



PHASA
NEWSLETTER



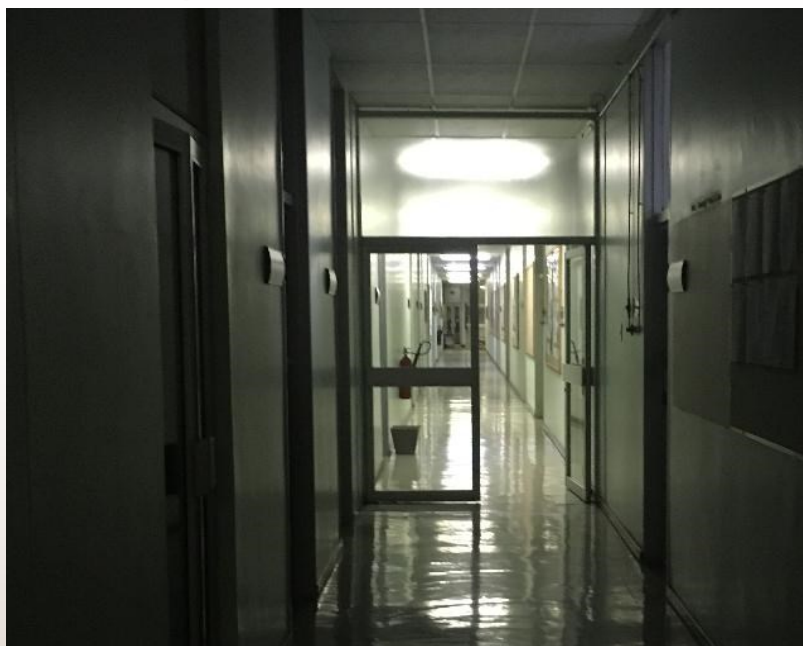
The Pulse

May 2018 Edition 1



FROM THE DESK
OF ANDRÉ ROSE
PHASA President

Welcome. As the President of PHASA, I am proud to launch the new look and feel of the PHASA Newsletter, "The Pulse". My hope is that we keep you engaged and informed. My feature article is on page two and speaks to the Life Esidimeni Victims. We welcome your comments and opinion on our new look. Enjoy!



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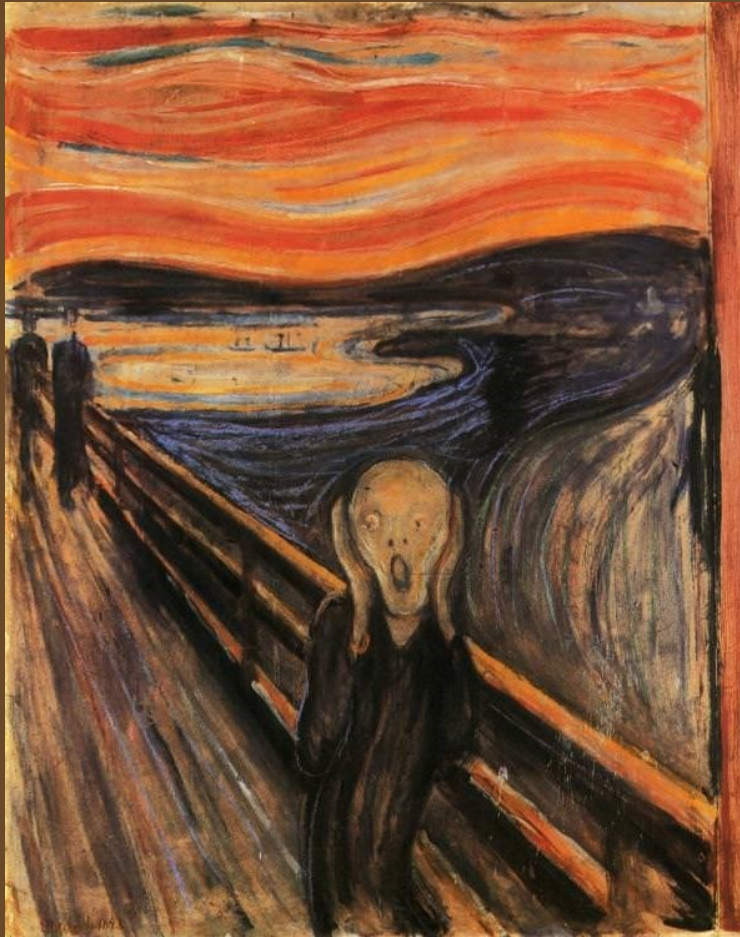
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**Improving child and
adolescent mental health
through school-based
interventions**

