (NAMI Chicago, 2020). In countries with mental health care professionals available, many people still struggle to access treatment due to its cost (Marchildon, 2020). Not all health insurance plans cover mental health care services, and psychiatric treatment and medications are too expensive for some to cover out-of-pocket (Rodrigo, 2020). Even with financial assistance, mental health treatment can be expensive, if a diagnosis necessitates therapy or medication, for instance, the fees can really add up (Marchildon, 2020).

d. **Stigma towards people with mental illness**

People sometimes avoid seeking help for mental illness for fear of being stigmatized and discriminated against (Marchildon, 2020). Some people may blame the individual who has a mental disorder, seeing it as a lack of self-control, mental weakness, or being plain weird (Rodrigo, 2020). Even when they a sense that seeking treatment could help them, they suffer in silence (Goff, 2020). People suffering from mental illnesses are often seen as unpredictable, different, weak, “crazy”, or even dangerous (Valera Health, 2017). In some cases, misconceptions around mental health disorders make this concern even worse (Marchildon, 2020). Cultural stigma and shame can cause people to hide what they are going through from their communities, contributing to a lack of recognition of mental health issues (Ringer, 2020).

e. **Lack of understanding about mental illnesses**

While many do not seek help because of social stigmas surrounding mental health, others do not understand or accept that they are experiencing a treatable health condition to begin with (Valera Health, 2017). People often dismiss their depression as "feeling down and lazy" and anxiety as simply "being over-worried". Here there is a lack of understanding of what mental illness is and the importance of getting treatment (Rodrigo, 2020). Yet these feelings of over-worried may be cases of clinical conditions (Valera Health, 2017). Many believe it is something that will go away or resolve on its own (Rodrigo, 2020).

2.1.16 Mental health promotion and the benefits of mental health promotion

Mental health promotion is the process of enhancing the capacity of individuals and communities to increase control over their lives and improve their mental health (Ontario Ministry of Health and Long-Term Care, 2018). Mental health promotion reinforces factors that contribute to health and resilience, while working to reduce or eliminate factors related to poor mental health (Kirmayer and Geoffroy, 2016). Addressing mental health and substance use disorders is an urgent matter, and expanded access to treatment is key (Miller, 2019). There is growing acknowledgement of the value of good mental wellbeing to individuals (National Health Services Scotland, 2016). It can contribute to heightened self-esteem, optimism and a sense of control and coherence (ibid). The benefits of promoting mental health and wellbeing extend to those not currently experiencing a mental illness, to those living with mental illness (Watson and McDonald, 2016). Thus, the benefit of mental health promotion should not be viewed as solely the prevention of mental illness with a subsequent reduction in mortality and morbidity (ibid). Ensuring equitable access within a value-based framework is needed to not only close existing treatment gaps but also to improve patient outcomes (Alegria, Nakash, and NeMoyer, 2018).

2.1.17 Community care for people with mental illnesses

Community- based mental health services are essential to mental health (Perera, 2020). An important aspect of recovery is rehabilitation and support from caregivers and the community in which they live (White Swan Foundation, 2016). Community is critical for us to thrive, especially for someone with mental illness who is already experiencing the common symptoms of loneliness and isolation (Gil19). Community care of the psychiatric patients improves their quality of life, reintegration, and vocational rehabilitation by providing early diagnostic, prevention, integrated care or complex support for those with multiple co-morbidities and additional disadvantages (Firuleasa, Popovici, Moldovan, Pintia, Teodorescu, Galaon, Scintee, Vladescu, Florescu, 2017). Community-based mental health care encompasses a wide variety of programs and services designed to meet local needs (Canadian Observatory on Homelessness, 2019). These programs are delivered primarily by community agencies and sometimes through hospitals or health clinics (ibid). One of the main aims of community mental is inclusion of mental healthcare into primary healthcare, to reach out to larger communities living in areas that do not have adequate medical facilities (White Swan Foundation, 2016). The dichotomy between hospital and community psychiatry is a cornerstone of mental health policy in countries around the world (Perera, 2020).

2.1.18 Eswatini mental health budget

The government of Eswatini fails to adequately fund the health sector, with only E2.8 billion directed towards health which is 11.5 % of the total expenditure for the year 2021 (Budget speech, 2021), this falls far below the government commitment to scale up health spending and meet the Abuja Declaration of 2000, which provides that 15% of all resources generated to be allocated to health (UNICEF-ESWATINI, 2018). Equally the mental health sector is inadequately funded, the National Psychiatric Referral Hospital which is the only psychiatric hospital in the country only receives a mere share of E37 million annually (National Psychiatric Referral Hospital, 2021). Worth noting is that of this E37 million 90% goes to salaries, paying overtime for staff, and transport, then the 10% is actually for the operation of the hospital, for example purchasing of stationery, furniture, and all others (ibid).

2.2 Internationals conventions on the right to mental health

2.2.1 Convention on the rights of people with disabilities (CRPD) of 2006

This Convention endorses the rights of persons with all types of disabilities (including mental disabilities) must enjoy all human rights and fundamental freedoms (CRPD of 2006). It clarifies and qualifies how all categories of human rights and fundamental freedoms apply to persons with disabilities and identifies areas where adaptations have been made for persons with disabilities to effectively exercise their rights and areas where their rights and areas where their rights have been violated, and where protection of rights must be reinforced (CRPD of 2006).

2.2.2 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979

Article 11 safeguards women's right to protection of health and safety in working conditions (CEDAW of 1979). Under Article 12,

> "*States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning*" (CEDAW of 1979).

2.2.3 International Covenant on Economic, Social and Cultural Rights of 1966

The Covenant requires State Parties to guarantee that the rights enshrined in this instrument will be exercised without discrimination of any kind as to race, colours, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status (International Covenant on Economic, Social and Cultural Rights of 1966). Article 12 states that:

> *"States Parties recognize that all persons have the right to the enjoyment of the highest attainable standard of physical and mental health"* (International Covenant on Economic, Social and Cultural Rights of 1966).

In order to achieve the full realization of this right,

"State Parties will, among other things, take steps to ensure the healthy development of children and young person without any discrimination for reasons of parentage or other conditions" (International Covenant on Economic, Social and Cultural Rights of 1966).

According to the Covenant,

"States Parties must take steps, individually and through international assistance and cooperation, to progressively achieve the full realization of the rights recognized in this Covenant including by adopting legislative measures" (International Covenant on Economic, Social and Cultural Rights of 1966).

2.2.4 Universal Declaration of Human Rights (UDHR) of 1948

The declaration states *"all people are free and equal in rights and dignity"* (UDHR of 1948). This all-encompassing provision implies that people with mental disabilities also entitled to enjoy their basic human rights and entitles everyone to all rights and freedoms set forth in the Declaration, without distinction of any kind such as race, colour, sex language, religion, political or other opinion, national or social origin, property, birth or other status (emphasis of this research) (UDHR of 1948). It also states that "*no distinction shall be made based on a person's political, jurisdictional, or international status or the country or territory to which the person belongs, regardless of whether it is independent, trust, non-self-governing, or under any other sovereignty limitation*" (UDHR of 1948). Article 7, states "that all persons are equal before the law and are entitled to equal protection of the law without any discrimination" (UDHR of 1948). Article 19 safeguards *the "right to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers"* (UDHR of 1948. The Declaration also recognizes the *"right to work, to a free choice of employment, to just and favourable work conditions, to protection against unemployment and to medical care"* (UDHR of 19480). Article 5 protects every person from being subjected to torture or to cruel, inhuman, or degrading treatment or punishment (UDHR of 1948).

2.2.5 The Convention on the Rights of the Child (CRC) of 1989

Contains human rights provisions in regard to children. Article 23, recognizes the right of children who suffer from physical and mental disabilities to receive special care (CRC of 1989). The article also establishes measures that States Parties should take to guarantee the development of the child as an individual and ensure his or her participation in the community (CRC of 1989). Article 24 recognizes the

"*Right to the enjoyment of the highest attainable standard of health"* (CRC of 1989).

Article 25 recognizes the

"*Right to periodic review of treatment given to children placed in institutions for physical or mental health reasons*" (CRC of 1989).

Article 27 recognizes the

"Right of children to be protected from performing any work likely to be hazardous or to interfere with their education or to be harmful to their health or physical, mental, spiritual, moral or social development" (CRC of 1989).

2.2.6 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) of 1984

The provisions contained in this Convention protect persons with mental disabilities who are supposed to be under the protection of government officials (CAT of 1984). Under Article 2,

> *"States Parties agree to take effective legislative, administrative, in any territory under their jurisdiction"* (CAT of 1984).

Article 4 requires States Parties to:

"Ensure that all acts of torture are offenses under its criminal law" (CAT of 1984). Moreover, this article binds State Parties to make offenses punishable by appropriate penalties, which reflect their grave nature (CAT of 1984). This instrument postulates that:

> *"Each State Party shall take steps to prevent in any territory under its jurisdiction acts of cruel, inhuman or degrading treatment or punishment when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity"* (CAT of 1984).

These provisions are extremely important for the protection of mental and physical health in the context of public institutions.

2.2.7 Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health care of 1991

These principles are one of the most complete and detailed international standards for persons with mental health problems. They provide guidelines for setting up or evaluating national mental health systems and they offer an interpretation of general human rights norms in the mental health context (Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care of 1991). They state that:

> "*Persons with mental disabilities shall enjoy all the rights and fundamental contemplated in general human rights conventions*" (Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care of 1991).

Furthermore, it states that:

> *"the most important rights and freedoms for persons with mental disabilities are the right to medical care, the right to equal protection, the right to be cared for in the community, the right to provide informed consent before receiving any treatment, the right to privacy, the freedom of communication, the freedom of religion, the right to voluntary admission, and the right to judicial guarantees"* (Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care of 1991).

2.3 Regional instruments on mental health

2.3.1 The African (Banjul) Charter on Human and People's Rights of 1981

This is a legally binding document supervised by the African Commission on Human and People's Rights (African (Banjul) Charter on Human and People's Rights of 1981). The instrument contains a range of important articles on civil, political, economic, social and cultural rights. Clauses pertinent to people with mental disorders include Article 4, 5 and 16, which cover the right to life and the integrity of the person, the right to respect of dignity inherent in a human being, prohibition of all forms of exploitation and degradation (particularly slavery, slave trade, torture and cruel, inhuman or degrading punishment) and the treatment and the right of the aged and disabled to special measures of protection (African (Banjul) Charter on Human and People's Rights of 1981). It states that:

> *"The aged and disabled shall also have the right to special measures of protection in keeping with their physical or moral needs"* (African (Banjul) Charter on Human and People's Rights of 1981).

The Charter guarantees the right for all to enjoy the best attainable state of physical and mental health.

2.3.2 Southern African Development Community (SADC) Protocol on Health of 1998

Article 22 outlines that:

> *"in order to provide mental well-being, which is critical to sustained human and economic growth, state parties shall cooperate and assist one another with regard to: a) developing compatible legislation in respect of mental health; b) developing regional guidelines for training, and the integration of mental health services into primary health care;* c) *providing of proper treatment and care that respects the dignity and human rights of mentally ill persons; d) development of supportive community care services and facilities; e) cost-effective and culture specific mental health research"* (SADC Protocol on Health of 1998).

2.4 Local legislation on mental health

2.4.1 Constitution of the Kingdom of Swaziland of 2005

The constitution as the supreme law of the land and has a Bill of rights that include rights of people with mental illnesses. In section 18 (1) it states that:

> *"The dignity of every person is inviolable"* (Constitution of the Kingdom of Eswatini of 2005).

In section 18 (2) it continues to state that:

> *"A person shall not be subjected to torture or to human or degrading treatment or punishment"* (Constitution of the Kingdom of Swaziland of 2005.

In addition, Section 30 spells out the rights of persons with disabilities, subsection 1 states that:

> *"Persons with disabilities have a right to respect and human dignity and the Government and society shall take appropriate measures to ensure that those persons realise their full mental and physical potential"* (Constitution of the Kingdom of Swaziland of 2005).

2.4.2 National Disability Policy of 2013

The policy seeks to promote healthy lifestyles, prevention of diseases and disabilities, provision of care and rehabilitation for persons with disabilities (National Disability Policy of 2013). The policy under Section 4.9 on health it outlines strategies which are relevant to people with mental illnesses, and these are:

> c) *facilitate community awareness and community mobilization on health promotion to prevent disability*; d) *ensure provision of effective medical interventions for prevention, early detection, diagnosis and treatment of disability and disabling conditions, rehabilitation and necessary referrals and counselling for individuals who have disability and their family members;* f) *ensure access for health information for all persons with disabilities including the training of health workers in relevant communication skills such as Braille and sign language"* (National Disability Policy of 2013).

From the National Disability Policy of 2013, Section 4.10 on rehabilitation states that:

> *"Government will strengthen and extend comprehensive rehabilitation and rehabilitation services, which go beyond health services and include employment, education and social services"* (National Disability Policy of 2013).

It outlines strategies of promoting the rehabilitation of people with disabilities that include:

> *"h) Raise awareness on how to prevent the various forms of disabilities. Establish new centres in all regions and provide community-based rehabilitation programmes. There should be emphasis on early detection and early intervention, and necessary facilities will be created towards this end; I) Strengthen and capacitate the existing rehabilitation centres and have these facilities adequately regulated and monitored; j) government to develop formal relationships with the private sector on the establishment of rehabilitation centres and possible partnerships"* (National Disability Policy of 2013).

Finally, section 4.15 of the National Disability Policy of 2013 acknowledges that for a long-time mental illness has been treated as a taboo in the Swati culture. Therefore, it states that:

> *"Government will promote and support the full and meaningful participation of persons with disabilities in culture and cultural events at all levels"* (National Disability Policy of 2013).

The government will do these through the following strategies:

> "*a) promote research on effective ways of integrating persons with disabilities to make them self-reliant and have the appropriate human status and dignity; d) promote awareness campaign with a view to make society view persons with disabilities as whole beings who can contribute to the society*" (National Disability Policy of 2013).

2.4.3 Persons with disabilities Act of 2018

This act recognizes that the need to make mental health to be at equilibrium with physical health. Section 33 (1) states that:

"*Persons with disabilities have the right to the enjoyment of health on an equal basis with persons without disability" (*Persons with disabilities Act of 2018).

This act also raise the need for mental health care services, as such section 33 (3) it states that:

"*The government and private healthcare service providers shall make available essential health services to persons with disabilities which shall include the following- a) prevention of further occurrence of disabilities, immunization, nutrition, environmental protection and preservation and genetic counselling; and b) early detection of disabilities and timely intervention to arrest disabilities and treatment for rehabilitation*" (Persons with disabilities Act of 2018).

2.4.4 National Health Policy (2007-2015)

Mental health is often overlooked in Eswatini even in this health policy there is no single mention of mental health. Mental health does not form part of the key policy issues herein. As such section 1.3 states that:

"*The policy has been put together with intention of addressing the following key sectoral issues: A) Health service delivery and interventions; managerial performance, balance between curative, preventive and health promotive services, quality services, equitable distribution of services, coordination of sectoral activities, HIV/AIDS, Environmental health issues, decentralization of authority and decision making, referral system, supervision, monitoring and evaluation. B) Resources for Health; broadening the financing base for health services, coordinating donor activities and resource tracking, health and development, utilization of available resources, access to safe medicine and diagnostic technology, transparency and fairness in training, appointments and promotions*" (National Health Policy2007-2015).

2.5 Conclusion

This chapter on literature review focused on the most common mental disorders and it is evident from literature that depression is the most common mental disorder. The chapter also focused on the stigma and discrimination associated with mental disorders, and it is evident from literature that mental illnesses are associated with stigma worldwide. Furthermore, the chapter focused on how people with mental illnesses are denied their right to mental health and it is evident from literature that people with mental illness suffer a lot of discrimination, with their rights violated. The chapter also focused on suicide due to mental disorders and it evident from literature that most suicides related to psychiatric problems stem from depression. Moreover, the chapter focused on the integration of mental health care into primary health care, and it is evident from literature that psychiatric alone cannot meet the demand for care. The chapter gave an overview of the barriers that limit people from accessing mental health care, and it is evident from literature that lack of policy can actually be barriers that limit people with mental illnesses form accessing mental health care. The chapter further focused on investing on mental health, and it is clear that as the mental health gap widens as result of COVID-19 significant investment is needed to bridge the gap. This chapter also focused on mental health promotion and the benefits of mental health promotion and it is evident form literature that good mental health leads to improved self-esteem. The chapter

also covered the role of traditional healers and spiritual leaders in the healing for mental health, and it is evident form literature that traditional healers and spiritual leaders play a key role in the healing of mental illnesses as people often associate mental illnesses with witchcraft and beliefs about divinity. Lastly, it is evident from international and regional instruments that mental health is a human right.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

Chapter three focuses on the theoretical frameworks, which guided the study on mental health as a human right in Eswatini. This chapter outlines the Human Rights Based Approach, Functionalist perspective, and Social Constructionism Theory. All these approaches are important in conceptualizing mental health as a right, they provide basis for our understanding of mental health.

3.1.1 Human Rights Based Approach (HRBA)

> "*HRBA is a conceptual framework that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights*" (Mann, Bradley, and Sahakian, 2016).

