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Children's Right to Mental Health in Ethiopia: The Law and the Practice

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CHILDREN'S RIGHT TO MENTAL HEALTH IN ETHIOPIA: THE LAW AND THE PRACTICE

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A thesis submitted in partial fulfillment of the requirements for a Master of Laws degree in Human Rights Law at the School of Law, College of Law and Governance Studies of Addis Ababa University.

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Declaration

I, **Rebka Kassaye**, hereby declare that the study on "Children's Right to Mental Health: The Law and The Practice" is my own work, and the sources used are duly cited and acknowledged.

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Approved by the board of examiners.

Examiner 1	**Examiner 2**
Name……	Name ……...
Signature ……	Signature……...
Date…….	Date……...

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Abstract

This research was conducted with the aim of assessing the normative and practical barriers against children's right to mental health in Ethiopia. The research applied a qualitative approach using St. Paul's Millenium Medical Hospital's Child and Adolescent Psychiatry Outpatient Department (OPD) as a Case Study. Data was gathered through Key Informant Interviews, In-depth Interviews, and an Observation Checklist. Then the collected data was transcribed and analyzed thematically. The research found that there are major barriers against children's right to mental health in Ethiopia due to distance from mental health facilities, lack of information, a limited number of mental health professionals, lack of sufficient resources, unavailability of medication, price of medication, absence of in-patient services, and discrimination and stigma. The government should design a child-specific mental health strategy and prioritize allocating resources toward ensuring quality mental health services are accessible to all children across Ethiopia.

Key Words: Mental Health, Children's Right**,** the Right to Health

Acronyms

ACRWC: African Charter on the Rights and Welfare of the Child

ADHD: Attention-deficit hyperactivity disorder

AIDS: Acquired Immunodeficiency Syndrome

ASD: Autism Spectrum Disorder

BSc: Bachelor of Science

CBHI: Community-Based Health Insurance

CRC: Convention on the Rights of the Child

CRPD: Convention on the Rights of Persons with Disabilities

CST: Caregiver Skill Training

FDRE: Federal Democratic Republic of Ethiopia

HEWs: Health Extension Workers

HIV: Human Immunodeficiency Virus

HSDP: Health Sector Development Program

HSTP: Health Sector Transformation Plan

ICESCR: International Covenant on Economic, Social, and Cultural Rights

IDI: In-depth Interview

IRB: Institutional Review Board

KII: Key Informant Interview

LMICs: Lower and Middle-Income Countries

MOH: Ministry of Health

MSc: Master of Sciences

NGO: Non-Governmental Organization

OPD: Outpatient Department

SBC: Social and Behavior Change

SUD: Substance Use Disorder

WHO: World Health Organization

UNICEF: United Nations International Children's Emergency Fund

Glossary of Medical Terms

Specialist/psychiatric Nurses: They have specialized in assessing and treating children and families with mental health problems.

Psychotherapists: Undergo extensive training in the emotional development of children and those traumatic events that may affect them.

Clinical Psychologists: Have undertaken a first degree in psychology and then further training in applying psychological theories within a clinical setting. Their skills Include training in assessing children's abilities, and they may work with cognitive behavioral therapy techniques to treat children presenting with various difficulties.

Family therapists: Have a professional background and undertake further training as family therapists. They train in family relationships and how to change behavior patterns using a family or systems approach.

Occupational therapists: Are trained in helping children, especially those with developmental difficulties and motor coordination problems.

Psychiatry Resident: A medical resident practicing in a psychiatry specialty under the supervision of a psychiatrist with more years of experience.

Runner: Takes messages, documents, or supplies to and from different areas of the hospital to another.

Sub-specialist: A doctor who has additional training in a very specific area of medicine.

Psychotherapy: Also called talk therapy, refers to treatments that help a person identify and change troubling emotions, thoughts, and behavior.

Neurodevelopmental disorder: A condition in which the growth and development of the brain are affected.

Stimulant: A drug that raises levels of physiological or nervous activity in the body.

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CHAPTER ONE

INTRODUCTION

1.1. Background of the Research

The UN Convention on the Rights of the Child (CRC) defines a child as "Every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier."[1] Similarly, Article 2 of the African Charter on the Rights and Welfare of the Child (ACRWC) defines a child as "every human being below the age of 18 years".[2] Article 215 of the Ethiopian Revised Family Code defines a minor as "a person of either sex who has not attained the full age of eighteen years."[3] The FDRE Constitution declares that all international instruments ratified by Ethiopia are an integral part of the law of the land.[4] Ethiopia has ratified the CRC on December 9, 1991,[5] and the ACRWC on October 2, 2002,[6] respectively.