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**Towards a more responsive
mental health system in
South Africa: The Mental
Health
Integration (MhINT)
Programme**

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THE SCREAM OF THE LIFE ESIDIMENI VICTIMS.

In 2018 we celebrate the centenary of Nelson Mandela and Albertina Sisulu. These icons will continue to be affirmed by history as children of the soil that epitomised the values anchored in Ubuntu. Their passion for justice and equity was embodied in their selfless pursuit to see the humanity of others respected and upheld. It is this legacy that we should expect to see expressed in political leadership. The Life Esidimeni tragedy has however demonstrated that the most vulnerable people in our communities continue to be neglected, abused and pushed even further to the fringes of society by leaders that had committed to protect and uphold their humanity and dignity.

The Esidimeni tragedy raises a number of issues that underscore the fault lines in the South African health system. First, it draws attention to the paucity in political health leadership at the time of the tragedy. The dearth in leadership integrity is demonstrated in the initial reluctance and resistance by the health leadership in the Gauteng Department of Health, when called to

account for their contribution to the tragedy. Their lack of accountability is illustrated by their blame shifting tactic when called to clarify their actions. The protagonists involved in the management of mental health in the Gauteng Department of Health demonstrated little remorse for the consequences of their actions.

Public health is a discipline that requires that collaboration of different sectors and disciplines for successful implementation. Secondly, the proceedings and the ruling in the Esidimeni tragedy underplayed the importance other departments played in facilitating the tragedy and as such failed to hold all relevant stakeholders accountable for the tragedy. Public health and especially public mental health requires a plethora of sectors such as social development to collaborate. Their absence in averting the tragedy and being held co-responsible for this catastrophe is an indictment on the functionality of our health system.

Thirdly, the disaster highlights how public health has lost sight of the most important stakeholder in delivering healthcare; namely the people we serve. In our quest to understand public health phenomena; to develop sound policies; to show sleekness in implementation of strategies and guidelines; and to monitor and evaluate the programmes we develop, we often forget that we do it for the people on the ground. It took the death of 144 marginalised mental health patients to remind us that even when tough decisions about resources allocation of funds have to be made we still have to be cognisant of how it affects those who cannot speak for themselves. There are many other aspects that could be explored here but time and space does not allow it.

In the well-known painting, *The Scream* by Norwegian artist Edvard Munch the artist transports us into the anguish of the central figure of the artwork. The static painting is filled with movement and the bright sunset is juxtaposed against the perturbed almost sexless figure. We are drawn into the scene only because we have had the experience of trepidation the figure conveys. The emotions in the painting embodies the voicelessness of the Life Esidimeni victims. Their silent cries implore us to heed to their plea that their suffering should serve as a reminder that such a travesty should never repeat itself.

In this edition of *The Pulse* we are reminded by the four contributing authors that the Life Esidimeni tragedy was about people who have a name and a face. We are asked to consider how simple interventions can have positive ramifications. And we are offered hope, that we can steer the public mental health agenda in the right direction in South Africa by learning from this tragedy.





Life Esidimeni: Post-mortem of a broken system

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...frail, disabled and incapacitated patients were transported in inappropriate and inhumane modes of transport, some 'without wheel chairs but tied with bed sheets' to support them; some NGOs rocked up at Life Esidimeni (LE) in open 'bakkies' [trucks] to fetch MHCUs [mental healthcare users] while others chose MHCUs like an 'auction cattle market' despite pre-selection by the GDMH [Gauteng Department of Mental Health] staff; some MHCUs were shuttled around several NGOs; during transfer and after deaths several relatives of patients were still not notified or communicated to timeously; some are still looking for relatives; these conducts were most negligent and reckless and showed a total lack of respect for human dignity, care and human life. – Professor Malegapuru Makgoba, Life Esidimeni report.