An HRBA to health has long been seen as an important way in which to address public health needs in a manner that is equitable and conducive to social justice (Mahomed, Bhabha, Stein, and Puras, 2020). The HRBA aims to support better and more sustainable development outcomes by analysing and addressing the inequalities, discriminatory practices and unjust power relations which are often at the heart of development problems (WHO, 2017c). An HRBA to health specifically aims at realizing the right to health and other health-related human rights (ibid). In the context of mental health care, an HRBA means placing emphasis not only on avoiding human rights violations but making sure that human rights principles are at the centre of a service-providing organization (Mann, Bradley, and Sahakian, 2016). Health policy making and programming are to be guided by human rights

standards and principles and aim at developing capacity of duty bearers to meet their obligations and empowering rights-holders to effectively claim their health rights (WHO, 2017c).

The HRBA offers a lens or basis to look at the barriers that hinder people with mental illnesses from accessing mental health care services in Eswatini. With the HBRA the researcher was able to understand the social justcice and human rights violations experienced by people with mental illness in Eswatini. The HRBA also provided insight in promoting mental health and addressing the challnges faced by people with memtal illness. The HRBA offers an opportunity to answer the following questions:

1. Why are people reluctant to seek mental health services in Eswatini?
2. How do people in Eswatini perceive people with mental illnesses?

3.1.2 Functionalist Perspective

Functionalism is a framework for building theory that sees society as a complex system whose parts work together to promote solidarity and stability (LibreText, 2020). The functionalist perspective emphasizes that good health and effective medical care are essential for the smooth running of society (Lee, 2017). When members of society fall ill, they take on the 'sick role' (ibid). Taking on the sick role allows them exemption from obligations such as work, which would be considered disruptive to the functioning of society. Poor medical care is likewise dysfunctional for society, as people who are ill face greater difficultly in becoming healthy and people who are healthy are more likely to become ill (ibid).

The functionalist perspective offered a lens and basis to look at the importance of mental health and why it is important not to neglect mental health during the COVID-19 pandemic. As the functionalist perspective dictates that all systems in society are interconnected, this perspective was helpful in understanding the mental health gap and provided basis for advocating for the elevation of mental health into the same level as physical health. This perspective was also helpful and provided the basis of advocating for an improved investment on mental health in Eswatini. This perspective offers an opportunity to answer the following question:

How has the COVID-19 pandemic affected mental health care in Eswatini?

3.1.3 Social constructionism theory

Constructionism is a theory that posits that humans are meaning makers in their lives and essentially construct their own realities (Caddell, 2019). In constructionism theory, the meaning is not necessarily created by an individual but socially in relation to another (ibid). It posits an evolving set of meanings that emerge unendingly from the interactions between people. In constructionism, the reality is something that is created. Social constructionism theory says that humans create construct in order to make sense of the objective world (Bainbridge, 2020). One-way humans create social constructs is by structuring what they see and experience into categories (ibid). For example, they see people with different psychological behaviour and create the social

construct of mental illness. Social constructs can include values and beliefs that humans have about the construct (Bainbridge, 2020). Humans can alter the construct as they continue to interact.

The social constructionism theory offered a lens or basis to understand perceptions of mental illness and how people with mental illnesses are stigmatized and discriminated. Since the social constructionism theory postulate that mental illnesses are a social construct, and these constructs can change as people continue to interact, so this theory assisted in discussing how society can change the narrative on embracing people with mental illness instead of ostracizing them. This theory offers an opportunity to answer the following question:

How do people in Eswatini perceive people with mental illnesses?

3.2 Conclusion

This chapter focused on the theoretical frameworks that guided analysis of the research questions. The human rights-based approach to health specifically aims at realizing the right to health and other health-related human rights. Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty bearers to meet their obligations and empowering rights-holders to effectively claim their health rights. The chapter further focused on the functionalist perspective. Functionalist proposes that for society to function all parts must function. Similarly mental health is a key part that is required for society to function. Furthermore, the chapter focused on the social constructionism theory, this theory proposes that mental illness is a social construct that can be changed as people continue to interact.

CHAPTER FOUR

METHODOLOGY

4.1 Introduction

This chapter presents the research methodology relating to how the study was conducted. This chapter outlines qualitative research. It also outlines sampling, and provide a synopsis of non-probability sampling. This chapter

further explains data collection and data collection methods, while focusing on semi-structured interviews, telephonic interviews, and online survey. Furthermore, this chapter focuses on data analysis, it gives a synopsis of thematic analysis and interpretative phenomenological analysis. Lastly, the chapter presents the ethical considerations for this research.

4.2 Qualitative Research

Qualitative research is the process of collecting, analysing, and interpreting non-numerical data, such as language (Mclead, 2019). This type of research is based on scientific methods and provides empirical evidence requiring deep interpretation and critical thinking to generate creative knowledge about attitudes, opinions and behaviour (Mehrad, 2019). Approaches to qualitative research involve ethnography (racial or culture), grounded theory (how participants make sense of their social world), interpretative phenomenological analysis (observational facts of how participants make sense of their world), conversation analysis, narrative analysis (let participants narrate a story and collect data), content analysis (naturally occurring speech on social organization of conversation) and discourse analyses (understanding the language used) (Bhandari, 2020). Researchers use these approaches to express new creative ideas and innovative knowledge using various types of data collection methods such as semi-structured interviews, focus groups, observation and open-ended questions (Mehrad, 2019). The data that is collected by researchers can be used in micro, mezzo and macro levels to develop new insights and find solutions to social problems.

4.3 Sampling

Sampling is the process of selecting units (for example, people, organizations) from a population of interest so that by studying the sample we may fairly generalize our results back to the population from which they were chosen (Trochim, 2020). Studying the whole population of an area would be difficult and a waste of money, time and energy, unless of course the population is small (Alvi, 2016). The number of respondents for a sample is known as a sample size and it varies according to your study. Sample procedures mean how to select participants from a population to make a sample that is a representative of the population. Sampling procedures include, random sampling, probability sampling, stratified sampling and non-probability sampling to mention a few. The sampling procedure and size should be mentioned in the research design.

4.3.1 Sample Size

The target population were mental health professionals at the National Psychiatric Hospital in Manzini, because of their relevance to the objectives of the study; students at the University of Eswatini, to ascertain their views about the concept of mental illness, due to limited resources and the COVID-19 pandemic the researcher only focused on the Kwaluseni Campus only. However, social work students were excluded here because they would have replied from an academic perspective, yet the researcher just wanted to gather general views on the subject. Since, few students were allowed on campus at the university, the researcher selected students that he knew and familiar with, and asked them to participate in the study; the study also included community members of Motshane

area to ascertain their perceptions about mental health. Motshane community was chosen because it is of familiarity to the researcher as he is a community member himself, and also due to the COVID-19 restrictions. Children did not participate in this study due to consent protocols. Otherwise, this study was open to all community members who are competent enough to handle research questions; the Principal Secretary in the Ministry of Health was also included as the one responsible for the health system in Eswatini. The study had 80 participants, which consisted of: 13 mental health professionals from the National Psychiatric Hospital, since statistic from the WHO (2018), states there is a total of about 132 mental health professionals (both government and non-governement) in Eswatini, the study used a sample of 13 of mental health professionals at the National Psychiatric Hospital in Manzini; 40 students from the University of Eswatini, Kwaluseni Campus; 26 People from the community of Motshane; and 1 government official (PS) from the Ministry of Health and Social Welfare.

4.3.2 Non-Probability Sampling

Non-probability sampling is a sampling method where the odds of any member being selected for a sample cannot be calculated (Trochim, 2020). Non-probability sampling involves non-random selection based on convenience or other criteria allowing you to easily collect initial data (McCombes, 2020). Non-probability sampling is often associated with case study research design and qualitative research (Taherdoost, 2016). A major advantage of non-probability sampling is that-compared to probability sampling-it is much cost and time-effective (Trochim, 2020). Snowball sampling helped the researcher to collect data from mental health professional as the researcher already knows one mental health professional. Convenience sampling helped the researcher to select students from the University of Eswatini, Kwaluseni Campus as participants, due to limited time and resources. The researcher used heterogeneous sampling to select community members who will able to handle research questions.

4.4 Data Collection

Data collection is the process of gathering and measuring information from various sources such as books, periodicals, newspaper, records, and people in a way that enables you to answers to real questions, and to gain new insights that would not otherwise be immediately obvious-for example the accurate assessment of collected data can help you analyze current trends and even predict future trends (Lalehzari, 2020). Data collection focuses on finding out all there is to a particular subject matter (Formplus, 2019). Data is collected to derive findings, theories and results. There are two types of data, primary and secondary data. Primary data, also known as raw data, is the data you collect yourself and are the first person to interpret (Ndukwu, 2020). This could be in-person interviews, questionnaires, sent out to participants (ibid). However, in a time of unprecedented change and disruption due to COVID-19, data collection is being forced to transition from face-to-face data collection to some other methods of data collection such as phone or internet based. Therefore, this study used semi-structured interviews, telephonic interviews, online focus groups and online surveys. On the other hand, secondary data is data that has already been collected through primary sources and made readily available for researchers to use for their own research, and use it to carry out new research (Formplus, 2020).

4.4.1 Semi-structured Interviews

According to Doyle (2020), a semi-structured interview is a meeting in which the interviewer does not strictly follow a formalized list of questions. Instead, they will ask more open-ended questions, allowing for a discussion with the interviewee rather than a straightforward question and answer format (ibid). The major advantage with using semi-structured interviews is that the interviewer can prepare questions ahead of time, this allows the interviewer to be prepared and appear competent during the interview (Keller and Conradin, 2019). Semi-structured inyterviews allow for the comparison of participants, while also providing an opportunity to spotaneously explore topics relevant to that particular participant (Pollock, 2019). With online semi interviews it is important that the researcher starts by establishing good rapport with the participants to have an interview that generates meaningful and useful data (Balushi, 2018).

> "*Regarding ethical considerations, when conducting interviews, it is crucial to try to reassure the interviewee at the start about your purpose and about confidentiality*" (Balushi, 2018).

4.4.2 Online Survey

Online surveys facilitate affordable and often quite easy access to large geographically dispersed populations, something rarely possible in student, unfunded, or time-limited research (Braun, Clarke, and Gray, 2017). Due to the COVID-19 regulations the researcher resorted to online surveys to gather views of students and community members. Open-ended questions are presented to participants in written format via email or within an online survey tool, often along qualitative survey questions on the same topic (Deakin University, 2020).

> "*Researchers may provide some contextualising information or key definitions to help frame how participants view the survey questions, since they cannot ask the researcher in real time*" (Deakin University, 2020).

A key advantage of online surveys is openness and flexibility to address a wide range of research questions of interest to social researchers, as the method allows access to data that range in focus from people's view, experiences, or material practices, through to representational or meaning-making practices (Braun, Clarke, Boulton, Davey, and McEvoy, 2020). When it comes to student research, online surveys can open up research possibilities, because there is no direct interact with participants, there are likely fewer ethical concerns around inexperienced researchers addressing sensitive topic (Braun and Clarke, 2020). Online surveys can collect a greater number of responses in a set period of time, so while data may be less detailed, there is more of it overall to compensate (Deakin University, 2020).

In order to collect data on people's perceptions about mental health this study used *the Community Attitudes towards Mental Illness scale* (CAMI), and the *Reported and Intended behaviour scale* (RIBS). CAMI was designed by Canadian researchers Taylor and Dear in 1981 (Abi Doumit, Haddad, Sacre, Salameh, Akel, Obeid, Akiki, Mattar, Hilal, Hallit, and Soufia, 2019). CAMI contains 40 claims about mental illness that are related on a five-degree Likert-scale (from strongly agree to strongly disagree) (Community Attitudes to Mental Illness'

Scale, 2017a). Since the 80s the CAMI scale has been in continuous use, applied in many settings worldwide (Community Attitudes to Mental Illness' Scale, 2017b). On the other hand, RIBS is a measure of mental health stigma related behaviour, which can be used with the general public and is feasible to use with large population (Evans-Lacko, Rose, Little, Flash, Rhydderch, Henderson, and Thornocroft, 2011).

4.5 Data Analysis

In simple words, data analysis is the process of collecting and organizing data in order to draw helpful conclusions from it. Data analysis is how researchers go from a mass of data to meaningful insights (Bhatia, 2018). There are many different data analysis methods depending on the type of research. In qualitative analysis the data obtained consists of words, pictures, symbols and observations (Perez, 2019). This type of analysis refers to the procedures and processes that are utilized for the analysis for the analysis of data to provide some level of understanding, explanation or interpretation (ibid). For qualitative research some of the most common used methods are: content analysis, narrative analysis, grounded theory, and thematic analysis (Bhandari, 2020).

4.5.1 Thematic Analysis

According to Brule (2020) thematic analysis is an approach to analysing qualitative data to answer broad or narrow research questions about people's experiences, views and perceptions, and representations of a given phenomenon. For this study the researcher used thematic analysis to make sense of the data. Thematic analysis is usually applied to a set of texts, such as interview transcripts (Caulfied, 2020). The researcher closely examines the data to identify common themes-topics, ideas and patterns of meaning that come up repeatedly (ibid). Thematic analysis is theoretically flexible: it can be guided by concepts from a variety of fields, as well as being used in a variety of research approaches (Brule, 2020). The result of the analysis is a theme explaining people's experiences, perceptions, views or representations of a given topic (Mortensen, 2020).

4.6 Ethical Considerations

Research ethics are moral principle that guide researchers to conduct and report research without deception (Lee, 2020). Ethical considerations are vital because they promote the aims of the research, such as knowledge, truth, and avoidance or error (Resnik, 2020). Moreover, they ensure that researchers are held accountable (ibid). The researcher seek permission to undertake the study from the Research Ethics Committee, University of Eswatini, Kwaluseni Campus. The Eswatini Health and Human Research Review Board gave a go ahead for this study.

Participation to this study was voluntary. Participants did not feel coerced, threatened or bribed into participation (Cherry, 2020b). At the start of the study, a paper explaining the research project was provided to each participant. For online data collection, consent forms were emailed to the participants, and request that the participant reply to the message as an expression of consent (Lobe, 2017). The paper contained information about the research including title, rationale, aims, research design, and methodology, procedure participants likely to undergo during research, estimated duration likely to be spent in research, any incentives provided for participation. Every chance should be provided to the research participants to be fully informed about the research process and the options for

voluntary participation and withdrawal at any time (Khanal and Maharjan, 2018). All information was explained in language that is understandable by the participants. Two copies of consent forms were signed by the participant and the researcher, and one copy will be given to the participants.

The researcher respected and upheld the principle of confidentiality. Confidentiality refers to researcher's responsibility of not disclosing information learned during research to anyone without the participant's permission (Jain, Kuppili, Pattanayak, and Sagar, 2017). The researcher then established trust with the participants by explaining about confidentiality of information gathered during interview. Consent for legal obligations regarding privilege communications was obtained beforehand. Privacy was always maintained while gathering information from the participants, interviews in front of others including relatives will avoided. The participants' records were fully secured and did not lie unguarded where they could be accessed by persons other than the researcher. Data was kept safe on One Drive cloud storage. Data was deleted after the researcher has processed and made a report.

4.7 Conclusion

This chapter focused on the research design and research methodology. The research method for this study is qualitative research. The chapter outlined that nonprobability sampling method was used, and under this method snowball samples and heterogeneous samples were used. Furthermore, this chapter focused on data collection, of which the COVID-19 restrictions and uncertainty resulting from the pandemic were factored in. Data collection methods that were used are semi-structured interviews, telephone interviews, focus group, and online focus group. Lastly, the chapter outlined the ethical issues considered in the study, participants' informed consent was respected

CHAPTER FIVE

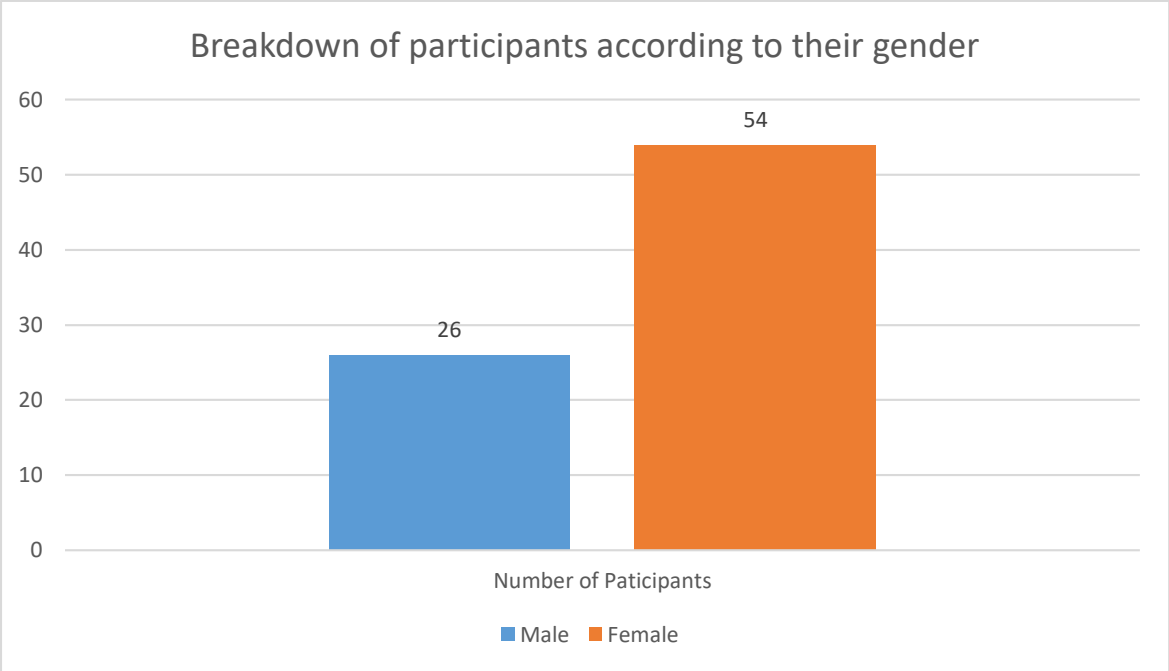
DATA ANALYSIS

5.1 Introduction

Chapter Five presents the findings and analysis from the research on mental health as a human right in Eswatini. Internet survey and face-to-face interviews were the main methods of collecting primary data and from international treaties, legislation and programme documents, literature, journals articles, books, and newspaper articles provided secondary data for the study. Thirteen (13) in-depth interviews were conducted with mental health professionals at the National Psychiatric Referral Hospital in Manzini. Mental health professionals who participated in the study included: psychiatrists, social worker, psychologist, occupational therapists, and psychiatric nurses. An online survey was also successfully administered, with 40 students from the University of Eswatini, Kwaluseni Campus participating in the study. There were also 26 people from the community of Motshane who participated in the online survey. An interview was done with the Principal Secretary of the Ministry of Health and Social Welfare. All in all, the study had 80 participants, 26 males and 54 females.