Childhood and adolescence are crucial times for forming one's identity and engaging in various roles, particularly with peers. Mental health issues can hinder a young person's capacity to develop positive relationships and handle conflicts within these relationships effectively.[7] Mental

[1] Convention on the Rights of the Child, (General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990), Art. (1)

[2] African Charter on the Rights and Welfare of the Child (ACRWC), (26th Ordinary Session of the Assembly of Heads of State and Government of the OAU Addis Ababa, Ethiopia - July 1990 Entered into force on 29 November 1999), Art. 2

[3] The Revised Family Code, (Federal Negarit Gazette of the Federal Democratic Republic of Ethiopia, Federal Negarit Gazette Extra Ordinary Issue No. 1/2000 The Revised Family Code Proclamation No. 213/2000, July 4th, 2000) Art. 215.

[4] Constitution of the Federal Democratic Republic of Ethiopia, (Proclamation no. 1/1995, Federal Negarit Gazeta, 8th December 1994), Art. 9 (4)

[5] Girmachew Alemu (Ph.D.) and Yonas Birmeta, *Handbook on the Rights of the Child in Ethiopia*, (Center for Human Rights College of Law and Governance Studies Addis Ababa University) 7.

[6] Ibid.

[7] Ibid

disorders are illnesses that impact behavior, emotion, and thought processes.[8] They significantly impair children's capacity to learn and affect their family and social lives. [9] The CRC as well as the ACRWC recognize children's right to health and medical services under Article 24[10] and Article 14[11] respectively.

States are the primary duty barriers under international human rights treaties. State duties include the duty to respect, the duty to protect, and the duty to fulfill.[12] Article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) encourages states to take steps, individually and through international cooperation, to progressively achieve the full realization of the rights under the ICESCR including the right to health.[13]

The concept of progressive realization pertains to a state's responsibility to gradually meet and safeguard human rights, especially economic, social, and cultural rights, taking into account their resources, societal practices, and international minimum standards. This includes developing a public healthcare system that ensures basic health services are accessible to everyone.[14]

The government of Ethiopia also has the above obligations which includes the obligation to protect and fulfill the mental health of children.

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[8] Jamison DT, World Bank, and Disease Control Priorities Project (eds), *Disease Control Priorities in Developing Countries*, (2nd ed, Oxford University Press; World Bank 2006 Chapter 31) 605.

[9] Ibid.

[10] CRC (n 1): Article 24 (1) Reads: Parties recognize the child' to the enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right to access such health care services.

[11] ACRWC (n 2) Article 14 (2) (b) and (f) reads: (b) "to ensure the provision of necessary medical assistance and health care to all children with an emphasis on the development of primary health care."
(f) to integrate basic health service programs in national development plans

[12] United Nations, 'The Foundation of International Human Rights Law' (*United Nations*) <https://www.un.org/en/about-us/udhr/foundation-of-international-human-rights-law> accessed 16 March 2024

[13] International Covenant on Economic, Social and Cultural Rights, (Adopted and opened for signature, ratification, and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976, in accordance with article 27) Art. 2

[14] ICESCR, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant) Adopted at the Fifth Session of the Committee on Economic, Social and Cultural Rights, on 14 December 1990 (Contained in Document E/1991/23) para. 9

1.2. Statement of the Problem

According to UNICEF, an estimated 58,272,539 of the population is under the age of 18 in Ethiopia as of 2023,[15] which shows children and adolescents encompass a large section of the population. Children and Adolescents in Ethiopia suffer from a wide range of mental disorders and psychological disabilities, ranging from attention deficit hyperactivity disorder (ADHD) to autism spectrum disorders. The prevalence of these disorders varies depending on the specific disorder and ranges from 0.6% to 25% in children.[16]

According to Ethiopia's National Mental Health Strategy, there are only two Hospitals in Ethiopia that give mental health and psychiatric services to children.[17] These are St. Paul's Hospital and Yekatit 12 Hospital, both located in Addis Ababa, the nation's capital city. Both facilities do not have in-patient services for children.[18]

Considering the huge number of persons under the age of 18 and the geographical size of the country, significant barriers to accessing mental health services exist, denying children and adolescents their fundamental human rights to health care and the right of the child to life and development. Ensuring that children have access to mental health services is not only a matter of upholding their fundamental human rights but also an investment in their future well-being and development as the next generation.