Much has been written about the Life Esidimeni tragedy but the sheer weight of the event calls for thoughtful analysis. In the aftermath of 143 deaths and many unaccounted for – both dead and alive – a process of arbitration was instituted, presided over by Deputy Chief Justice Dikgang Moseneke, who remarked that it is a "total post-apartheid tragedy, bigger than the Sharpeville massacre and Marikana". He ruled that families should each be compensated R20 000 for funeral expenses, R180 000 for shock and anxiety and R1-million for Constitutional breach. The MEC was almost universally condemned, and the vast bulk of public commentary on the tragedy seems to have laid blame at the door of incompetent or irresponsible government officials. While individual accountability is central, no full sense of social justice will be achieved without serious introspection of the structural and contextual drivers that made the Life Esidimeni tragedy possible. Two critical omissions in the post-event narratives are 1) the Berlin Wall between the Department of Health (DoH) and the Department of Social Development (DoSD), and 2) the relationship between provincial governments and NGOs.

The Life Esidimeni tragedy was framed as a deinstitutionalisation exercise. This motive was questionable, given the well-known pitfalls of deinstitutionalisation in the contexts of an almost complete absence of a community safety net. Nonetheless, the structural dimensions of this strategy warranted the deflection of responsibility from health facilities to NGOs, and from the DoH to the DoSD. It is unsettling that the DoSD's role in this fiasco went almost completely unnoticed in the Health Ombud report and the arbitration hearings – the focus was almost exclusively on the DoH, the steward of healthcare. The rift between health and social sectors is not new and it is particularly evident in mental health services in South Africa, where biomedical approaches to care dominate at the frontline. This is an important - but often overlooked - influence in the management of people living with serious mental disorders.

The transition of NGOs in South Africa's post-apartheid period from advocates and champions for the poor and maligned to service providers of the government have not been made easier by the adoption of the Paris Declaration on Aid Effectiveness in 2005, which swayed the power of international funding streams to the state sphere. NGOs play several roles in this regard: some assist clients accessing their disability grants, some provide housing and basic care, while



some even provide medical care. This loosely-knit network should – technically speaking – be assisted, coordinated and regulated by provincial-level government, the absence of which results in tragedies such as that of Life Esidimeni.

Furthermore, there is also the matter of funding. None of the Life Esidimeni NGOs were registered at the DoSD, meaning that none of them received funding or regulation from the government. NGOs are compensated for certain services according to priorities set by provincial social development departments which often makes NGOs – especially ones that provide shelter and basic care to clients with serious mental conditions – dependent on charity, or, more commonly, a cut of each client's disability grant. The physical presence of people suffering from serious mental conditions is incentivised, not their well-being. Ultimately, people afflicted by serious mental disorders who cannot afford exorbitant private psychiatry rates are left at the mercy of relationships within and between the government and its non-governmental partners

Micro, Life Esidimenis continue to unfold regularly in South Africa. If it were not for NGOs with strong advocacy roots (Section 27) and media coverage, many more patients might have died or gone missing. The families endured incredibly severe trauma and are undoubtedly owed an equitable compensation. Nonetheless, by focusing the penalties owed by the government on a purely financial level is short-sighted, not to mention an "easy" escape for government officials. Even in death, money is exchanged over the bodies of the patients, reducing them to mere commodities. It is regrettable that Judge Moseneke did not put into motion an accountable and transparent process of systems transformation for the care of people with serious mental disorders.

We are facing a systemic problem, rooted in an absence of structures that protect the vulnerable. Strong governance and communication structures between provincial government departments (particularly the DoSD and DoH) should be underwritten by intersectoral provincial mental health policy. Formal agreements with key NGOs, who should be paid at a market-related rate for strategic services, will alleviate the burden on an already overextended public sector. This, however, will require political leadership and stewardship, perhaps the most underrated elements of the health system. There is no question that the Life Esidimeni tragedy was preventable but we should not fall into the trap of only trying to prevent death; it is not only living that is a human right, but living a quality and meaningful life, something that continues to be unattainable for thousands of people on the peripheries of society.