Figure 1Bar graph presenting participants' gender

Source: Research (2021)



The chapter highlights: people's perceptions towards mental illness, people's behaviour in seeking treatment for mental illnesses, accessing mental health care services from the National Psychiatric Referral Hospital, challenges experienced by mental health professionals at the National Psychiatric Referral Hospital, and mental health during the COVID-19 pandemic.

In analysing the research findings, the Human Rights Based Approach enabled the researcher to address the following questions:

1. Why are people reluctant to seek mental health services in Eswatini?
2. How do people in Eswatini perceive people with mental illnesses?

The Functionalist Perspective helped in answering the following question:

3. How has the COVID-19 pandemic affected mental health care in Eswatini??

The Social Constructionism Theory was used to explain the perceptions towards mental illness.

4. How do people in Eswatini perceive people with mental illnesses?

Themes that emerged from the responses were reviewed in terms of the guidelines to the Human Rights Based Approach, Functionalist Perspective, and Social Constructionism Theory were that of: importance of mental health, stigma, culture and society, treatment of mental illnesses, lack of resources, poor education on mental health, and mental health during the COVID-19 pandemic.

5.2 Importance of mental health

Mental health is as important as general health.

"*Emotional and mental health is important because it is a vital part of our life and impacts our thoughts, behaviours and emotions*" (Xiong, 2018).

Therefore, mental health is integral to living a healthy life. In alignment with the *holistic health approach,* which puts so much emphasis on caring for the whole person, providing for your physical, mental, spiritual, and social needs (Holland, 2018). Respondents seemed to have a clear meaning of mental health and identify it as a fundamental aspect of our life. The following responses support these views:

"*Basically when you are in tune with your mental health state generally you will be a healthy person in all aspects. With the definition of* ***health****, which clearly states that it is not merely the absence of disease, that means you may not have any disease, but if you are not good mentally you may not be able to function. Therefore, mental health is key for people to fucntion at 100%"* (Interviewee 2: female).

Similar sentiments shared by other participants were as follows:

"*Like you said before there is no health without mental health…to me as a therapist if you mental state is not okay, all other things become affected. So ideally you start with your mental health, before you can address all other things*" (Interviwee 6: female).

Another participant alludes that mental health is essential for keeping us at work. From the following response one can correlate mental health with work productivity, without mental health workers cannot be completely fit for work. In total agreement with this view, Article 22 of the SADC Protocol on Health of 1998 outlines that:

"in order to provide mental well-being, which is critical to sustained human and economic growth, state parties shall cooperate and assist one another with regard to: a) developing compatible legislation in respect of mental health; b) developing regional guidelines for training, and the integration of mental health services into primary health care; c) *providing of proper treatment and care that respects the dignity and human rights of mentally ill persons; d) development of supportive community care services and facilities; e) cost-effective and culture specific mental health research"* (SADC Protocol on Health of 1998).

"*It is complete health, it is that basic. It means fit for work, and fit for everything*" (Interviewee 3: female).

In support of the above sentiment, the Functionalist Perspective sees society as a complex system whose parts work together to promote solidarity and stability (LibreText, 2020). It therefore, emphasizes that good health and effective medical care are essential for the smooth running of society (Lee, 2017). On another note, mental health is of grave importance, because is it inter-linked with all other aspects of life. Eswatini as a country that is on a journey to grow its economy and move out of third world status, mental health should not be ignored as it vital to functioning of society.

Another respondent highlighted human rights issues on mental health. He shared the following view:

"*It must be a legal right for everyone, because some family members cannot afford to take care for their relatives*" (Interviewee 1: male).

The above sentiment is in line with the aim of this study which is to advocate for mental health to be seen as a human right in Eswatini. By equating mental health to be a human right, it amplifies the importance of mental health. Mental health care services should be made accessible and affordable for everyone to get mental health care treatment.

5.3 Stigma

Ostracizing people with mental illnesses

Figure 2: A picture showing how people with mental illnesses are stigmatized. Courtesy of Katie Gerten

Source: Gerten (2017).

Mental illness carries so much stigma in Eswatini, people view mental illness in a negative way. Mental illness in Eswatini is viewed as burden, and the general public is not receptive towards people who are suffering from mental illnesses. While the HBRA aims to support better and more sustainable development outcomes by analysing and addressing the inequalities, discriminatory practices and unjust power relations which are often at the heart of development problems (WHO, 2017c), people with mental illnesses experience a lot of social injustices in Eswatini. They are often discriminated, marginalized, and labelled as 'crazy'. The following responses support this view:

> "*When the general public speak about someone with mental illness… they think someone who is crazy, has no value in society, cannnot amount to anything. So basically they are taken as people who are not important, to such an extent that I feel that they are not involved in decision making on things that will directly affect them,because we consider them as incapable*" (Interviewee 10: female).

Generally people with mental illness are not so welcomed and often sidelined by society, we view them as different and not 'normal' and these were the views:

> "*People with mental illnesses are stigmatized and discriminated…in a way that when you have a mental illness you are not part of the society*" (Interviewee 12: male).

Similar sentiments shared by another participant were as follows:

> "*They do not trust them, they do not love them, they do not support them…they think they are bewitched*" (Intervieewee 3: female).

Partly some of these stigma lies in the way we feel about people with mental illnesses. Some participants in the survey indicated that they pity people with mental illnesses, worth noting is that some mental health professionals also pity those with mental illnesses, which is a cause for concern. The following sentiments were shared:

> "*It's an unfortunate situation because mostly they are discriminated at home and everywhere they go so it is a pity*" (Interviewee 8: female).

Similar sentiments shared by another participant were as follows:

> "*I feel pity for them because living with a mental illness is very difficult, it denies you a lot of rights to employment, if you have a mental illness employers do not want to employ you, because they do not know when you will relapse…they do not trust you*" (Interview: male).

Employers who refuse to employ or give employees with mental health illness time to get the necessary mental health care services, are in fact perpetuators of stigma themselves. The UDHR of 1948 recognizes the right:

> *"To work, to a free choice of employment, to just and favourable work conditions, to protection against unemployment and to medical care" (*UDHR, 1948*).*

Therefore, it is imperative that we do not pity people with mental illness, because this leads to doubt which in turn can result in lack of economic opportunities for them.

The stigma on mental illness also extends to mental health professionals, they are also discriminated for working at the National Psychiatric Referral Hospital. The following views support this view:

> "*Even us here when you tell people you work at the National Psychiatric Hospital, they tell you ow…you work you work where they are crazy people (etinhlanyeni)"* (Interviewee 11: male).

Similar sentiments shared were as follows:

> "*When people see me, they think I work at the nearby RFM Hospital, but when I correct them and tell them I work at the National Referral Hospital they become surprised and ask me how do I manage to work here, so there is still stigma*" (Interviewee 2: female).

Some mental health care workers also stigmatize people with mental illnesses. The following sentiments support this view:

> "*The stigma is very high, we have stigma even among mental health care workers, and some of them still stigmatize people with mental illness. We still have a long way to go*" (Interviewee 6: female).

5.4 Culture and society

In Eswatini mental health is still seen as a taboo. Mainly people's views and perceptions on mental illness are influenced by culture and society. In the Swati culture people with mental illnesses are said to be bewitched. Society thinks of mental illness as the worst-case scenario and label people with mental illnesses as 'crazy' (bayahlanya). The Social Constructionism Theory suggest that humans are meaning makers in their lives and

essentially construct their own realities (Caddell, 2019). Therefore, these labels that society give to people with mental illnesses become a reality for those living with mental illnesses. They accept these labels and see themselves as 'crazy'. Furthermore, the Social Constructionism Theory posits that these social constructs can include values and beliefs that humans have about the construct (Bainbridge, 2020). In essence the Swati culture view mental illness as being bewitched and taboo, this is because of the beliefs and value placed on mental health. The following shared views support these views:

> "*Values and beliefs that they grow up with, and the people they associate with, influence the way view mental health. If you grew up in a home that is traditional that believes that each time you are sick you have been bewitched, so generally you might have a mental illness and think its bewitchment…but when you stay with people who are enlightened, then you will know that when you have a problem and it does not meet any other criteria of sickness then it is a mental illness*" (Interviewee 2: female).

Similar sentiments shared were as follows:

> "*It is society at large; they do not take them serious… when you have a mental illness, they see you as someone who cannot contribute anything in the community*" (Interviewee 12: female).

Another respondent highlighted that culturally we abuse people with mental illnesses for their labour because we view them as worthless. Yet,

> *"All people are free and equal in rights and dignity*" (UDHR, 1948).

In addition, this is also in contrary with the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care of 1991, which puts it clear that:

> "*Persons with mental disabilities shall enjoy all the rights and fundamental contemplated in general human rights conventions*" (Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care of 1991).

Therefore, the HBRA would come in and call not only for the promotion of mental health care services for those suffering from mental illnesses, but also ensure that human rights are not violated. In this instance social justice need to prevail. He following views support these views:

> "*In the Swazi culture especially in the rural areas you find that person being used, you find that person doing all have chores…he fetches water, he comes backs he makes fire or even some cook, just because he is mentally ill, they see him as someone who cannot consent for anything and then they use that person*" (Interviewee 5: male).

5.5 Mental health treatment

Mental health care services are vital in the management of mental illnesses. Mental health care services must be widely available and accessible by all people. However, in Eswatini mental health care services are minimal, there is only one psychiatric hospital, which is situated in Manzini making it difficult for Swazis to access services

offered there. This is in contempt of section 4.9 of National Disability Policy of 2013 on health it outlines strategies which are relevant to people with mental illnesses, and these are:

> "*Ensure provision of effective medical interventions for prevention, early detection, diagnosis and treatment of disability and disabling conditions, rehabilitation and necessary referrals and counselling for individuals who have disability and their family members"* (National Disability Policy of 2013).

Similarly, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care of 1991, pronounces the right to medical care as one of the most important rights and freedoms for persons with mental disabilities. Furthermore, the HBRA emphasizes on the realization of right to health however, in Eswatini people are denied their rights to mental health care as a key aspect of health, because many people have to travel long distances to receive mental health care services since there is only one psychiatric hospital in the country. Some people do not have enough resources to reach mental health care services, so they suffer without getting any help.

Even though there are some other places where people can seek treatment or help for mental illnesses, these places offer limited services. They offer mostly counselling, and because they are private institutions most some people cannot afford seeking services from them. The government has tried to make mental health units within its major hospitals, for example, there is one at the Mbabane Government Hospital, Pigg's Peak Government Hospital, and Good Sheppard Hospital to mention a few. While this could be seen as a manifestation of Article 22b of the SADC Protocol on Health of 1998 which points out to the integration of mental health into primary health care. However, these mental health units also do not offer advanced mental health care services. They are more or less the same as distributors of mental health care medications that is where people refill their mental health care medications after being discharged at National Psychiatric Referral Hospital. The government is simply trying to bring mental health care medications closer to people. Participants shared the following views:

> "*There is none, but what the government has done is to try and make a small portion of mental health in all the hospitals…So there are other mental health services in other hospitals, but there no psychiatrists there, there are no doctors there. So, it is only those who are fit and who are doing well with the treatment, those ones can get their treatment from the nearest facility…but when it comes to complications, when the person needs a psychiatrist, he is not well, it is a challenge. The psychiatrists are only in this hospital, the nurses there are just psychiatric nurses they just refill the medication for you, but when you need more attention, you need to come here*" (Interviewee 3: female).

> "*Unfortunately, we are the only institution that specializes on mental health, but other facilities have mental health nurses that are put in place so that they can see the people, but if they need for a psychiatrist they need to come here*" (Interviewee 10: female).

There are also few mental health professionals in Eswatini which affects the promotion of mental health. As such some of the doctors and nurses who offer mental health care services especially in private institutions are not

qualified mental health professionals, they just have an interest in psychiatry and mental health. The following shared view supports this view:

> "*Well, none…but generally private Hospitals, well they do not have psychiatrists but they do have doctors who have interest in mental health…We have one in Mbabane Clinic, well we also used to have one at Mkhiwa Clinic. There are also psychologists who practice privately in which one could go to, but if the psychologists see that you need medication, they refer you to us. Even those doctors who have interest in mental health, they do refer some patients to the National Psychiatric Hospital*" (Interviewee 2: female).

Even though there is only one psychiatric hospital in Eswatini, people still go there to seek mental health care services. With most respondents bringing it out that the numbers of people who come seek treatment for mental illnesses at the National Psychiatric Referral Hospital have actually increased in the last five years. From the Functionalist Perspective point of view, people are beginning to see and feel the importance of mental health for the functioning of our lives and society. The following shared views support these views:

> "*In my observation they do, the number of patients that we get now is actually larger than three years ago. I think people are getting the right information now*" (Interviewee 10: female).

From the data it emerges that most people who voluntarily seek for mental health care services from the National Psychiatric Referral Hospital, actually seek help for counselling related issues. Again, it transpires that the youth is the most active in seeking help for mental health problems. The following shared views support these views:

> "*Yes, they do, I can say that in my years working here I have noticed an increase, especially the youth, they are more coming now for services. However, mostly they come for issues related to counselling*" (Interviewee 9: male).

> "*Yes, they do come, they usually go to the OT where they do counselling, but they are a few, because statistics still has it that many people are committing suicide due to depression*" (Interviewee 5: male).

While most people are open to the idea of seeking mental health care services from a mental health facility, but there is still reluctance in seeking treatment for mental illnesses. Many people would prefer to suffer in silence than seek help for mental illnesses. Mental illness in Eswatini carries so much stigma such that being seen coming out of the National Psychiatric Hospital you will be labelled as "crazy" (uyahlanya). Even in communities when they hear that a person is taking psychiatric medication, they start calling that person a "lunatic". Some people prefer seeking help for mental illnesses from religious leaders and traditional healers, as mental illnesses are believed to be a result of witchcraft and/or demonic possession. Even some of those who end up seeking for help from mental health facilities, they first seek help from their pastors and from traditional healers. As would the Social Constructionism Theory posit that mental illness is a social construct, society has also attached values and beliefs to mental illness, which in this case is associating mental illness with witchcraft and craziness. These

believes and perceptions that people have about mental illness actually affect their behaviour in seeking treatment for mental illnesses. The following shared views supports these views:

> "*Even if family members can notice that this person is having an abnormal behaviour, there would advise that lets take you to the Psychiatric Hospital, but this person will refuse and ask 'Hha'…because of the stigma that once I go there and start taking medication everyone will be pointing a finger at me and saying he is a lunatic (luyahlanya). So, there would rather stay at home and not come here. They always stay in denial of being mentally unstable, why because there is stigma, once I go to that hospital even entering the gate people think this one is a lunatic. Swazis most of them even if they can be diagnosed with a mental illness he would decide to stay away from the hospital or even home*" (Interviewee 1: male).

Similar views shared were as follows:

> "*It is the stigma and discrimination, because we have this green card that we give to our patients, once people see you with this green card, they start calling you "crazy" and start treating you differently, maybe even at work you can lose your job and also not get promotions that you deserve just because you have a mental illness*" (Interviewee 8: female).

> "*It does especially with people who are religious, they prefer going to their pastors for prayer instead of going to mental health care hospitals to seek help…yes some go to traditional healers and some prefer to stay that is why people with depression and up committing suicide, because there is that stigma*" (Interviewee 11: male).