Even though this is an important subject in both policy and law, not many studies have been conducted on children's right to mental health in Ethiopia. Moreover, the implementation of policy and law has not yet been sufficiently studied from a Human Rights perspective. As such, this study aims to contribute to filling the gap in conceptual analysis and practice. It also attempts to explain the duty of the Ethiopian government to fulfill its obligations and the challenges in fulfilling them.

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[15] UNICEF, 'How many children are there in Ethiopia?' <https://data.unicef.org/how-many/how-many-children under-18-are-there-in-ethiopia/> accessed 06 January 2023.

[16] Ministry of Health, 'National Mental Health Strategy', (Addis Ababa, Ethiopia, 2020-2025) 15.

[17] Ibid 16

[18] Ibid

1.3. Objectives of the Research

This research has the following objectives:

1. Explain how access to mental health services for children is a crucial part of children's right to health under international human rights law.
2. Explain the policy, normative, and legislative framework for children's mental health in Ethiopia and assess the challenges and prospects of their practical implementation.
3. Explore potential solutions to overcome barriers to mental health services for children in Ethiopia.

1.4. Research Questions

This research will attempt to respond to the following questions:

1. What are the constituent elements of mental health under international human rights law?

2. What policies and laws recognize and protect children's right to mental health in Ethiopia?

3. What are the normative and practical barriers against children's right to mental health in Ethiopia?

1.5. Research Methodology and Methods

1.5.1. Methodology

The research employed a combination of qualitative and doctrinal research methodologies. The doctrinal method involved a textual analysis of legal texts and official documents such as national and international laws, government policies, strategies, and initiatives to understand the legal framework surrounding children's mental health.

The qualitative method utilized primary and secondary data sources. The primary sources were gathered from a Case Study of St. Paul's Millenium Medical Hospital's Child and Adolescent Psychiatry Outpatient Department (OPD) as indicative of the practice and challenges in the protection of the mental health of children. Secondary data sources were scholarly articles, books as well as relevant research papers.

1.5.2. Methods and Tools

A) Primary Data

Primary Data was collected using semi-structured In-depth Interview (IDI) and Key Informant Interview (KII) tools. (See Appendices II, III, and IV) IDIs are one of the various qualitative research methods used to collect information about participants' subjective experiences in an in-depth interview. The goal is to gather comprehensive data that shows a person's viewpoint and experience.[19] For this study, IDIs were conducted with Nine parents/caregivers of children receiving mental health services at St. Paul Hospital. (See Appendix I)

KIIs were conducted with individuals who possess in-depth expertise in a particular subject or problem under investigation.[20] For this study, KII was administered to Six mental health professionals namely clinical psychologists, psychiatry residents, and psychiatric nurses as well as one runner at the Child and Adolescent Psychiatry Outpatient Department (OPD) of the St. Paul Hospital, which is located in the Gulele sub-city. In total, 15 Interviews were conducted.

In addition to the IDI and KII tools, an observation checklist was utilized to allow the researcher to gather information by observing the delivery of mental health services at St. Paul Hospital. The objective of the observation was to assess facility sanitation, staff interactions with patients and their parents, patient waiting time, feedback mechanism, and the overall quality of care provided to children at the OPD. Furthermore, the researcher was able to look through the patient register to assess how many children and adolescents come to receive care.

B) Secondary Data

Secondary data sources included relevant scholarly literature. A systematic review of relevant scholarly articles, books, research papers, and literature was conducted.

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[19] Rutledge PB and Hogg JLC, 'In-Depth Interviews' in Jan Bulck (ed), *The International Encyclopedia of Media Psychology* (1st edn, Wiley 2020) <https://onlinelibrary.wiley.com/doi/10.1002/9781119011071.iemp0019> accessed 20 February 2024

[20] The Australian Prevention Partnership Centre, 'Key Informant Interviews', (2018), <https://preventioncentre.org.au/wp-content/uploads/2016/05/07-Key-Informant-Interviews.pdf> accessed 20 February 2024

1.6. Ethical Considerations

To gather the necessary data from St. Paul's Millenium Medical Hospital, the researcher had to pass through a mandatory Ethical Clearance screening process. To obtain ethical approval from St. Paul's Institutional Review Board, the researcher submitted a bound copy of the research proposal along with translated data collection tools (IDI, KII, and Observation Checklist) to local languages Amharic and Afan Oromo, a support letter from Addis Ababa University and the researcher's Curriculum Vitae. Additionally, the researcher was asked to submit an Ethical Clearance letter from AAU. However, because there is no operational ethical clearance committee at the AAU School of Law, the researcher had to request an additional support letter from the school explaining this absence.