Useful links related to Public Mental Health

Resources and information:

<http://www.mhinnovation.net/>

<https://www.centreforglobalmentalhealth.org/>

Global Mental Health:

<https://www.tandfonline.com/doi/full/10.3109/10673229.2012.649108>

[https://www.psychologytoday.com/us/blog/perspectives-global-mental-health/201606/](https://www.psychologytoday.com/us/blog/perspectives-global-mental-health/201606/what-is-global-mental-health)

[what-is-global-mental-health](https://www.psychologytoday.com/us/blog/perspectives-global-mental-health/201606/what-is-global-mental-health)

<https://www.nature.com/articles/475027a>

<https://www.nature.com/articles/nature16032>

<https://www.nejm.org/doi/full/10.1056/NEJMra1110827>

Mental health in Africa:

[https://theconversation.com/why-africa-needs-to-start-focusing-on-the-neglected-issue-of-](https://theconversation.com/why-africa-needs-to-start-focusing-on-the-neglected-issue-of-mental-health-91406)

[mental-health-91406](https://theconversation.com/why-africa-needs-to-start-focusing-on-the-neglected-issue-of-mental-health-91406)

<https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20489>



Improving child and adolescent mental health through school-based interventions

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Child and adolescent mental health (CAMH) is a major public health challenge. According to the World Health Organization (WHO), about 10–20% of children worldwide are living with a mental disorder. The proportion of children and adolescents suffering from mental disorders are even higher in low-and-middle-income countries (LAMICs), where investment into service provision is also lowest. Although epidemiological data on CAMH in LAMICs are scarce, a study conducted in 2006 revealed a 17% prevalence rate in South Africa, partly accounted for by the quadruple burden of diseases the country is faced with. Unfortunately, the majority of adolescents are unable to access the required services to treat and manage their conditions due to several factors. A prominent barrier to access is a lack of resources, ranging from human resources for mental health care, to physical infrastructure and financial resources. Regrettably, the consequences of late identification and poor management of mental disorders can be severe, as the majority of children and adolescents living with mental disorders are unable to function appropriately to reach their optimum level of competencies. Therefore, mental health interventions to ease access to child and adolescent mental health care are imperative.

Several interventions have been developed and have proven to be effective in managing child and adolescent mental health in different countries. Although different interventions are being implemented in LAMICs, there are very few evidence-based reports on the effectiveness of these interventions. A particularly popular intervention point is the school environment. Schools are strategic locations for implementing CAMH programmes, which often include packages that are beneficial for parents/caregivers, teachers and learners. Learners are able to master critical life skills, personal development strategies and problem solving strategies. The school environment is also a suitable setting to educate parents and caregivers on CAMH, the emotional needs of their children and the risk factors faced by children and adolescents. This is especially important in low socioeconomic contexts, where the need for improved help-seeking behaviour and access to care becomes central. Educators are significant role players, capable of impacting children and adolescents during these developmental years. The school environment should promote continuous training for educators to identify CAMH symptoms in pupils, competent use of CAMH screening tools, conduct first aid psychotherapy and provide support for learners with mental health challenges. School-based interventions also create opportunities for the intersectoral delivery of CAMH services along with pathways to care for CAMH disorders.

The South Africa Integrated School Health Programme (ISHP) provides a suitable opportunity to conduct CAMH services in schools. The ISHP is a collaborative initiative between the Departments of Health, Basic Education, Social Development, and non-government partners. The ISHP emphasizes the importance of providing mental health care assessment for learners in schools; however, priority is currently placed on key interventions such as vaccinations and health screening, and hopefully will later move onto other priority programmes such as TB and mental health. It is, however, not clear whether the initiative is capable of implementing the mental health component as the initial roll-out was faced with certain challenges such as inadequate resources, particularly human resources (way too few school health teams for the amount of schools that need to be visited), a lack of funding, a weak referral system, as well as lack of adequate collaboration between the implementing departments and partnership with NGOs. It is therefore important to address these challenges that impede the adequate implementation of ISHP in order to broaden the range of services provided to school-going children in South Africa.