There is also a need for the government to build a new psychiatric hospital which will be in line with its decentralization of services programme, since some people do not seek treatment for mental illnesses because they have to travel long distance to get help. The following shared view supports this view:

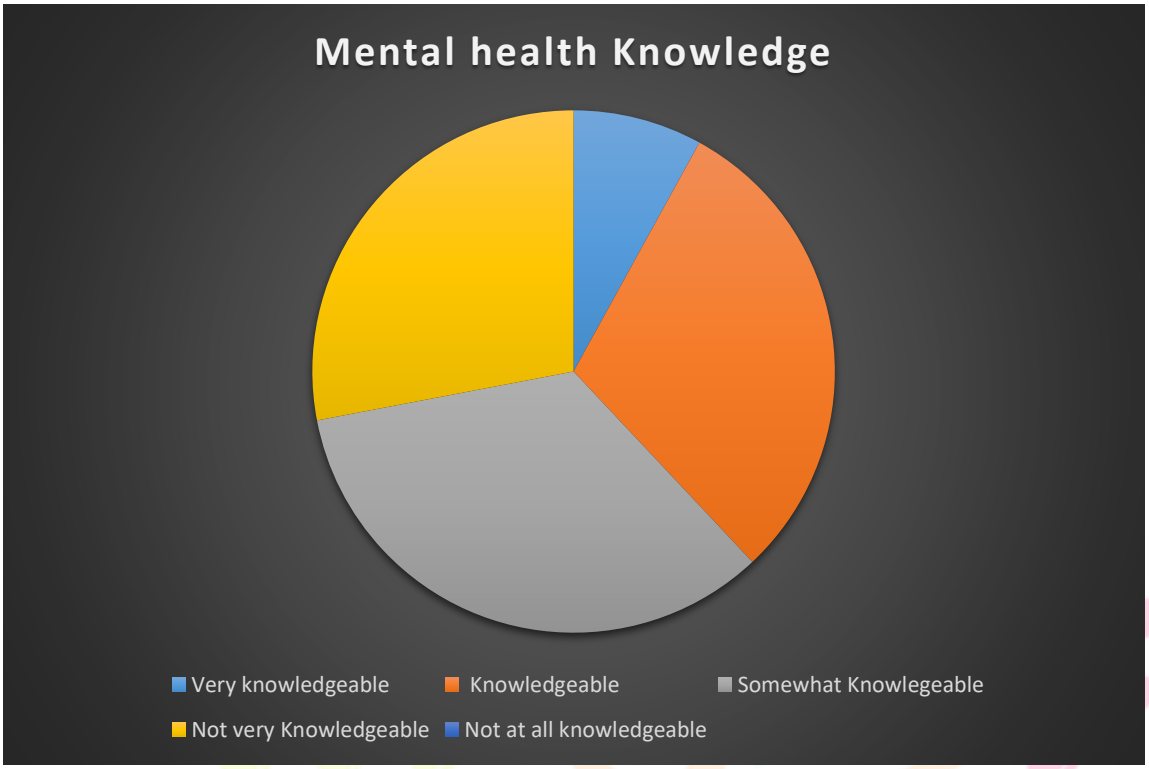
> "*I think for me, there is a need for such. There is a need for another facility or an extension of the existing facility*" (PS of the Ministry of Health and Social Welfare).

5.6 Lack of mental health awareness

While education helps people to understand more about mental health, in Eswatini there is poor education on mental health. Despite mental health playing a crucial role in the functioning of society as the Functionalist Perspective suggests, a lot of people are not so knowledgeable about mental health.

Figure 3: A pie chart illustrating participants' mental health knowledge

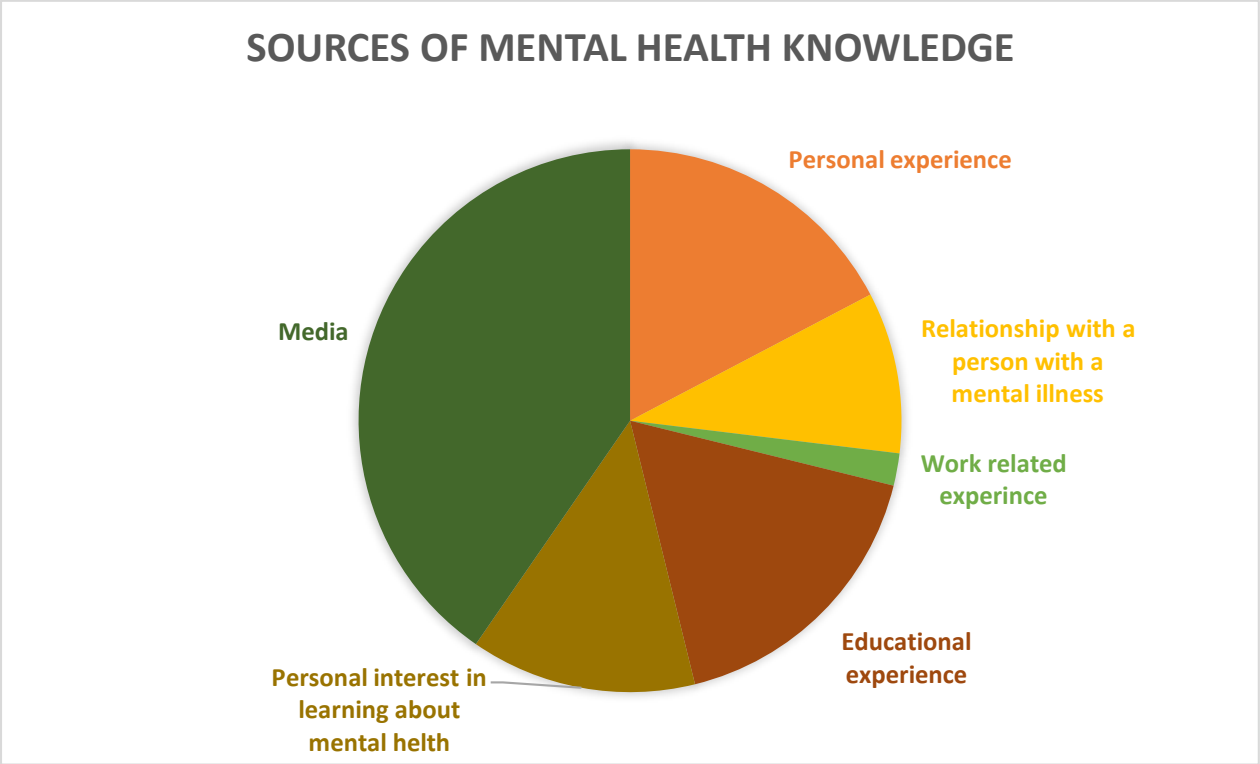
Source: Research (2021)



Those who seem to have knowledge on mental health, have gained it through tertiary or work-related education. Most of the participants gained their little knowledge on the mental health through the media.

Figure 4: A pie chart showing sources of mental health knowledge

Source: Research (2021)



It appears that in Eswatini depression and anxiety are the most popular mental illnesses. However, if one was to investigate further you would find that people actually, they do not even know what depression and anxiety are. A lot of people confuse depression and anxiety for stress-related mental illness, this is because for most people, the signs and symptoms that they stated were that of stress-related mental illness not of depression or anxiety. Education on mental health can also a pivotal role in fighting the stigma against mental illness. As the Social Constructionism Theory posits that the stigma on mental illness is a social construct that means it can also be deconstructed, in this case through mental health education.

Mental health awareness can also be fundamental in encouraging people to go and seek help for mental illnesses. In Eswatini some people suffer in silence because they do not know that they can get help for their mental health problems. They perceive the National Psychiatric Hospital as an institution for those who are "crazy" or those with extreme schizophrenia, yet even if you have minor depression or stress-related illness you can still get help. Even though, there is poor mental health awareness in the country credit must also be given to the National Psychiatric Referral Hospital for their efforts in raising awareness on mental health through their radio programme. However, there is need to penetrate social media, because that is where most people are and the fact that most people do not listen to the radio. Worse is that this mental health program is aired during the day when people are busy at work or at school, so there is very poor audience. The following shared views support the above views:

> "*Maybe it could be mental health education, teach people on the radio, in their communities. I think it could work to encourage people, because some people do not know about mental health, once you speak*

about mental health, they think you are speaking about someone who is "crazy" ...so I think education mostly" (Interviewee 8: female).

Similar sentiments shared were as follows:

"*In my view I'm saying we do not do education but they lack information and maybe they think if you want to learn something about mental health you will have to go to the hospital*" (Interviewee 5: male).

Moreover, there is also a general lacklustre attitude when it comes to mental health, there is no specific focus on mental health. There is not even a civil society advocacy for mental health. Well, there are one or two people talking about mental health, but there is a lack of effort in promoting mental health. The following sentiments support this view:

"*My view is we lack champions at policy level who will have mental health at heart, who will advocate for it and make sure that when it comes to policy development, you lobby for it and when it comes to funding for mental health programmes*" (PS of the Ministry of Health and Social Welfare).

5.7 Lack of resources

Despite mental health being essential as stipulated by the Functionalist Perspective, in Eswatini mental health is often neglected. The government under the Ministry of Health does not have mental health in its list of priorities. There is a huge gap in as far as mental health is concerned in Eswatini. The following sentiments support this view:

"*There is a gap, there is a huge gap I as far as policy is concerned within government. There is no specific policy for mental health. Yes, mental health as part of fundamentals of well-being it is a right for every human being, for every Liswati. Unfortunately, we as government, as this country we have not prioritized the policy aspect*" (PS of the Ministry of Health and Social Welfare).

<u>Bridging the gap between physical health and mental health in Eswatini</u>

Figure 5: A picture advancing the need to close the gap between mental health and physical health. Courtesy of Community Reach Center.

Sources: Community Reach Center (2019)

The picture above emphasizes the need to close down the existing gap between physical health and mental health in Eswatini. As there is sometimes a shortage of medications at the National Psychiatric Referral Hospital which causes relapse, as the government focus is on other health facilities, the National Psychiatric Hospital is the last to receive medical drugs from the government.

Likewise, the National Psychiatric Referral Hospital did not have a COVID-19 testing facility until recent, they had to liaise with other health facilities for COVID-19 testing. However, this is in contrary to the National Disability Policy of 2013 under section 4.9 D which stipulates that:

> "*Ensure provision of effective medical interventions for prevention, early detection, diagnosis and treatment of disability and disabling conditions, rehabilitation and necessary referrals and counselling for individuals who have disability and their family members"* (National Disability Policy of 2013).

The lack of resources for mental health also affects the delivery of mental health care services. While the National Psychiatric Referral Hospital offer a wide range of services, these services are still not enough as there are a lot of people that they are not able to reach. There is also lack of a rehabilitation unit for people with mental illnesses especially those related to substance abuse.

The lack of resources towards mental health can be partly attributed to the unavailability of mental health policies in Eswatini (Rodrigo, 2020). It has always been claimed that a mental health policy is on the cards. However, from the Social Constructionism Theory point of view the government of Eswatini has also fallen trap of the way society views mental illness. Society associates mental illnesses with witchcraft and demon possession, so the government becomes reluctant in providing resources towards mental health because it believes people should seek help from religious leaders and traditional healers, as it is a widely held belief in society.

There are also acute shortages of transport at the National Psychiatric Referral Hospital which often affects the delivery of services. As such the social worker's duty of making follow ups and patient transition to the

community has been greatly affected, as this require the practitioner to visit the community as he tries to reintegrate the patient to the community. Now the social worker relies heavily on telephone communication to engage families of people with mental illnesses who have been admitted at the hospital, rather than visiting their homes and communities. Outreach programs have been greatly affected since the van which was used for outreach programs broke down last year. The government does not feel any need to replace the car, despite having procured new vehicles for the police department and cars for cabinet ministers. This is because mental health in Eswatini is not perceived as important and key to the functioning of society as the Functionalist Perspective stipulate.

5.8 Mental health in the COVID-19 pandemic

As the COVID-19 pandemic continue to haunt the country, it has brought so much uncertainty in our lives. The COVID-19 pandemic has tremendously affected people's mental health. We are all anxious about what will happen in the future. People have lost jobs and relatives so there is so much grief. Relationships are breaking down as lockdown regulations a put in place, people cannot travel to see their loved ones, so stress levels are so high. Some people are locked down together which is something they are not used to, so conflicts are bound to happen which affects people's mental health. Some respondents even highlighted that they have observed an increase of people who come and seek for mental health care services during this dispensation of COVID-19.

Figure 6: A picture showing how our mental health has been affected during the COVID-19 pandemic. Courtesy of Dianova

Source: Dianova (2020)

The picture above presents some of the prevalent mental disorders during the COVID-19 pandemic. From the data depression and anxiety can be said to be the most prevalent mental illness during the COVID-19 pandemic. The following views support this view:

"*Mostly depression and anxiety are the most prevalent during this time of COVID-19*" (Interviewee 6: female).

Another participant said the following:

"*Mostly it is depression those we have seen because people have lost their relatives*" (Interviewee 8: female).

The COVID-19 pandemic has also affected the delivery of mental health care services in Eswatini. Mental health professionals at the National Psychiatric Referral Hospital now minimize ward visits because they fear their patients might be COVID-19 positive. Occupational therapists who work with children now face a challenge in engaging their clients, because when you work with a child you definitely need physical contact so he or she could feel the warmth and compassion.

Just like general health, mental health is still very much important even in this era of COVID-19. In fact, we need mental health more now than ever before. From the data all participants suggested that mental health is so essential in our fight against the effects of COVID-19. However, mental health has been neglected for the longest time in Eswatini, and worse now in the COVID-19 pandemic, this is because the government and donors do not value or see mental health as vital for the functioning of society as suggested by the Functionalist Perspective. All funding or focus has now been shifted towards COVID-19 (testing kits, vaccines, personal protective clothing), yet people need to be healthy mentally to be able to fight COVID-19, as most people turn to panic when they have tested positive for COVID-19. The following shared views support these views:

"*It is very important because for us to be able to do this…uhm we need to be in our healthiest state mentally*" (Interviewee 10: female).

Similar views shared were as follows:

"*Mental health is very important in this time in helping the person to cope, because in as much as we can try to say you will be fine okay, but the person has to cope alone at home. When you have lost a relative mental health helps the person to cope, its speeds the recovery, because in as much as we can try and give you pills, but if your mental state is not okay you are afraid, you are scared, recovery will be very hard. So mental health is important in helping people to recover; in helping people to recover; and not to be scared and be able to share information with others and not seek the wrong information, because people end up panicking*" (Interviewee 11: male).

Grief counselling is also very much important during this time of COVID-19 pandemic to help those who have lost their relatives accept their loss. One participant shared the following that supports this view:

"*It is very important because we give the support to those affected families and we do counselling to those children who have lost their parents or relatives. For me it is very important this mental health*" (Interviewee 1: male).

5.9 Conclusion

The persistent stigma and discrimination of mental illnesses is a clear indicator that it is a result of the way society has made meaning out of mental illness. Our views or perceptions on mental illnesses have an impact on how we go about seeking help for mental health problems. Mental health in Eswatini never enjoys parity with health because of the way mental illnesses have been perceived, hence the reason why we one mental health hospital, when the government has tried to decentralize all other services to the people in all four regions. Mental health still lags behind, government and donors have put so much money on HIV/AIDS and now COVID-19, but not mental health.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

There is no health without mental health. However, in Eswatini mental health does not enjoy parity with health in terms of resource allocations. Mental health is constantly looked down upon by the government and other development partners (donors). As such there a very poor allocation of resources towards mental health in Eswatini. Evidently, there is only one psychiatric hospital which is based in Manzini. The centralization of mental health services makes it difficult for people with mental illnesses to seek treatment or help. Added to this conundrum is the high stigma that exists towards mental health in the country. Mental health stigma is deep-rooted in Swati society, as such the Swati cultural values also support stigma towards people with mental illnesses. While education can be a lever to ending the stigma towards mental health, mental health education is still poor in Eswatini. Unlike HIV/AIDS, mental health is not mainstreamed into the education system of this country. A lot of people are not knowledgeable when it comes to mental health. As result, people suffer in silence because they do not know where they can get help for their problems. Worse the COVID-19 pandemic has even made this more awful. With the COVID-19 pandemic, our mental health has been stretched as we are uncertain about the future.

6.2 Summary of key conclusions from the study

a. Mental health stigma

From there study it emerged that stigma towards mental illness is high in Eswatini. Mental health stigma is perpetuated by cultural and religious beliefs. Culturally, mental illness is viewed as taboo and often associated with witchcraft. On the other hand, religiously mental illness is associated with demonic possession. As such the National Psychiatric Referral Hospital which is based in Manzini is often referred to as “etinhlanyeni” meaning a place of lunatics and crazy people. People in Eswatini think that when you have a mental illness you are ‘crazy’ or think of it in the worst-case scenario. The stigma is so strong such that even mental health professionals working

at the National Psychiatric Referral Hospital are often condemned for working with “crazy” people. Even when you come out of the gate at the National Psychiatric Referral Hospital, people start labelling you as “crazy”.