Upon receiving the request, the School of Law wrote St. Paul a letter clarifying that the School of Law does not have an operational ethical review committee and asking the Research Directorate at St. Paul's for collaboration and assistance in accepting the documents submitted for screening. (See Appendix V) This process of translating the tools, obtaining the support letters, and submitting the documents took several weeks. After submitting the document for screening, the researcher had to wait for a few more weeks before receiving the approval letter. (See Appendix VI)

Dealing with human subjects of research requires several ethical considerations. The first one is obtaining informed consent and ensuring confidentiality. The researcher has articulated the research objectives verbally so that they are clearly understood by the informants. Moreover, the researcher has disclosed the use of data collected and acquired the consent of all informants. Confidentiality means that the information shared during the interview will only be used for this study. Respecting informants and protecting their integrity and privacy is another ethical consideration. The researcher has avoided subjective characterization and stigmatization against all informants. All tools were designed in compliance with ethical considerations. (See Appendices II, III, and IV)

1.7.Literature Review

Mental health does not exist in a vacuum. It is a crucial and fundamental component of the overall health of a person. A person in good mental health is presumed to be able to establish and sustain loving relationships with others, function in the social roles that are customarily performed in their culture, manage change, recognize, acknowledge, and communicate positive actions and thoughts, as well as manage emotions.[21] Mental health is just as important as physical health, and each person's mental health is distinct from another. This holds true for adults, children, and adolescents.[22]

Roughly 10% of children and adolescents between the ages of 5 and 16 struggle with mental health issues. It has been demonstrated that experiencing mental health issues as a child or adolescent increases the likelihood of experiencing mental health issues as an adult.[23] These issues raise the risk of substance abuse, self-harm, and suicide in addition to decreasing the likelihood of social and academic achievement.[24] Jane Padmore suggests that to prevent damage and develop lifelong resilience in these children and adolescents, early detection, intervention, and support are crucial.[25]

Persons with mental illness face numerous human rights violations, both within institutions and outside, such as inadequate care and mistreatment, limiting their civil liberties and rights to education and employment.[26] Adolescents with mental health issues are also more susceptible to risk-taking behaviors, social isolation, discrimination, and stigma, which might impact their willingness to seek help.[27] Children's well-being is crucial for their adult and future lives, and

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[21] Bhugra D, Till A and Sartorius N, 'What Is Mental Health?' (2013) 59 International Journal of Social Psychiatry 3 <http://journals.sagepub.com/doi/10.1177/0020764012463315> accessed 12 January 2024

[22] CACHE (eds) 'Certificate in Understanding Children and Young People's Mental Health', (Workbook 1, Level 1, January 2018), 8.

[23] Padmore J, *Mental Health Needs of Children & Young People: Guiding You to Key Issues and Practices in CAMHS* (Open University Press 2016)

[24] Ibid

[25] Ibid

[26] Carla A. Arena Ventura, 'International Law, Mental Health and Human Rights', (University of Notre Dame, enter for Civil and Human Rights, 2014) 1

[27] 'Mental Health of Adolescents' <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

vulnerability in childhood is a concern for subsequent stages in life and future generations. It is essential to address this vulnerability to ensure the well-being of all individuals.[28]

Carla Arena describes the relationship between the right to mental health and international human rights as interdependent because international human rights instruments are crucial in the realm of mental health as they serve as the sole legal framework for international scrutiny of mental health policies and practices within a sovereign country, offering fundamental protections that political processes cannot undermine.[29]

The prevalence and treatment practices of child mental health problems in Ethiopia remain unidentified despite the existence of few studies attempting to identify such issues, making it challenging to determine the prevalence rate of symptoms and diagnoses.[30] Recent studies reveal a high burden of mental health issues in Ethiopia, despite the country's lack of comprehensive research on the subject.[31] The research paper by Kidus Yitbark and others found that low concern among health system leaders, low public-private partnership, inadequate budget, low acceptability of services from both communities and health extension workers (HEWs), low commitment of HEWs, and absence of mental health indicators in the Ethiopian health information system are barriers to adequate mental health services.[32]

Ethiopia's children's mental health care service is a neglected health program with inadequate policy planning, skilled professionals, and resources, even though there is a prevalence rate of child mental illness.[33] Mental Health Services are often provided by untrained individuals, such