While a few studies have reflected on several aspects of the ISHP, they are inadequate in reflecting on the mental health assessment procedures for school-going children and the available mental health care pathways (identification, assessment and access to mental health care services) for school-going children in South Africa. ISHP is a significant possibility for improving access to CAMH and the

opportunities it provides should be adequately explored. The importance of adopting task-shifting approaches to enhance access to CAMH services cannot be overemphasized, and the ISHP provides the opportunity to train educators, caregivers and community health workers to provide CAMH services in resource-scarce settings. It is crucial that mental health be prioritised in ISHP initiatives. The mistakes made in the 2003 school health policy should be avoided by incorporating mental health in its rightful place in the ISHP. This can only be achieved by means of adequately investigating robust and sustainable ways in which to provide mental health through the ISHP vehicle.



The other “M” in maternal health

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Pregnancy, birth, motherhood. New beginnings, anticipation, love. For many women these experiences are inextricably linked, evoking feelings of hope and excitement. Yet, for some women, the joy of a planned and much anticipated pregnancy or motherhood is inexplicably marred by feelings of anxiety and depression. Pregnancy that is unplanned or unwanted can also result in depression and anxiety. This significant biological experience can cause untold psychological distress to women for varied reasons including physiological, social and emotional causes. It is the extreme cases that catch the headlines – depressed women who harm their infants or themselves, and this is often the face of maternal depression that many people including some health professionals and lay people interpret –the extreme. Yet is not the norm and depression can be treated successfully. Increasingly, addressing maternal depression is becoming a priority for funders and other key players in research and in healthcare, and in a clinic in the North West province in South Africa, a team of researchers and health care providers are piloting an intervention for maternal depression.

As is typical in many urban clinics, women sit sometimes for many hours in the maternal care section of a clinic waiting for a nurse or a doctor consultation. In the hot, dusty summer heat, as well as the cold and dry winters the waiting room is stuffy and sometimes airless, usually filled with the sounds of chatting women and restless children. I visit as regularly as I can to speak to the nursing staff to discuss the process of screening maternal care patients for depression. This is a relatively new practice at this Study Clinic, indeed in this district, negotiated with the district health management, who, recognising the gap that exists in mental health screening in maternal care, have embraced screening and referral for maternal depression. I am based some 700 km away at an urban university in a different province, KwaZulu-Natal, but I try to check in as often as I can when I am in the district, to chat with the manager or the nurses to get a feel of how things are working in terms of identifying and caring for maternal care patients with depression. At this Study Clinic we are piloting a collaborative care package for maternal depression.

The need for this service is palpable. During the formative phase of the study we interviewed a number of women, many who expressed a sense of relief and unburdening after being interviewed by the research team, and this even before they receive any formal counselling.

Being listened to and having their problems and their feelings acknowledged is cathartic. Poverty, interpersonal disputes, intimate partner violence, abandonment and lack of support are themes that run through the women's stories like the precious threads of ore in the bedrock that is the foundation and lifeblood of this mining district. Sadly, these are personal issues that are generally considered "normal" part of life, issues that you wish someone could help you to overcome but that are to be stoically borne. Feelings of depression are seldom articulated, particularly not to the nurses or doctors.



As I write this, observing events set against the backdrop of a province in political turmoil, public healthcare has been a significant casualty of the violence amid forced closure of essential services. Some hospitals have been forcibly closed and patients sent home, as have many clinics through intimidation and threat of violence been forced to close. This morning, the district in which I have been privileged to conduct research also became a casualty of the spreading tumult, and many clinics including the clinic that has so willingly and diligently participated in the mental health research activities that our project has undertaken including the depression intervention for maternal health, were forced to close their doors and turn away patients sorely in need of healthcare services. As is often the case, it is the poor, the marginalised and those most in need of services that suffer. Primary care is the bedrock of public health service, and in a country where the vast majority of citizens rely on public health services, disruptions of this scale are difficult to recover from. I sit on the side-lines and observe with apprehension, hoping that health services return to normal as soon as possible. When some semblance of normality resumes, overwhelmed clinicians will have a lot of catching up to do as chronic diseases are prioritised for medication supply, adherence and treatment. I fervently hope that screening and care for vulnerable patients with depression will not be affected and will continue as they have prior to the crisis that shut the clinic doors.