The stigma towards mental illness, affects those with mental illnesses heavily because they cannot seek help or treatment for their mental health problems. They fear being labelled and marginalized. So, these people end up not seeking any treatment, and they suffer in silence. Maybe one can also attribute these to the increasing suicide cases, people suffer psychologically and they do not get any help because they fear being labelled, so it escalates to a point where they then decide on committing suicide. Our perceptions as emaSwati towards mental health strongly are influenced by culture and religion. Evidently, this is seen in our behaviour patterns in seeking help for mental illnesses. People go and seek help from traditional healers and religious leaders. Which in most cases they do not get complete healing.

Mental health professionals indirectly fall trap of this stigma. They indicated to feeling pity for people who suffer from mental illnesses, they people with mental illnesses should not be pitied. Partly this is because of the way society has constructed mental illness, we view people with mental illness as weak and hopeless. All these perceptions influence how we interact with people with mental illnesses. From the data it emerges that some people would not want to be friends with people with mental illnesses. Furthermore, other people would not want to be neighbours with someone who has a mental illness. These shows that there is still a lot that needs to be done to break the stigma towards mental illness in Eswatini.

b. Mental health awareness

While education is vital in raising awareness on the importance of mental health, in Eswatini there is little effort put in raising awareness. Mental health is not mainstreamed in the education system, unlike HIV/AIDS which is taught from pre-school to tertiary. As a result, a lot of people in the country are not knowledgeable when it comes to mental health. From the data it emerges that those of whom are knowledgeable about mental health have gained that knowledge through career related knowledge or through personal interest on mental health. Most people have gained their little knowledge on the subject through the media. However, the major concern is that in the media mental health is not portrayed clearly. The media sometimes perpetuates negative perceptions about mental health, so relying on the media a medium mental health knowledge is not ideal. However, the media can be used to raise awareness, in fact social media is a very effective platform nowadays because most people are on social media.

c. Treatment for mental illnesses

Getting help when having a mental illness is of paramount importance. There are many treatment options that people with mental illnesses have. From the data it emerges that most people would opt to seek help from a mental health facility. Other people would seek help from traditional healers and religious leaders. Worth noting is that even those who end up seeking treatment at the National Psychiatric Referral Hospital, they first seek help from traditional healers and religious leaders. There are also those who would not seek for help at all. These people fear being labelled and stigmatized as mental illness is viewed in a negative way in Eswatini. All in all, our treatment options are influenced by our perception towards mental illness.

d. Mental health services

In Eswatini there are few mental health services. While other places offer mental health services, their services are minimal and often times have to do with counselling. They do not offer advance mental health services such as psychiatric medications. Even the services offered at the National Psychiatric Referral Hospital are not enough. There is no rehabilitation unit to help people with substance abuse related mental illness.

e. Factors making people reluctant from seeking mental health treatment

There are a lot of factors that hinders people suffering from mental illnesses from seeking treatment. The most prominent among these is stigma, as aforementioned mental illness in Eswatini is viewed in a negative way, so most people with mental illnesses prefer not to seek for help because they fear being labelled. Again, mental health services are not widely accessible, they are centralized. Rural areas have no mental health services. This is despite of the government's plan of decentralizing services, which is alignment of the Tinkhundla system. Though the government has made advances in decentralizing mental health services by creating mental health units within its major hospitals (Pigg's Peak Government Hospital, Good Sheppard Hospital, Mbabane Government Hospital, etc.). These units are stationed in towns not in the rural areas. A lot of people who are supposed to be benefiting from these services do not actually access these services because they are too far, so they do not have the means to get there.

f. Lack of resources towards mental health

Generally, there is a huge crisis within the health sector of Eswatini. The government is consistently failing to allocate adequate resources towards the health sector. This is in contempt of the Abuja Declaration of 2000, which provides that 15% of all resources generated to be allocated to health. Similarly, mental health endures very little or poor resources. This often leads to poor or ineffective treatment for mental illnesses, as there are sometimes shortages of drugs at the National Psychiatric Referral Hospital leading to relapses. The inadequate funding towards mental health also affects other mental health services such as outreach services. The National Psychiatric Referral Hospital's outreach program was halted by lack of resources, the vehicle that they were using for doing

outreach services broke down last year and it has not been fixed or replaced due to lack of resources. The inadequate resources towards mental health also contribute to the inability to completely decentralize mental health services, so that they can be widely accessible to everyone in the country.

g. Mental health and COVID-19

The COVID-19 pandemic has hugely affected people's mental health as we are uncertain about the future, anxiety and depression cases are on the raise during this era of COVID-19. Lockdowns, social distancing, and other COVID-19 regulations have all contributed to people not mentally stable during these difficult times. The COVID-19 pandemic has also affected mental health care services. Mental health professionals are not able to engage with their clients as they would have wanted to or as dictated by their professional standards. For example, at the National Psychiatric Referral Hospital, Occupational Therapists are no longer able to be in physical contact with children who are clients, yet when working with children you need to make contact. Even with psychiatric nurses, they now spend little time in the wards with patients because they fear that their patients might be COVID-19 positive, yet before they would spend more time in the wards engaging with the patients. Mental health during this time is of paramount importance because it also influences recovery from COVID-19. A lot of people who have tested positive for COVID-19 get into a panic mood often leading to fatalities.

6.3 The National Psychiatric Referral Hospital

The National Psychiatric Referral Hospital which is the only mental health hospital in Eswatini, is generally underfunded. The government sometimes fails to procure the necessary drugs for this institution. This affects the work of mental health professionals, who then have to improvise often leading to relapses. For example, a patient can be given a certain drug today and be told to come back after 30 days for review, when he or she comes back after those 30 days the drug that was prescribed or working for him or her is finished. So, the psychiatric nurses or doctors will have no other option that to prescribe a different or available drug which is not guaranteed to work for that patient. The works of this institution has also been limited by lack of resources, there is no rehabilitation unit for people with substance abuse related mental illnesses. The social work office is not able to complete execute its roles in terms of linking and integrating patients into their communities, as well as making follow ups, due to acute shortages of transport at this facility.

The facility is also under staffed, so mental health professionals there endure heavy workloads. Mental health professionals at this facility also voiced out their concerns about the poor working environment at this facility. Mental health professionals sometimes work with violent patients and these patients fight them hence they get injured. Mental health professionals at this facility have scars all over their bodies which they got from being assaulted by violent patients. As a result, the morale of these mental health professionals is low or poor, because even the government fails to give them allowances or insurances to cover for injuries inflicted by patients. So, they have to use their own money to seek treatment for these injuries which is often out of their budget.

6.4 Government's actions towards mental health

In Eswatini there is no stand-alone mental health policy. The government in the past has always promised that a mental health policy draft was on the way. Three years ago, the government formulated and commissioned a committee to work on the finalisation of the draft mental health policy. However, to date that mental health policy is still not finalised which is slowly becoming a norm in Eswatini that committees are formulated and tasked to work on things that would develop the country, but at the end they fail to deliver. As usually under the era of COVID-19 they will make excuses that it is because of the COVID-19 pandemic. However, the government has tried to provide for or incorporate mental health in the revised health policy even though its actions on the ground is slacking, yet on paper it is nice and promising. The government has also tried to ensure that nurses in the country are well knowledgeable on mental health so that they can be able to understand patients with presenting mental health issues, through working with the Ministry of Education and Training (MoET) to ensure that there is a major in mental health in the nursing program in the local colleges and universities. However, the government has not made any effort to sensitize and educate those nurses who had already graduated and qualified before the restructuring of the nursing curriculum was made. Those who were on the field remain uneducated about mental health and they are a majority, more especially because the restructuring of the curriculum was made recently. There is a dire need to educate and sensitize nurses and other health professionals on mental health.

6.5 Human rights issues

Mental health as a human right is nowhere respected and upheld in Eswatini. Eswatini is a signatory of a lot of both regional and international treaties that address mental health, however, the government has persistently failed to honour the provisions made by those covenants. The CRPD of 2006 clearly states that people with disabilities including those with mental disabilities should enjoy all human rights and fundamental freedoms. However, in Eswatini people with disabilities are discriminated and marginalized, and they do not enjoy the right to be health as enshrined in the UDHR of 1848, as there are fewer mental health care services. Government has also failed to honour her own provisions spelled out in the National Disability Policy of 2013 and the Constitution of the Kingdom of Eswatini of 2005. The Constitution of the Kingdom of Eswatini of 2005, Section 30, subsection 1 states that *"persons with disabilities have a right to respect and human dignity and the Government and society shall take appropriate measures to ensure that those persons realise their full mental and physical potential"* (Constitution of the Kingdom of Eswatini of 2005). However, the government is lagging behind in putting measures in place in promoting mental health. There is a huge gap as far as mental health rights are concerned in Eswatini.

6.6 Implications for social work

Advancing mental health is in the best interest of the social work profession whereby a deeper understanding and promotion is essential not only to improve the mental health of emaSwati, but also to fight the social injustices experienced by those people with mental illness. Advocacy is one of the key areas of social, therefore social

workers have a duty to advocate for mental health. In a country where there is no stand-alone policy for mental health, social workers need to advocate for the development of a mental health policy. Moreover, social workers in their role as counsellors they need to provide counselling to people with mental illnesses and rehabilitate them. Fighting social injustices as part of the social work ethics, social workers need to fight the stigma against mental illness and promote the right to mental health. Lastly, through their roles as educators, social worker needs to educate and sensitize people about the importance of mental health.

6.7 Recommendations

a) Educating religious leaders and traditional healers about mental health

It is crucial that religious leaders and traditional healers are knowledgeable about mental health because mental illness in Eswatini is often associated with witchcraft and demonic possession. So, a lot of people with mental illnesses seek help from religious leaders and traditional healers, which often fail to provide full treatment. Therefore, there is need to sensitize or educate religious leaders and traditional healers on mental health so that it could be easy for them to refer people with mental illness to the National Psychiatric Referral Hospital where they would get professional treatment. This would also help in people with mental illnesses getting treatment early before their situation escalates often requiring institutionalization, because when they go to their pastor or traditional healer, he or she would see that the problem is psychological in nature and advise them to go to the mental health hospital. Rather than trying all traditional medicines and praying and praying while the situation gets worse.

b) Raising awareness on mental health

There is huge gap in people's understanding of mental health in Eswatini. Therefore, it is crucial that we strongly raise awareness on mental health so that people can be knowledgeable about mental health. We need to penetrate social media and raise awareness there because that is where the youth is, not only the youth but most people are on social media. A social media awareness would be able to reach masses of audiences.

c) Formulation of a mental health policy

There is a dire need for a stand-alone mental health policy in Eswatini. A mental health policy is needed to coordinate mental health care services in the country. A mental health policy would help in fighting the high stigma towards people with mental illnesses. A mental health would also unveil programmes that seek to promote mental health in Eswatini.

d) Mental health programmes

While there are few programmes that promote mental health in Eswatini, the government can utilise the School's Health Programme together with the Career Guidance and Counselling programme to educate and promote mental health in schools in Eswatini. Similarly, the government can introduce a mental health module which would be compulsory in all the tertiary institutions in the country, like they did with HIV/AIDS. Furthermore, the government should establish a mental health programme targeting employers and employees both in the corporate and civil service. Lastly, there should be a programme that would focus on promoting mental health at community or constituency level.

e) Funding for mental health

There is huge need for an improved funding for mental health in Eswatini, both from the government and development partners. The government should consider seeking funding for mental health from international donors and those countries which they have good bilateral relations such as the Republic of China on Taiwan, United States of America, Republic of India, etc.

f) Decentralizing mental health services

Mental health care services are centralized in Eswatini making it difficult for people from remote areas to access them. Therefore, the government should fasten and expand its decentralization plan to cover for mental health. The government should consider building another psychiatric hospital so that more people can get help when they have mental illnesses. Also, this would relieve pressure from the National Psychiatric Referral Hospital.

g) Boosting Mental health professionals' morale

To improve the working environment and avoid an exodus of mental health professionals National Psychiatric Referral Hospital, the government should introduce allowances or medical aid for mental health professionals there to cover for injuries at the expense of patients. This would also serve as staff motivation for improved work product.

6.7 Possible studies in the field of mental health

a. Trends in global mental health against the backdrop of COVID-19.
b. The effects of not having a having a stand-alone mental health policy.
c. The mental state of Eswatini students amid the COVID-19 pandemic.

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APPENDIX 1

Informed Consent form

Title of Research: Mental health as a human right in Eswatini

Researcher: Lindelani Nkosinomusa Masilela

Institutional Contact: University of Eswatini
Faculty of Social Sciences
Department of Sociology and Social work
Private Bag 4
Kwaluseni
Tel: 25170000

1. Aim of the study

Is to advocate for mental health to be seen as a human right in Eswatini.

2. Objectives of the study

a. To explore the views of people on mental health in Eswatini.
b. To examine the barriers that limit people from seeking mental health treatment Eswatini.
c. To understand the impact of COVID-19 on mental health in Eswatini.

3. Description of the Research

When you enter into this researcher as a participant you will be asked to be interviewed either individually or group discussion.

4. Interviews

Interviews will be conducted both telephonically and face-to-face.

5. Potential Risks and Discomfort

There are no risks in participating in this study.

6. Confidentiality

All information taken from the study will be coded to protect each participant's name. No names or other identifying information will be used when discussing or reporting data. The researcher will safely keep all files and data collected. Interviews will the audio recorded and will be kept safely on cloud storage. Once the data has been fully analysed it will be deleted.

7. Voluntary Participation

Participation in this research is completely voluntary. If you decide not to participate we will respect your decision and it will not ruin any relationship.

8. Withdrawal from the Study

If you decide to participate in this study, you are free to withdraw from your participation at any time without a penalty.

9. Cost

There is no cost for participating in this study.

I voluntarily agree to participate in this study

☐ **Yes**

☐ **No**

Name of Participant:……

Signature:……

Date:……

Person Receiving Consent:……

Signature:……

Date:……

APPENDIX 2

Interview guide for mental health professionals

1.0 Introduction

Good morning, I am Lindelani Masilela. I am a social work student doing my final year at the University of Eswatini, Kwaluseni campus. The title of my research is Mental Health as a Human right in Eswatini.

1.1 Aim of the study

Is to advocate for mental health to be seen as a human right in Eswatini.

1.2 Interview guide

1. How do people perceive people with mental illnesses?
   - What does mental health or mental illness mean to you?
   - How do you feel about people who have suffered from mental illness?
   - Have you had a personal experience with mental illness? If yes please explain
   - Do you think we as Swazis are receptive towards people with mental illnesses?
   - What do you think influences people's perceptions about mental illness?
   - Do you think these perceptions also influence people's behaviour in seeking mental health treatment, if yes how do perceptions influence seeking of treatment?
   - How do the public's perceptions of mental illness affect those who suffer from mental illnesses?

2. Why are people reluctant from seeking mental health services?
   - Do people seek treatment for mental health problems from the National Psychiatric Hospital (yes/no), if no please explain?
   - What challenges do you experience in delivering services at the National Psychiatric Hospital?
   - What do you think needs to be done that which would encourage people to access or seek mental health services from the National Psychiatric Hospital?
   - What mental health care services does the National Psychiatric Hospital provide, do you think they are enough, and why?
   - Where else do people in Eswatini seek help or treatment for mental disorders, other than the National Psychiatric Hospital?
3. How has the COVID-19 pandemic affected people's mental health in Eswatini?
   - Please share some of the mental health challenges people have experienced during the COVID-19 pandemic.
   - Has the COVID-19 pandemic affected the delivery of mental health care services to clients, if yes how has it affected the delivery of these services?
   - How has the COVID-19 affected your own mental health?

- What are some of the most prevalent mental disorders during the COVID-19 pandemic?
- How important do you think mental health is in our fight against the effects of COVID-19?

Thank you for sharing your experiences and thoughts with me.

APPENDIX 3

Interview guide for the Ministry of Health

1.0 Introduction

Good morning, I am Lindelani Masilela. I am a social work student doing my final year at the University of Eswatini, Kwaluseni campus. The title of my research is Mental Health as a Human right in Eswatini.

1.1 Aim of the study

Is to advocate for mental health to be seen as a human right in Eswatini.