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accessed 22 January 2024

[28] Desai M, *A Rights-Based Preventative Approach for Psychosocial Well-Being in Childhood* (Springer 2010) 24

[29] Carla A. (n 26) 2

[30] Selamu LG and Singhe MS, 'Barriers in Accessing Child Mental Health Care Services in Ethiopia' (2018) 08 Primary Health Care Open Access <https://www.omicsonline.org/open-access/barriers-in-accessing-child-mental-health-care-services-in-ethiopia-2167-1079-1000288-99605.html> accessed 8 May 2024

[31] Yitbarek K and others, 'Barriers and Facilitators for Implementing Mental Health Services into the Ethiopian Health Extension Program: A Qualitative Study' (2021) Volume 14 Risk Management and Healthcare Policy 1199 <https://www.dovepress.com/barriers-and-facilitators-for-implementing-mental-health-services-into-peer-reviewed-article-RMHP > accessed 20 February 2024

[32] Ibid

[33] Selamu LG (n 30)

as religious leaders, teachers, and older adults, who are not trained in the field when children's mental health issues need public hospital attention.[34] Liranso G. Selamu affirms that the inability to implement policies indicates insufficient attention from policymakers and professionals in addressing children's mental health issues, resulting in a decline in their cognitive, social, emotional, and educational development.[35]

The mental health services that are currently in place are not planned, backed by policies, or supported by data from scientific studies.[36] There is a large gap existing in prevention, early intervention, and policy formulation.[37] Liranso highlights a significant disparity in children's needs, service strategies, and professional care, with limited access to specialized services, child psychiatrists, and resources.[38] Barriers to mental health care include limited mental health professionals, financial resources, stigma, discrimination, and poor decision-making and policy implementation.[39]

However, despite the attempts to cover this study area, there is a noticeable gap in recent literature. There is a lack of adequate recently published material and frequently updated statistical data that highlights the prevalence of mental health problems in children, which shows a spatial gap and a lack of nationwide research. Furthermore, there is a lack of literature that explores children's access to mental health from a Human Rights perspective. This indicates that sufficient attention and importance has not been given to such a significant Human Rights issue. This thesis aims to contribute to the ongoing discourse by providing a Human Rights perspective and highlighting practical challenges as well as offering possible solutions.

[34] Selamu LG, 'Children's Mental Health Strategies and Practices in Addis Ababa Ethiopia' (2019) 48 International Journal of Mental Health 188 <https://www.tandfonline.com/doi/full/10.1080/00207411.2019.1644138> accessed 8 May 2024

[35] Ibid 191

[36] Ibid

[37] Ibid 193

[38] Ibid 195

[39] Selamu LG (n 30)

1.8. Scope of the Research

The research analyzed the accessibility understood as the availability and affordability of public (government-funded) mental health services for children in light of children's right to health. The study focused on International Human Rights Instruments and Ethiopia's Legal and Policy Frameworks. To assess the practice, the study used St. Paul's Millenium Medical Hospital's Child and Adolescent Psychiatry Outpatient Department (OPD) as a case study.

As one of the only two public hospitals that give children mental health services, St. Paul Hospital has been selected for this research because of the availability of necessary facilities, professionals, and resources required for the research as well as the more efficient process of obtaining the necessary ethical approval to conduct the data collection. The study focused on children aged 2-18 since mental disorders begin to demonstrate around the age of 2 according to mental health professionals.

The accuracy of medical treatments or diagnoses provided to children or other medical-related considerations as well as private and NGO-led mental health facilities are outside the scope of this study.

1.9. Significance of the Study

Adolescence and childhood constitute important life phases for mental health. The brain is going through a period of fast growth and development.[40] Children and teenagers develop cognitive and social-emotional abilities that are crucial for taking adult roles in society and that will influence their mental health in the future.[41] Moreover, evidence indicates that a significant percentage of adult mental health problems have their roots in early childhood and that this has long-lasting consequences.[42]

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[40] 'Child and Adolescent Mental and Brain Health' <https://www.who.int/activities/improving-the-mental-and-brain-health-of-children-and-adolescents> accessed 15 February 2024

[41] Ibid

[42] Kieling C and others, 'Child and Adolescent Mental Health Worldwide: Evidence for Action' (2011) 378 The Lancet 1515 <https://linkinghub.elsevier.com/retrieve/pii/S0140673611608271> accessed 15 February 2024

The failure to address mental health issues, such as intellectual and developmental disorders, in children and adolescents living in low-resource environments is a public health concern that has far-reaching effects because it hinders their attainment of fundamental developmental milestones.[43] Children's mental health has an impact on their overall health and development, and it is essential to ensure a sustainable future.