**Note: This article has been written in my capacity as a researcher currently writing my PhD. The study referred to in this piece is my PhD research study.*



Towards a more responsive mental health system in South Africa: The Mental Health Integration (MhINT) Programme

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The burden of chronic disease in South Africa is staggering. The epidemics of HIV and tuberculosis are now joined by the rise of non-communicable diseases, particularly type 2 diabetes and cardiovascular disease. Approximately 16.5% of all South Africans suffer from common mental disorders such as mood, anxiety, or substance use disorders each year and yet only one in four South Africans with common mental disorders have access to mental health treatment of any kind. Addressing the treatment gap for common mental disorders is critical as research has consistently found that common mental disorders are greater in people with chronic conditions such as HIV, TB and non-communicable diseases. Furthermore, patients with comorbid depression or alcohol misuse have been found to be two to three times less likely to be treatment adherent, thus resulting in poorer health outcomes. Therefore, the failure to deliver treatment for common mental disorders can be expected to have negative ramifications for the entire health system and increase the challenges associated with the management of non-communicable diseases.

In response to the growing burden of chronic conditions, the National Department of Health (NDOH) introduced a multi-disease integrated chronic disease model at facility, community and population levels. At the facility level, this model aims to strengthen the quality of care for chronic conditions through servicing all chronic care patients collaboratively, at one service point. A central aspect of this is strengthening decision support through the adoption and mentorship of nurse-led clinical guidelines for the identification and management of multiple chronic diseases called Adult Primary Care (APC), previously Primary Care 101 (PC101). In addition, the South African National Mental Health Policy and Action Plan 2013-2020 emphasizes the integration of mental health into primary care facilities, embracing a task-sharing approach to mental health service delivery. This is particularly appropriate in resource scarce contexts like South Africa where the pool of available psychological specialists is inadequate to meet population needs.

The Mental Health Integration Programme (MhINT) is a programme aligned with the above and its primary objective is to facilitate the integration of mental health care services into already existing primary health care systems. It is an evidence-based scale up of an integrated care package for common mental disorders that was developed and tested through the Programme for Improving Mental Health Care (PRIME) in the Dr Kenneth Kaunda District in the North West Province.

PRIME produced evidence that a collaborative stepped care model that includes additional APC training in mental health for professional nurses to improve detection of common mental disorders, as well as strengthened referral pathways for focused depression counselling by trained lay counsellors can substantially reduce the burden of depression as a result of improved identification, diagnosis and treatment (see diagram). The study also found that the intervention was acceptable to both service providers and patients. Key role players in the collaborative care model include:

- Primary care nurses: Case managers, identify common mental disorders using adult primary care, provide supportive counselling, repeat medication, refer and review patient response to treatments.
- Lay counsellors: Provide a structured manualised psycho-education, depression counselling and adherence counselling intervention under regular supervision from a Registered Psychological Counsellor.
- District Registered Psychological counsellors: Provide training and supervision to lay counsellors and also offer a referral service.
- District Psychologists: Train Psychological Counsellors to train and supervise lay counsellors. They also provide emotional support and debriefing to the lay counsellors and manage more severe psychopathology.
- Doctors: Diagnose and review complex/severe cases and prescribe psychotropic medication.