1.2 Interview guide

1. What are the current government interventions (policies or programmes) promoting mental health?

2. What are some of the issues that are preventing government from developing a mental health policy?

3. What are governments plan on promoting mental health care?

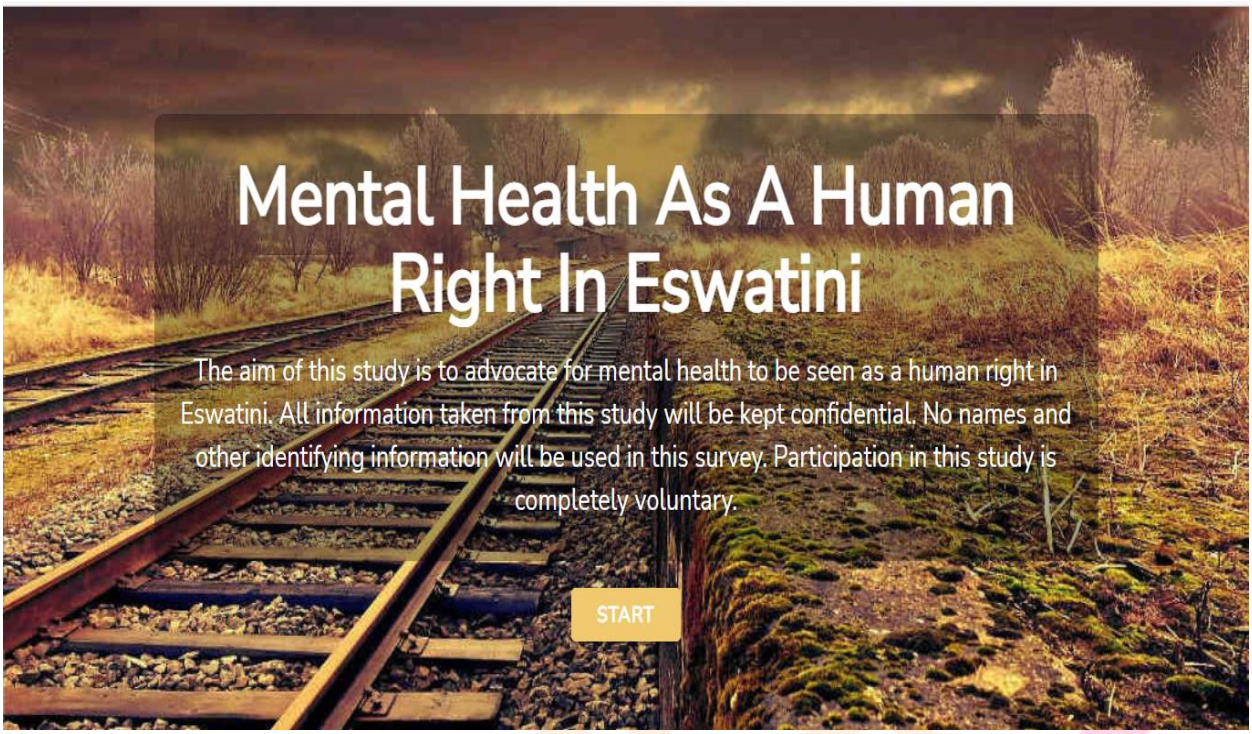
4. Does government consider building another mental health centre?

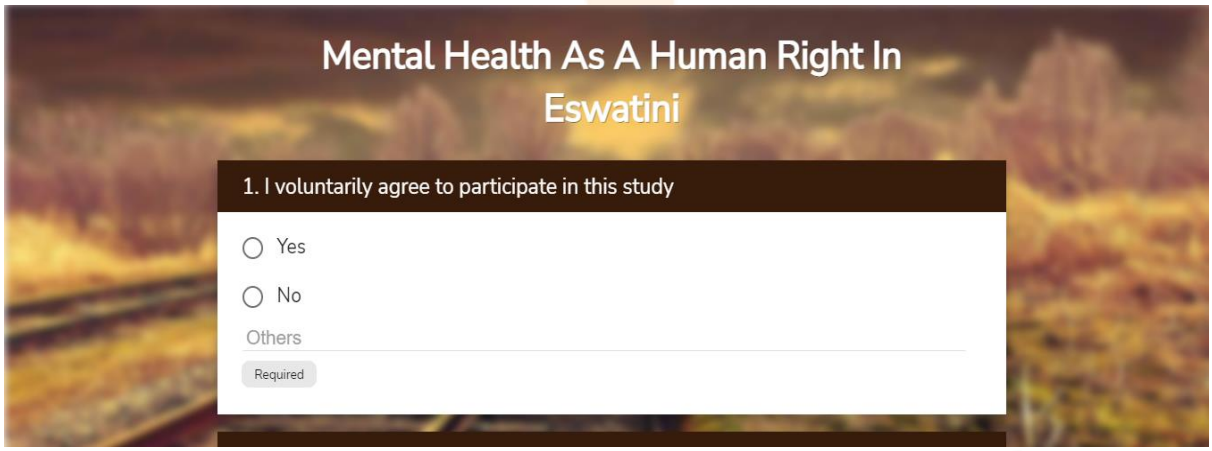
5. How much of the national health budget goes to mental health?

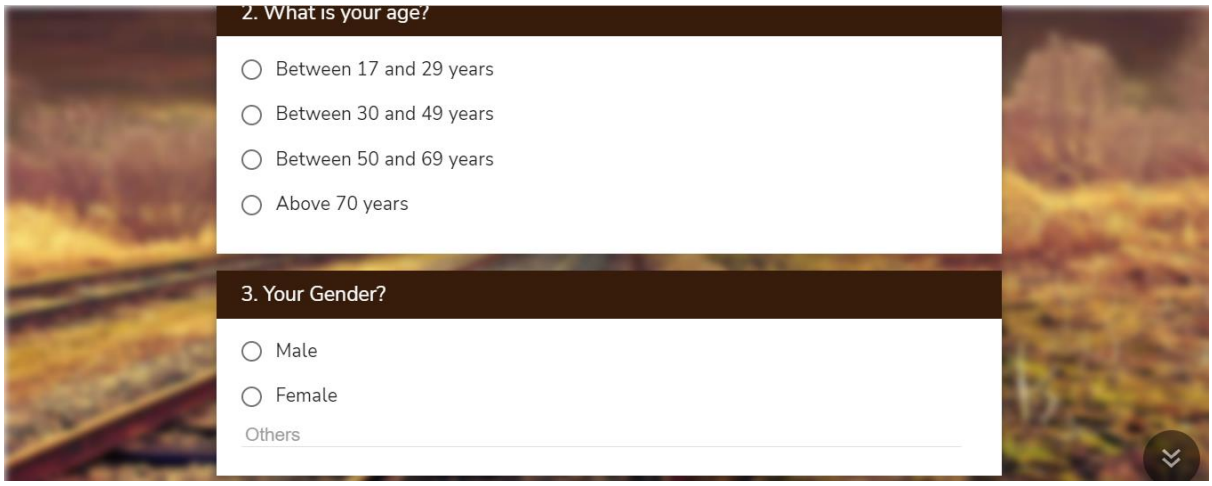
Thank you for participating in this study.