Children are the next generation who will inherit the world we live in. Protecting their right to mental health is an investment in their well-being. Providing equal access to quality healthcare for all children is one of the main components of child welfare.[44] Importance must be given to the right of children to mental health and studies should be conducted to assess the provision, or lack thereof, of mental health services for children in Ethiopia to aid the necessary interventions. Thus, this study aims to assess children's access to mental health services in light of their human rights to health and contribute by filling the gap in the existing literature.

1.10. Limitations of the Study

In conducting this study, the researcher has faced several limitations. The first is the lack of sufficient literature and access to up-to-date secondary sources. Second, in order to gather the necessary data, the researcher was asked to obtain Ethical Approval which had several steps and requirements and was a time-consuming process. Third, the availability of key informants was a challenge. Some of the mental health professionals at St. Paul were fully booked with patients and too busy to sit for an interview or unavailable due to annual leave or working in other clinics. Fourth, speaking to parents also proved to be a challenge because some mothers would come with several of their children since no one was available back home to look after them. This would mean they had no time to spare until they left. Even when some parents came with just the child that needed the mental health service, the child would require their full attention, making it difficult for them to engage in a long conversation. The fifth challenge is the numerous issues around the mental health of children and the time constraints as well as word limitations.

Although the sample size is small, the researcher used the method of saturation and the rule of redundancy to ensure the findings are detailed and thorough providing sufficient qualitative

[43] Ibid

[44] Ibid

insight. Since there are only two hospitals that give mental health services to children, thereby serving a similar population, selecting one hospital can provide a comprehensive view of the services offered within the scope of the study and capture a significant portion of the available data.

1.11. Organization of the Study

This thesis is divided into four chapters and structured as follows:

Chapter one is an introductory part of the thesis and deals with the background of the study, statement of the problem, research questions, objective, significance, scope, and methodology of the research. Chapter two of the research focused on a literature review related to Children's Right to Mental Health and discussed relevant international laws and national policies, legislations, and institutional frameworks in Ethiopia.

Chapter three deals with the results and discussion. This chapter covers how the researcher analyzed the collected data and presented the findings. The final chapter presents conclusions and recommendations. The researcher recapped the main points of the study and recommended possible solutions to the research problem.

CHAPTER TWO

2. The Policy and Legislative Framework of Children's Right to Mental Health

2.1. Introduction

This chapter discusses the policy and legislative framework of children's right to mental health. It begins with an overview of mental health in general and discusses children's mental health in particular. It covers the circumstances that affect children's mental health and the common disorders in children as well as the importance of protecting children's mental health. Following this, mental health services in Ethiopia are discussed along with the common mental disorders of children in Ethiopia. The chapter goes on to examine the International and National Legal Framework of Children's Right to Mental Health and a State's international core obligations. Lastly, the chapter discusses the common challenges in the implementation of Children's Right to Mental Health.

2.2. Mental Health: An Overview

Mental Health is known as a positive state of psychological well-being. The World Health Organization (WHO) included a sense of well-being as part of overall health defining it as an individual's ability to develop harmonious relationships with others and to participate in, or contribute constructively to, changes in his/her social or physical environment.[45] Mental health services can be offered to people with a wide range of mental health problems.[46]

Most individuals who are going to develop a mental disorder at any point in their life will first show signs of mental disorder in their childhood or adolescence.[47] Emotional and behavioral disorders that affect children are often temporary, but they may precede and predict the more severe forms of mental illness that affect adults.[48] Children who develop mental disorders experience the symptoms of the disorder for an average of two years before meeting the

[45] Pilgrim D, *Key Concepts in Mental Health* (4th edition, SAGE Pub 2017)

[46] Ibid 3

[47] Taylor E and others (eds), *Mental Health and Illness of Children and Adolescents* (Springer 2020) 5

[48] Ibid 5

diagnostic criteria.[49] However, only a small percentage of children and adolescents with these symptoms or a disorder go on to access treatment.[50]

There is mounting evidence of the widespread prevalence of severe and persistent mental disorders, such as schizophrenia, bipolar, depressive and related disorders, substance misuse, and intellectual disabilities.[51] Mental, neurological, and substance use disorders significantly contribute to the global burden of diseases, with 25% of people affected by these conditions at some point in their lifetime and accounting for 10.5% of disability-adjusted life years.[52] Therefore, we can see that mental disorders are common but they particularly have severe effects in low and middle-income countries, where they commonly co-exist and interact with issues such as poverty and social disruption.[53]