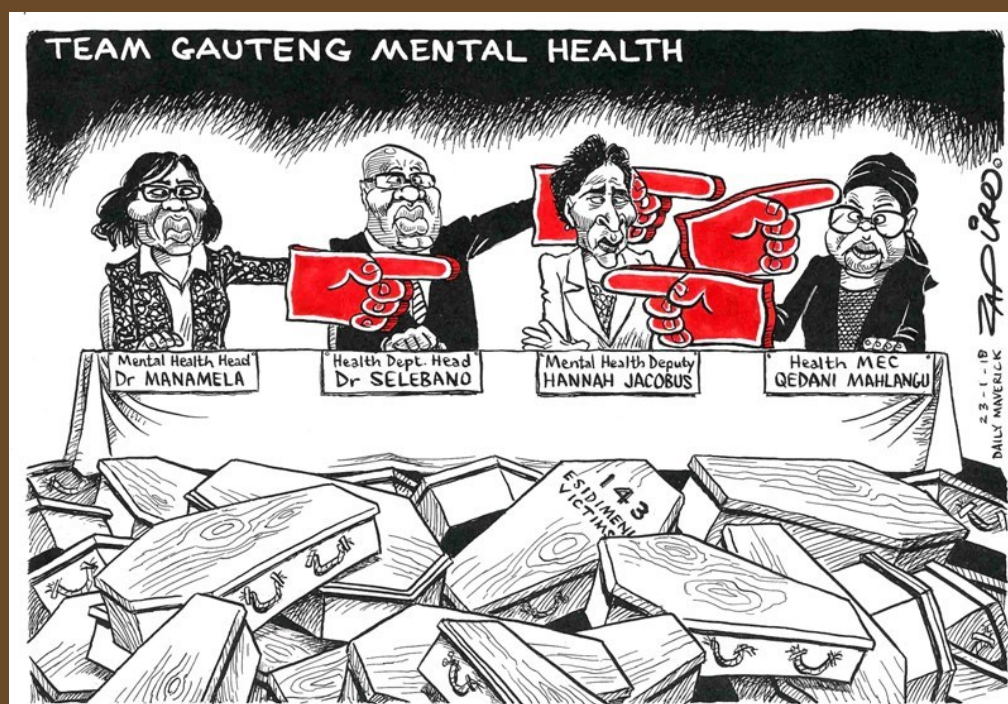
The results from the PRIME established that the use of lay counsellors to provide focused depression counselling can be effective with positive and lasting outcomes. Through funding from the United States Centers for Disease Control and Prevention (CDC) the MhINT Programme translated the PRIME intervention into a package that can be adaptable to local contexts and diverse settings and scaled up nationally. In addition to the Dr Kenneth Kaunda District the NDOH identified two sites for piloting the MhINT scale up intervention, namely Amajuba District in Kwazulu Natal (KZN) and Ehlanzeni District in Mpumalanga (MP). Following several processes of engagement at National, district and facility level implementation in KZN commenced in September 2017 at the Newcastle sub-district and the intervention was rolled out in March 2018 in Nkomazi sub-district in MP. As part of implementation MhINT provides technical support in developing a district mental health care plan in line with the guidelines of the National Mental Health Policy Framework and Strategic Plan 2013 – 2020 and capacity building interventions targeting the different role players in the collaborative care package for common mental health disorders.

Structured mentorship, supervision and support for district based DOH staff to facilitate embedding and sustainability of an integrated mental health service in PHCs is also provided. Additionally, an implementation framework informed by the principles of the Continuous Quality Improvement (CQI) methodology forms part of MhINT implementation. CQI provides tools for monitoring and evaluating clinical programmes, promoting performance to reach targets, achieve efficiency within the constraints of available resources as well as a platform for the development of innovative ideas to inform translation of NDOH policies into practice.

Whilst implementation of the MhINT intervention is in the early phase in both Ehlanzeni and Amajuba districts; over 405 patients have been identified and referred for depression counselling in Amajuba district with an uptake rate of 86.4% by March 2018. An additional 483 patients have been referred for the extended adherence counselling intervention with an uptake rate of 97.7%. Implementation of MhINT through the CQI lens has highlighted the importance of giving staff decision latitude in translating guidelines and policies into action and generate change ideas to improve achievement of targets at facility and district level. Additionally reviewing mental health data alongside other programmatic data, especially HIV, has helped show the synergies and importance of an integrated approach both in policy and practice.

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