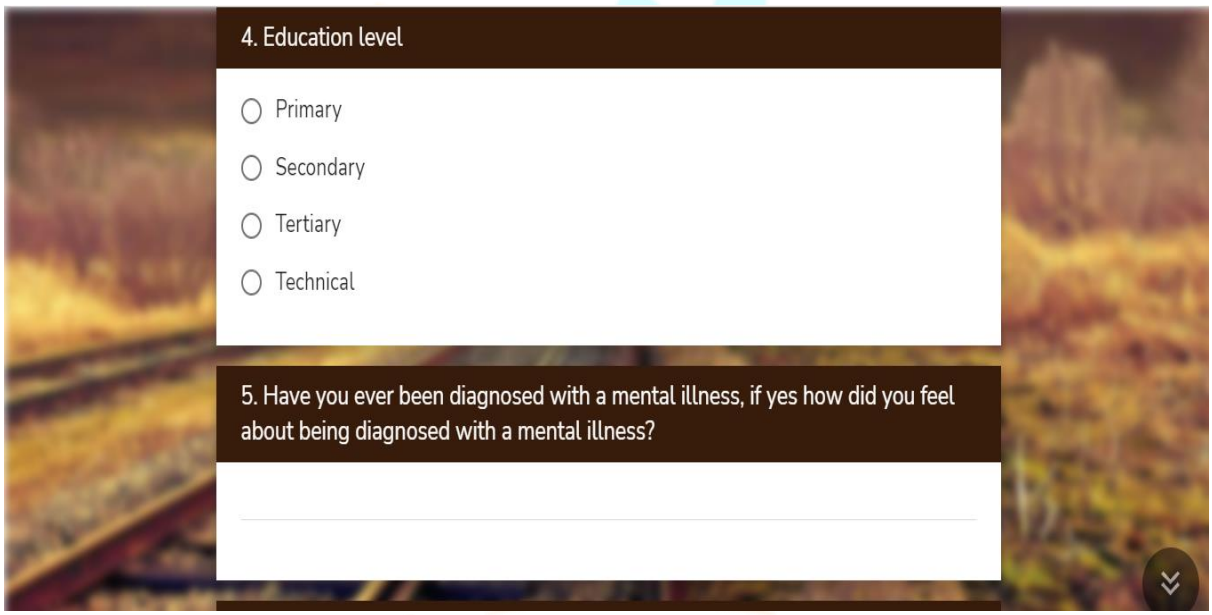
APPENDIX 4

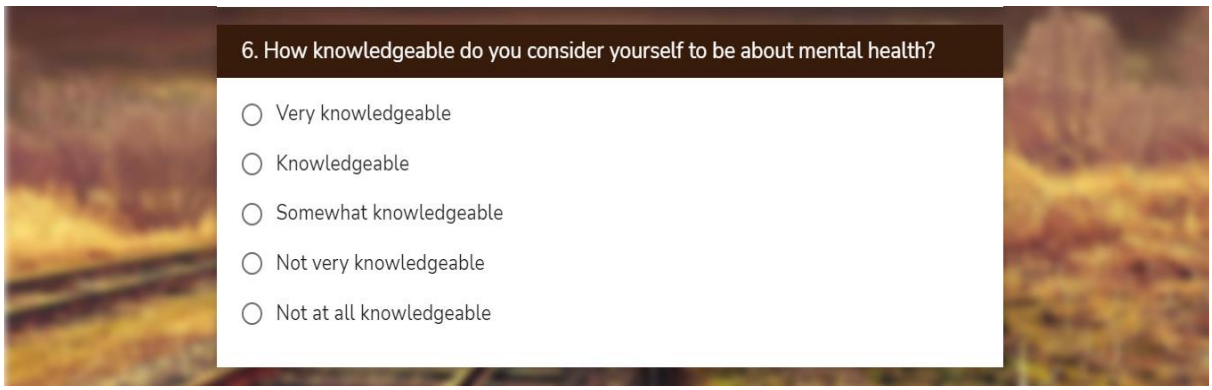
Online Survey

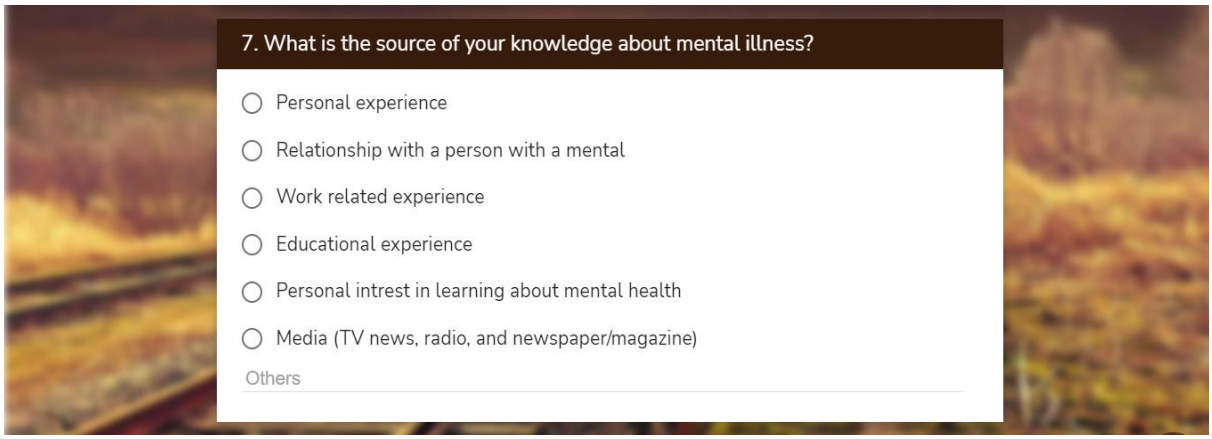


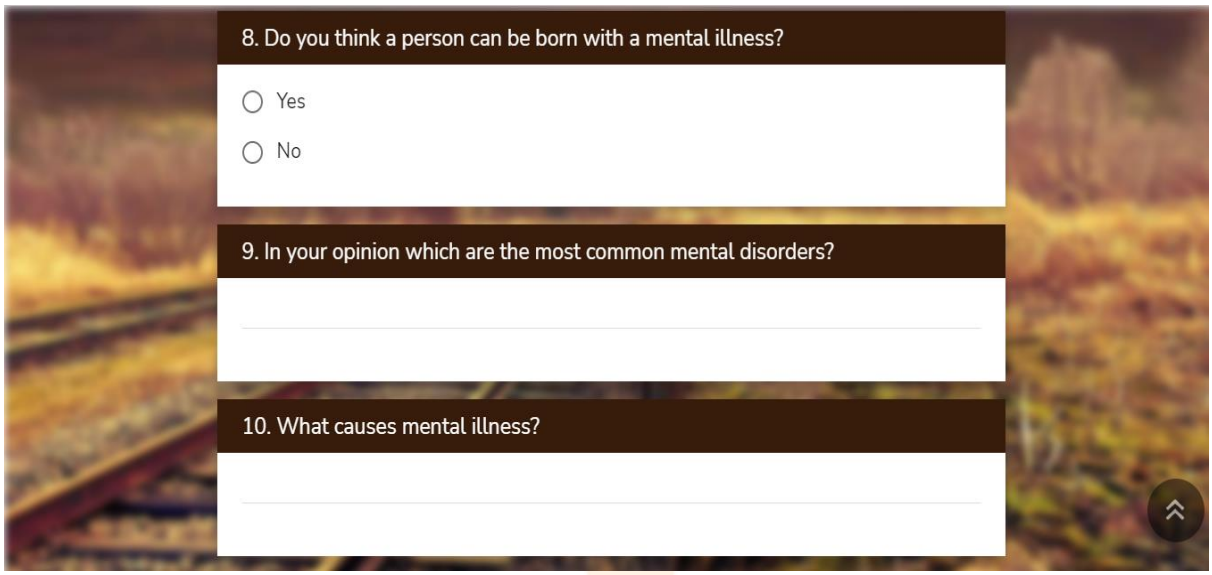


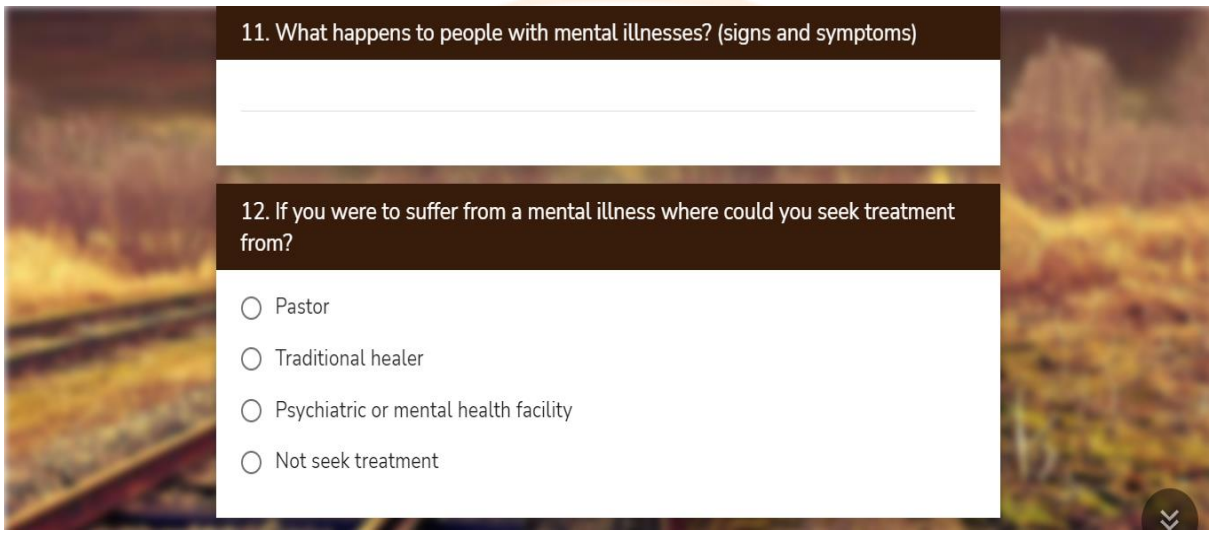


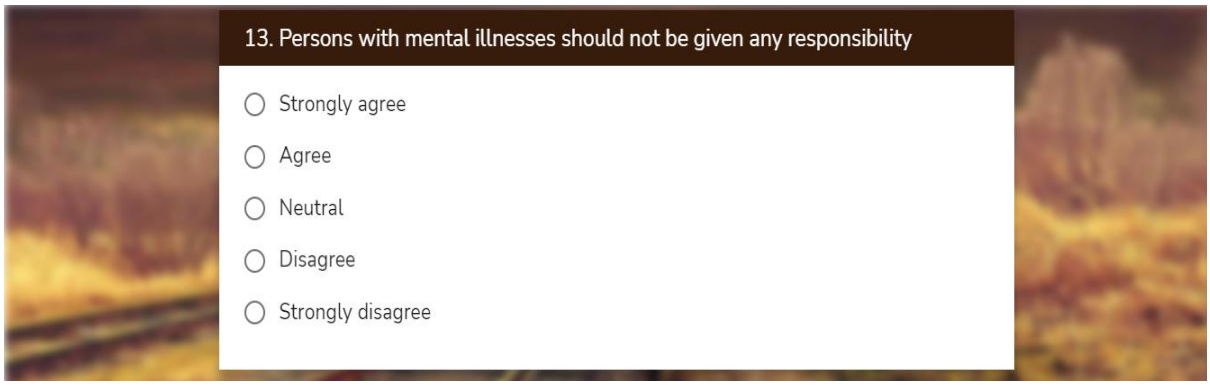


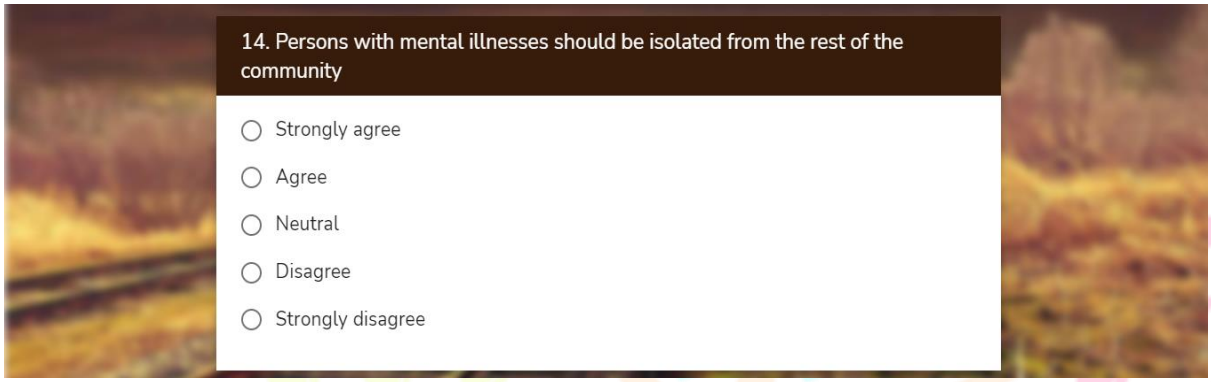


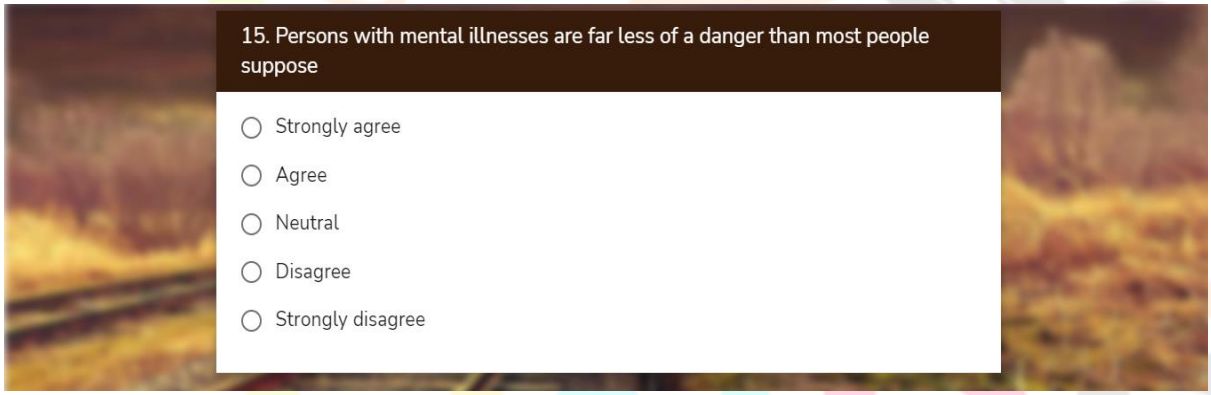

7. What is the source of your knowledge about mental illness?
Personal experience
Relationship with a person with a mental
Work related experience
Educational experience
Personal intrest in learning about mental health
Media (TV news, radio, and newspaper/magazine)
Others

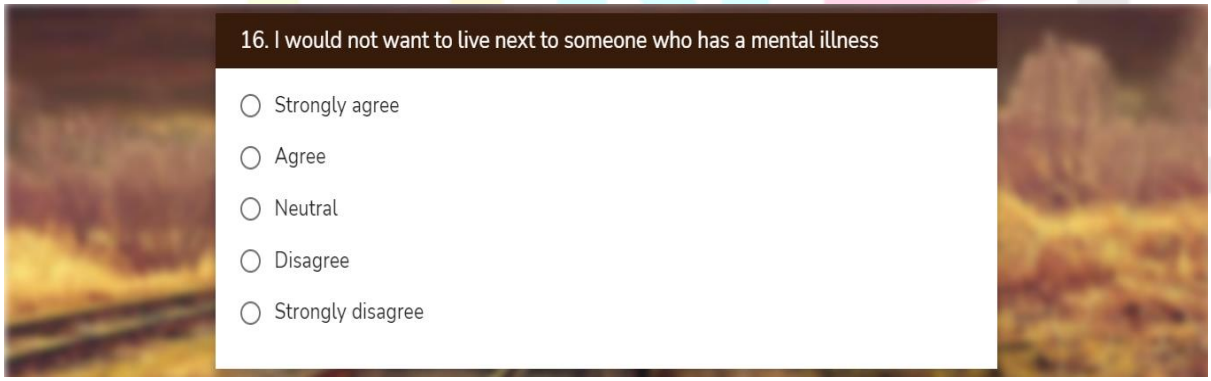

8. Do you think a person can be born with a mental illness?
Yes
No
9. In your opinion which are the most common mental disorders?
10. What causes mental illness?

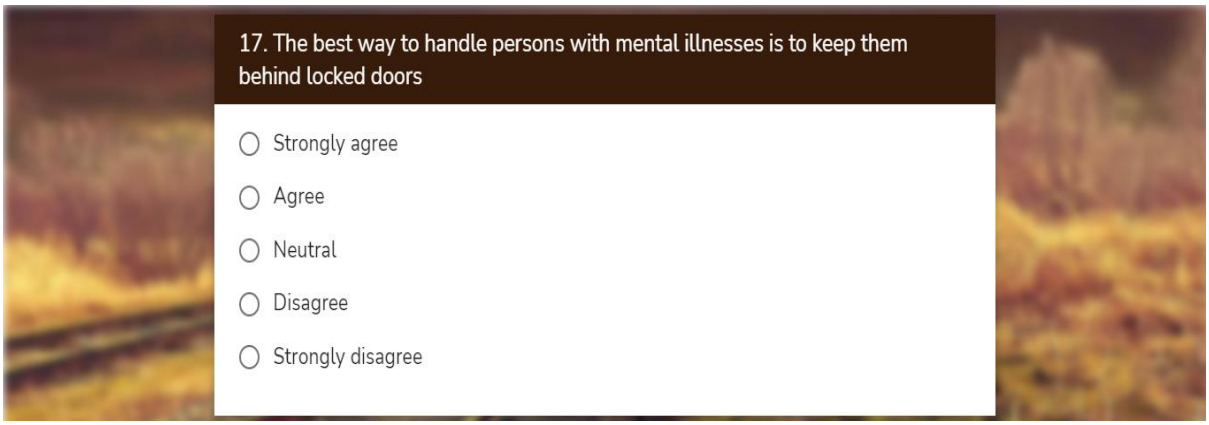

11. What happens to people with mental illnesses? (signs and symptoms)
12. If you were to suffer from a mental illness where could you seek treatment from?
Pastor
Traditional healer
Psychiatric or mental health facility
Not seek treatment

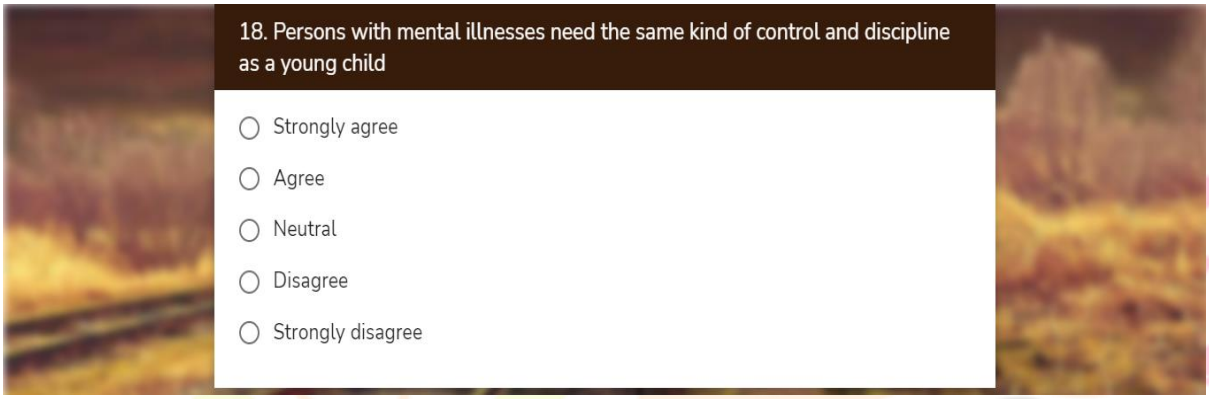

13. Persons with mental illnesses should not be given any responsibility
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

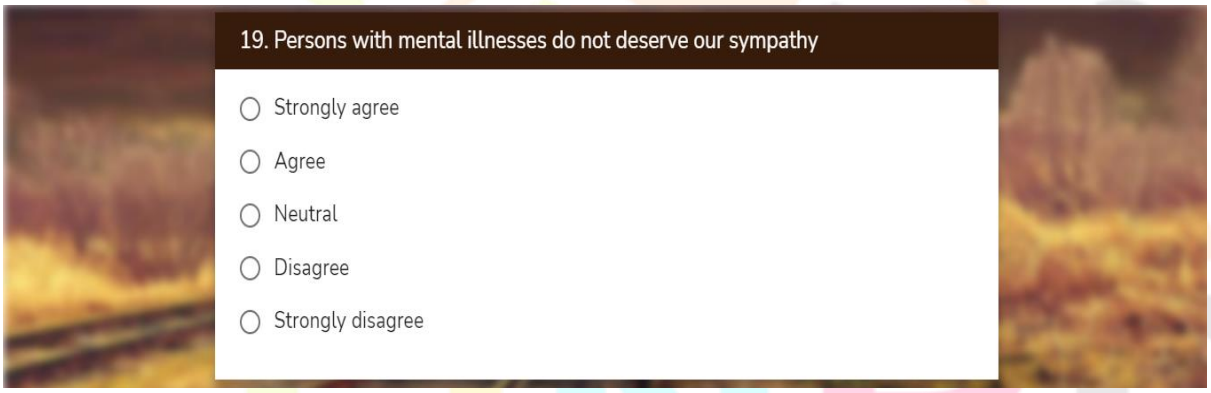

14. Persons with mental illnesses should be isolated from the rest of the community
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

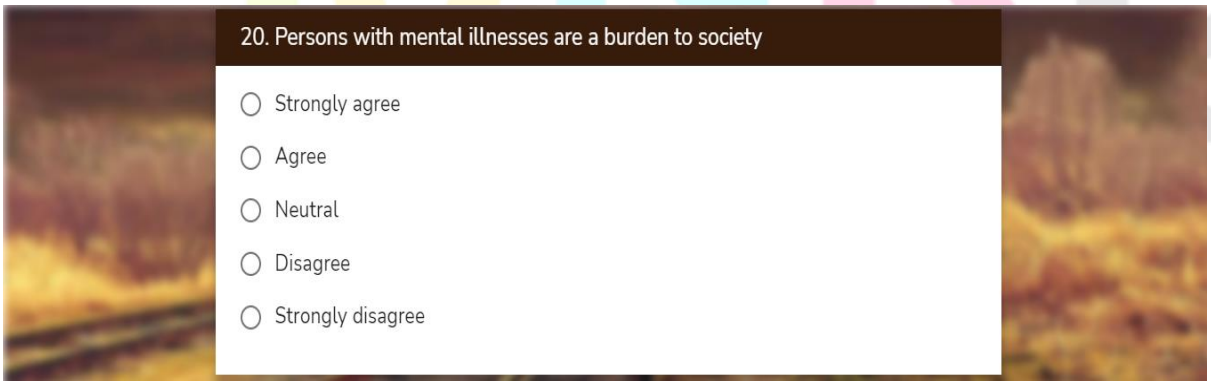

15. Persons with mental illnesses are far less of a danger than most people suppose
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

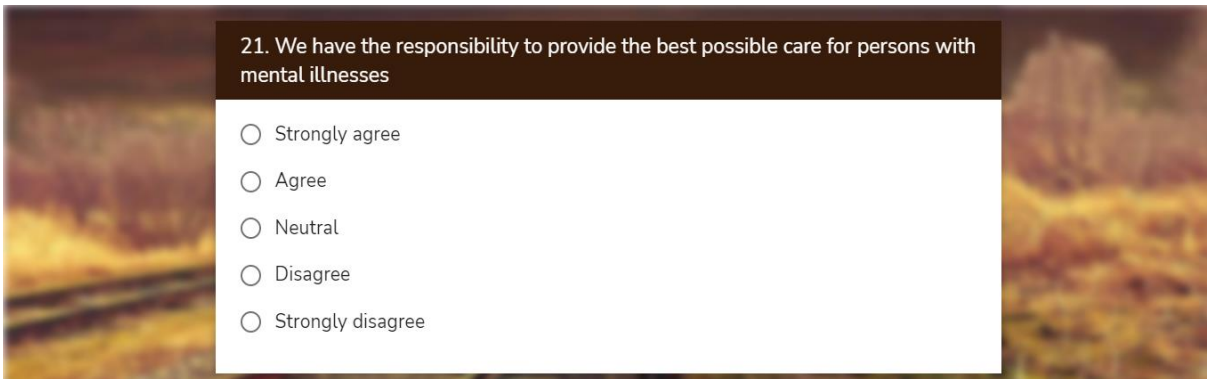

16. I would not want to live next to someone who has a mental illness
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

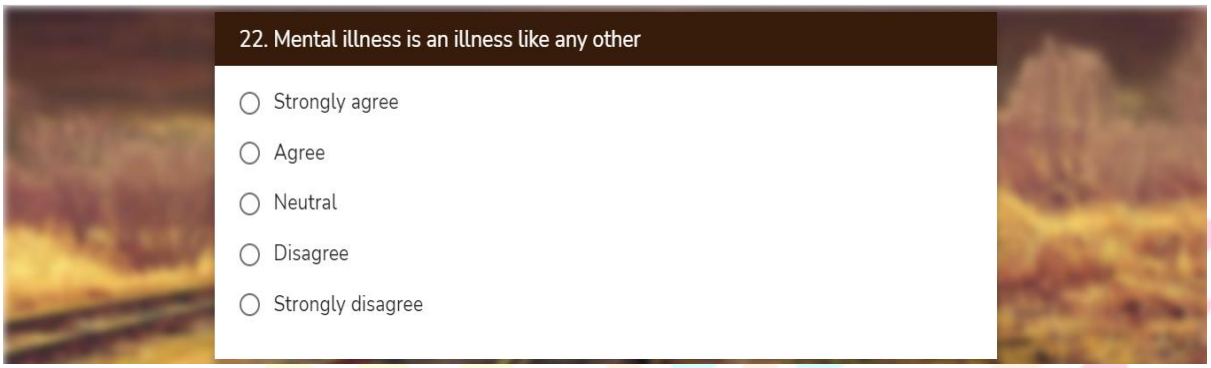

17. The best way to handle persons with mental illnesses is to keep them behind locked doors
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

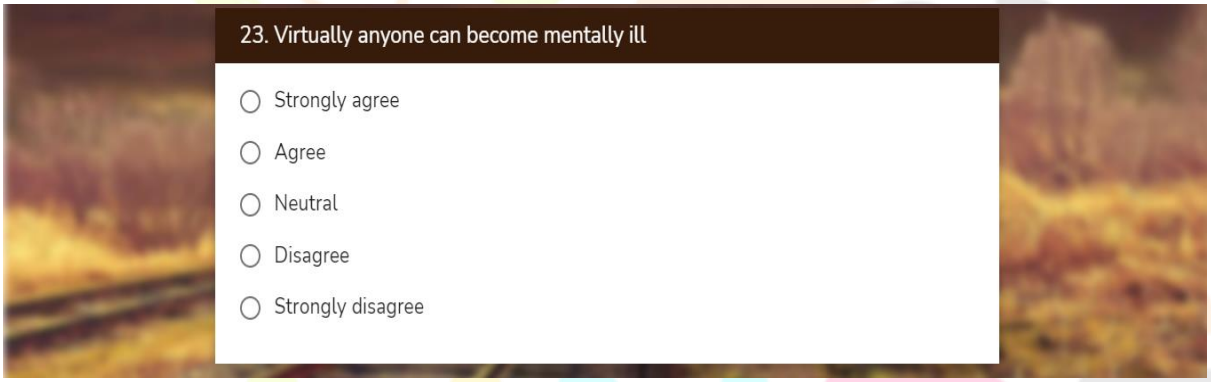

18. Persons with mental illnesses need the same kind of control and discipline as a young child
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