Mental disorders increase the risk of unintentional injury and violence, particularly among those in extreme poverty, particularly women, children, and young people who struggle with accessing services.[54] People with mental disorders experience some of the harshest living conditions in many societies, such as economic marginalization, discrimination, and a lack of legal protections against abusive treatment, thus they are often denied opportunities for education, employment, and access to public services, which shows the undesirable living conditions faced by these individuals.[55]

In recent years, mental health and human rights have become intersecting fields of research and practice, as more recognition is given to the fact that the two fields overlap in several complex ways since the important requirements that must be fulfilled for mental health and psychosocial well-being are the same ones that support the advancement of human dignity, which is the

[49] Ibid 21

[50] Ibid 21

[51] Dudley M, Silove D and Gale F (eds), *Mental Health and Human Rights: Vision, Praxis, and Courage* (1st ed, Oxford University Press 2012) 4

[52] MoH (n 16) 12

[53] Dudley M. (n 51) 2

[54] Ibid 5

[55] Ibid 29

foundation of human rights.[56] Globally, mental health receives a low priority because practitioners and advocates fail to provide clear, unified messages about mental health needs, there is a lack of evidence-based interventions, cost-effectiveness, marginalization of service users and their families, and lack of awareness and knowledge among communities.[57]

Concerning mental health, legislation should promote fair, equal, and minimally restrictive treatment, protection from discrimination, affirmative obligations, and standards to form effective policies.[58] It should also aim to guarantee equal rights for people engaging with mental health systems.[59] Progressive legislation and policies can promote mental health treatment, rehabilitation, aftercare, and societal promotion, while also developing and maintaining community-based services and integrating them with primary care to ensure all-inclusive care.[60]

2.3. Understanding Children's Right to Mental Health

2.3.1. Children's Mental Health

Many children and adolescents suffer from mental health conditions such as depression, anxiety, conduct, and attention disorders worldwide.[61] Research on child mental health trends is mainly conducted in high-income countries, despite the majority of 2.5 billion children and adolescents residing in Lower and Middle-Income Countries (LMICs).[62] There are often unique social challenges that affect children's mental health and LMICs often experience rapid social change. These challenges include higher rates of internal and international displacement/migration, rapid urbanization, and natural disasters associated with climate change.[63]

Improving children's and young people's mental health is a societal priority as mental health issues can significantly impact social development and education and are linked to poor long-

[56] Ibid 2

[57] Ibid 7

[58] Ibid 29

[59] World Health Organization (ed), *Mental health, human rights, and legislation,* (WHO, 2023) 22

[60] Dudley M (n 51) 29

[61] UNICEF (ed), *On My Mind: Promoting, Protecting and Caring for Children's Mental Health* (UNICEF 2021) 30

[62] Taylor E, (n 47) 68

[63] Ibid 68

term health.[64] Thus, monitoring the prevalence of mental health problems is important to assess the effectiveness of mental health interventions and to plan investments in mental health services to address future needs.[65]

Circumstances that might impact children's exposure to mental health issues include:

Socio-Economic Conditions: Youth mental health trends likely result from individual susceptibility and changes in children's lifestyles, family environment, and social conditions. However, Social change doesn't impact all young people in the same way as children growing up in more disadvantaged circumstances or with preexisting mental health problems are most vulnerable.[66]

Social Relationships and School Environment: Growing up, social issues like bullying, loneliness, and lack of supportive friendships can significantly impact children and adolescents. Additionally, academic expectations, pressure, and workload can also adversely impact young people's mental health**.**[67]

Family Risk: Research shows that youth mental health trends may involve intergenerational transmission risk, with problems like anxiety and depression being inherited and socially transmitted, which shows the importance of understanding and addressing these issues, which suggests that a rise in emotional issues among youth in one generation may increase the likelihood of the same issues in subsequent generations.[68]

The circumstances discussed above can be a cause of different mental disorders in children and adolescents. Some of the doctors who treat these disorders and have a specialization in child and adolescent psychiatry are Specialist/psychiatric Nurses, Psychotherapists, Clinical Psychologists, Family Therapists, and Occupational Therapists.[69] There are mainly three broad diagnostic

[64] Ibid 64

[65] Ibid 64

[66] Ibid 66

[67] Ibid 67

[68] Ibid 68

[69] Thompson M (ed), *Child and Adolescent Mental Health: Theory and Practice* (2nd ed, Hodder Education 2012) 21

categories of disorders relevant to child psychiatrists.[70] These are Emotional Disorders, Disruptive Behavior Disorders, and Developmental Disorders.[71]