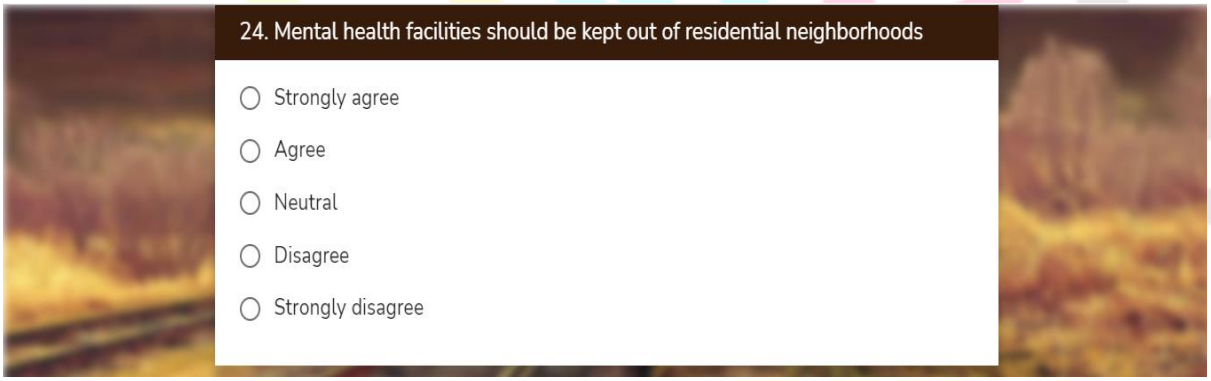

19. Persons with mental illnesses do not deserve our sympathy
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

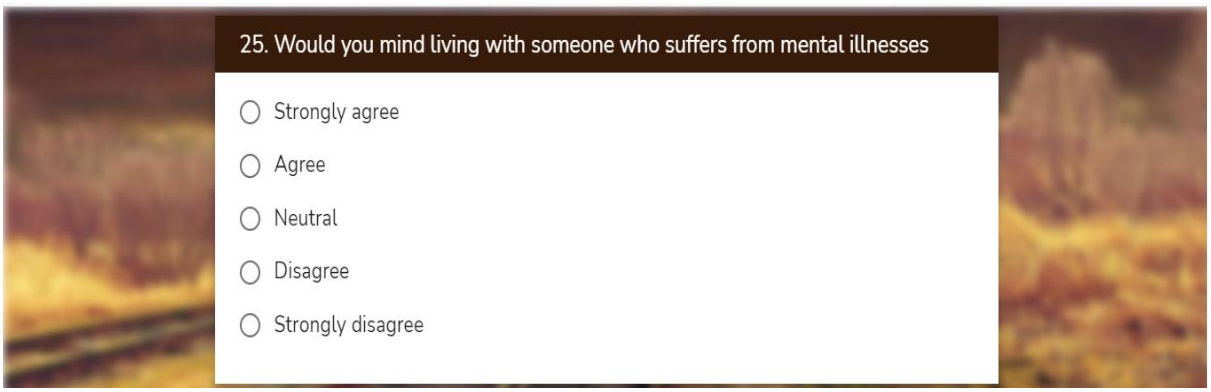

20. Persons with mental illnesses are a burden to society
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

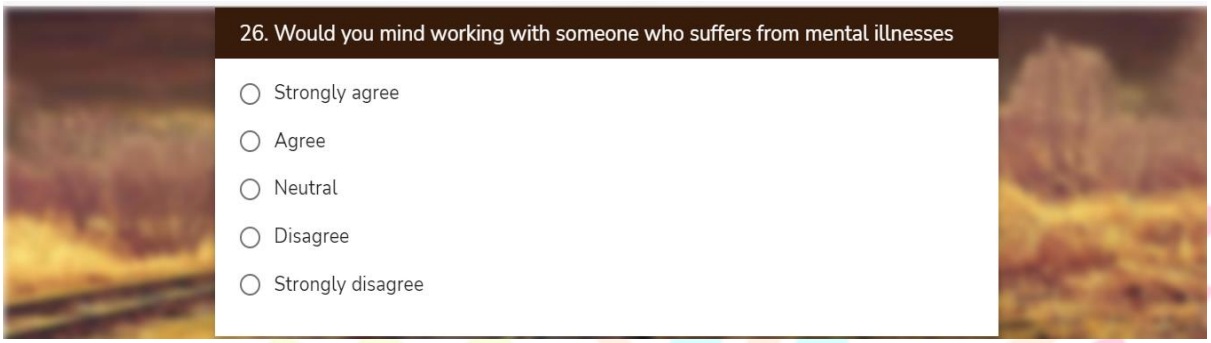

21. We have the responsibility to provide the best possible care for persons with mental illnesses
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

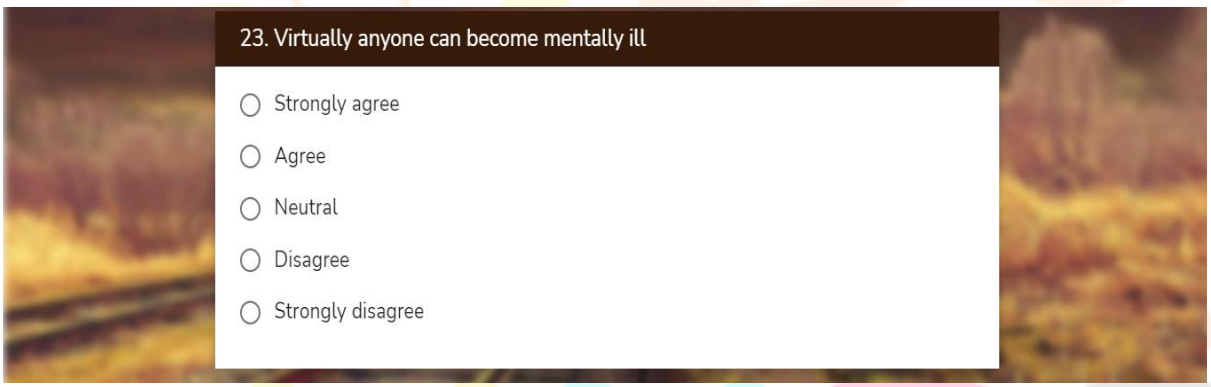

22. Mental illness is an illness like any other
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

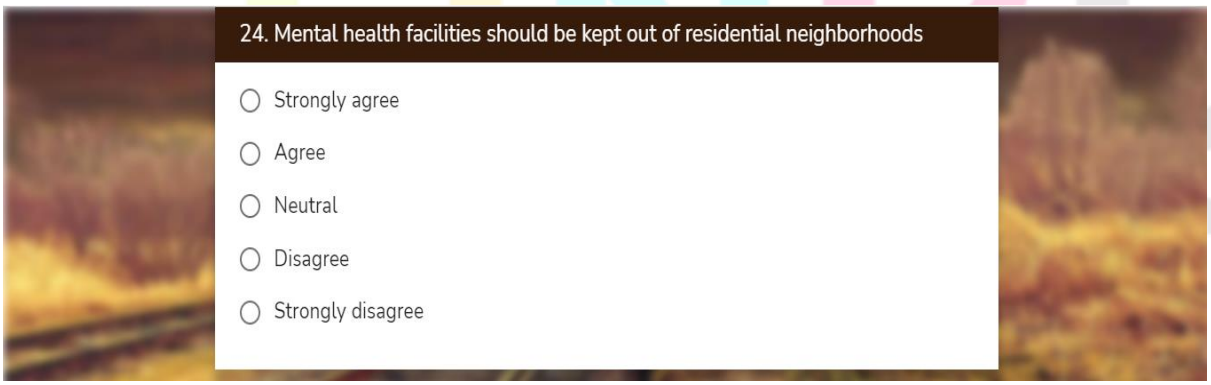

23. Virtually anyone can become mentally ill
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

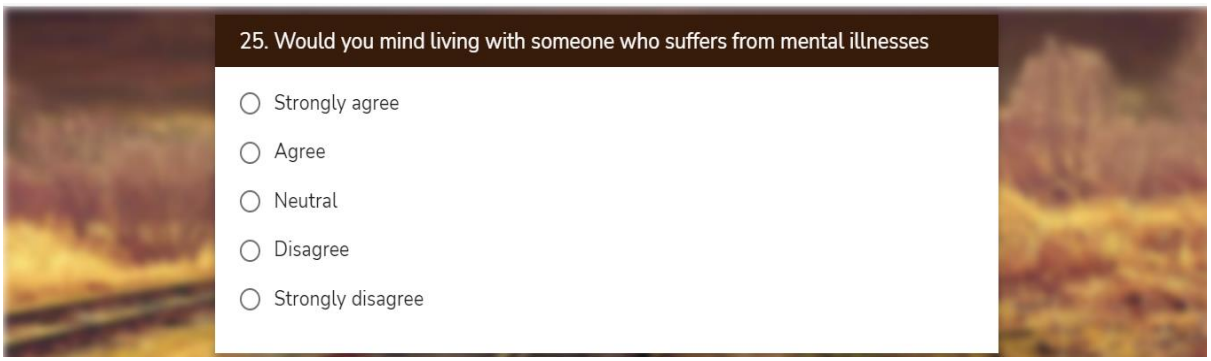

24. Mental health facilities should be kept out of residential neighborhoods
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

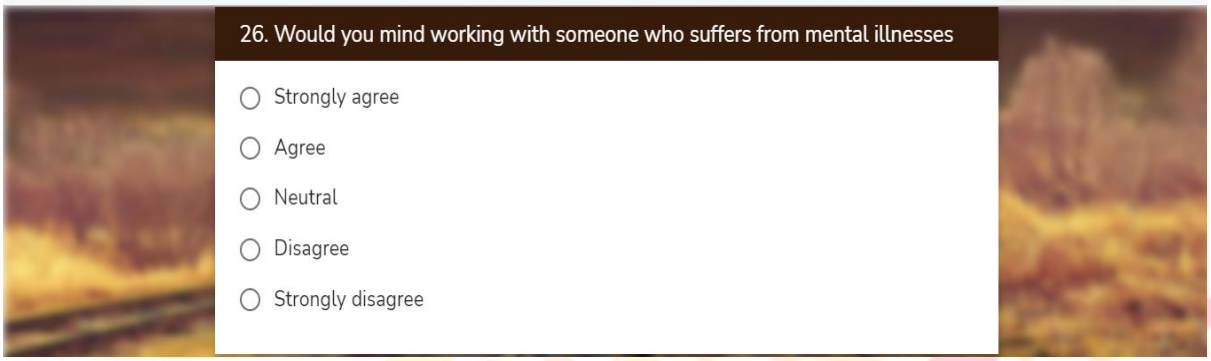

25. Would you mind living with someone who suffers from mental illnesses
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

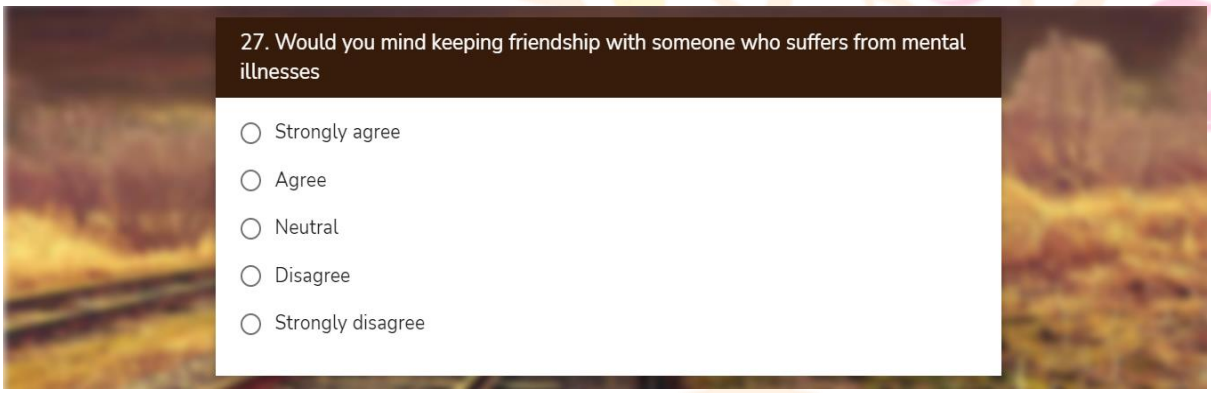

26. Would you mind working with someone who suffers from mental illnesses
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

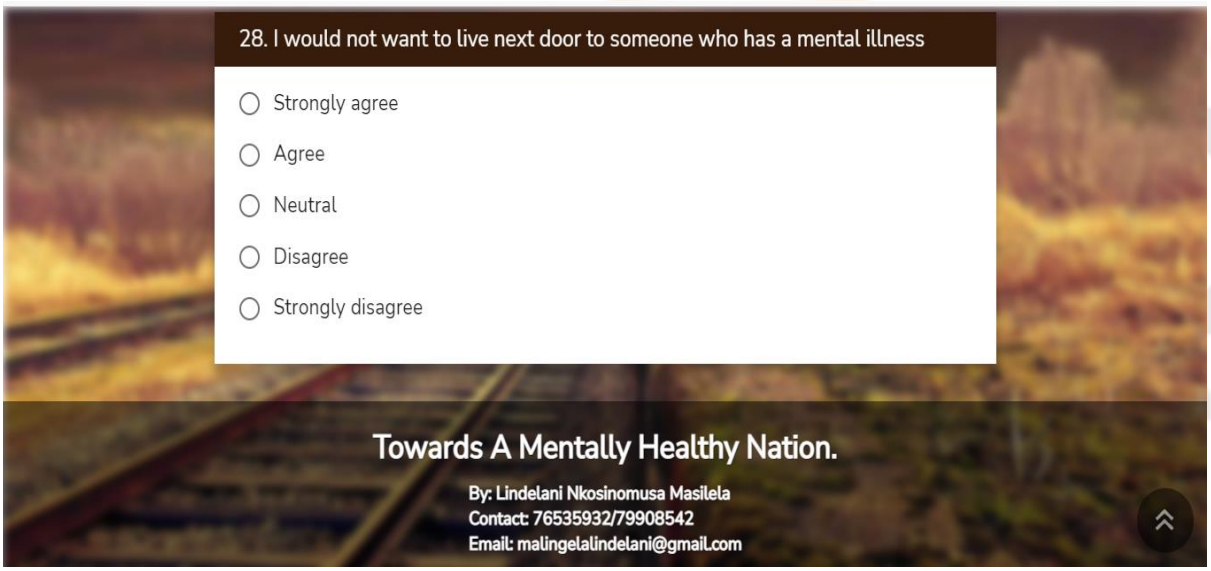

23. Virtually anyone can become mentally ill
Strongly agree
Agree
Neutral
Disagree
Strongly disagree


24. Mental health facilities should be kept out of residential neighborhoods
Strongly agree
Agree
Neutral
Disagree
Strongly disagree


25. Would you mind living with someone who suffers from mental illnesses
Strongly agree
Agree
Neutral
Disagree
Strongly disagree


26. Would you mind working with someone who suffers from mental illnesses
Strongly agree
Agree
Neutral
Disagree
Strongly disagree


27. Would you mind keeping friendship with someone who suffers from mental illnesses
Strongly agree
Agree
Neutral
Disagree
Strongly disagree


28. I would not want to live next door to someone who has a mental illness
Strongly agree
Agree
Neutral
Disagree
Strongly disagree
Towards A Mentally Healthy Nation.
By: Lindelani Nkosinomusa Masilela
Contact: 76535932/79908542
Email: malingelalindelani@gmail.com

ESWATINI
HEALTH AND HUMAN
RESEARCH REVIEW BOARD
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Telephone: +268 2404 7751/6039
Email: ehhrrbeswatini@gmail.com

July 27, 2021

Masilela Lindelani
Principal Investigator
Student number: 156504
UNESWA

FWA 00026661/IRB 00011253/ SHR0238/2021

Dear Lindelani,

RE: MENTAL HEALTH AS A HUMAN RIGHT IN ESWATINI

The committee thank you for your submission to the Eswatini Health and Human Research Review Board, an expedited review was conducted.

In view of the importance of the study and the fact that the study is in accordance with ethical and scientific standards, the committee grants you authority to conduct the study. You are requested to adhere to the specific topic and inform the committee through the chairperson of any changes that might occur in the duration of the study which are not in this present arrangement.

The committee requests that you ensure that you submit the findings of this study (Electronic and hard copy) and the data set to the Secretariat of the EHHRRB.

The committee further requests that you add the EHHRRB secretariat as a point of contact if there are any questions about the study on 24047751.

Yours Sincerely,

RUDOLPH T.D. MAZIYA
CHAIRMAN, EHHRRB

ESWATINI HEALTH & HUMAN RESEARCH REVIEW BOARD
27 JUL 2021
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MANZINI
ESWATINI

NATIONAL PSYCHIATRIC REFERRAL HOSPITAL

03 August 2021

Masilela Lindelani N. (156504)

MANZINI

RE: PERMISSION TO CONDUCT RESEARCH

The National Psychiatric Referral Hospital is pleased to grant you permission to conduct your research titled "***Mental Health as a Human Right in Eswatini***" in partial fulfilment of requirements for Bachelor of Social Work at the University of Eswatini

The management of the hospital requests that you ensure that you submit the findings of this study to the hospital.

NATIONAL PSYCHIATRIC REFERRAL HOSPITAL
MEDICAL SPECIALIST
05 AUG 2021
MENTAL HEALTH & PSYCHIATRY
P.O. BOX 424, MANZINI
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Dr. Violet Mwanjali

Senior Medical Specialist; Mental Health and Psychiatry