Emotional Disorder: Includes Anxiety disorders, Phobias, Depression, Obsessive-Compulsive Disorder, Somatization and Schizophrenia.[72]

Disruptive Behavior Disorders: Include Conduct Disorder, Oppositional Defiant Disorder, and Hyperactivity.[73]

Developmental Disorders: Speech/language delay, Reading delay, autism spectrum disorder, and Enuresis and Encopresis.[74]

The abovementioned mental health conditions not only impact children and young people if untreated, but also drain societies of human potential, leading to a loss of human capital and affecting the well-being and success of families, communities, and nations.[75] Policymakers proclaim children's mental health as a priority. However, compared to other aspects of children's health, there have been few improvements in prevalence, inequalities, and outcomes. Instead, things have worsened over time in several ways.[76] Mental health is often overlooked in international agendas unlike physical health, however, it is a necessary component for overall health and well-being.[77]

For a change to occur, there needs to be strategic plans. Strategically, mental health promotion requires changes in both public policies and public education.[78] Mental health legislation is

[70] Cooper M, Hooper CM and Thompson M (eds), *Child and Adolescent Mental Health: Theory and Practice* (Hodder Arnold; Distributed in the United States by Oxford University Press 2005) 3

[71] Ibid 3

[72] Ibid 3

[73] Ibid 3

[74] Ibid 3

[75] UNICEF (n 61) 30

[76] Taylor E (n 47) 70

[77] Dudley M. (n 51) 2

[78] Pilgrim (n 45) 156

crucial for enhancing the quality of mental health services, protecting human rights, and providing a legal framework to achieve its goals.[79]

Children's right to mental health should be promoted and protected as it can have the following positive effects:

- **Emotional well-being:** Positive, happy, calm, peaceful, and interested in life.[80]
- **Social well-being:** The ability to function in the world and a personal sense of value and belonging.[81]
- **Functional well-being:** The capacity to develop skills and knowledge that help a person make good decisions and deal with challenges.[82]

2.4. Mental Health Services in Ethiopia

In Ethiopia, mental health services are a highly disadvantaged health program due to a lack of basic facilities and skilled manpower.[83] The public faces a lack of adequate healthcare services for mental health practices to build on, limited scientific literature, and inadequate mental health professional preparation programs.[84]

Mental health professionals make up 0.26% of the country's health workforce, according to the MoH National Health Work Update 2019. Nationally, there are 111 practicing general psychiatrists, 46 Clinical Psychologists with an MSc, 10 social workers, 165 Mental Health professionals with an MSc, 320 Professionals in Psychiatry with a BSc, and 111 Professionals in

[79] World Health Organization (n 59) 3

[80] UNICEF (n 61) 32

[81] Ibid

[82] Ibid

[83] Sathiya Sussman A, 'Mental Health Services in Ethiopia: Emerging Public Health Issue' (2011) 125 Public Health 714 <https://linkinghub.elsevier.com/retrieve/pii/S0033350611002071> accessed 11 April 2024

[84] Hughes TL and others, 'Developing a Framework to Increase Access to Mental Health Services for Children With Special Needs in Ethiopia' (2020) 5 Frontiers in Sociology 583931 <https://www.frontiersin.org/articles/10.3389/fsoc.2020.583931/full> accessed 9 April 2024

Psychiatry with an advanced diploma. There are two psychiatrists specializing in children and adolescents, one in addiction, and one in forensics.[85]

There is little understanding of the national and sub-national burden of mental disorders since estimates vary across different settings according to previous pocket studies, indicating significant inter-regional variations in burden over time.[86] Ethiopia's progress in addressing mental health concerns is hindered by culture, civil war, natural conditions, and policies, despite studies showing the presence of mental disorders in the country being the same extent as in developed countries.[87]

Furthermore, the lack of data on mental health needs in different regions is concerning, as it makes it difficult to allocate resources and develop effective interventions without a clear understanding of their prevalence and impact.[88] A large community-based study in Ethiopia found mental illness to be the most burdensome condition, accounting for 11% of the total disease burden, with schizophrenia and depression ranking higher than HIV/AIDS.[89] Childhood mental illnesses, with a prevalence of 12-25%, significantly contribute to the health sector's burden of mental illnesses.[90] According to the National Mental Health Strategic Plan, the most common mental disorders in children and adolescents in Ethiopia as of 2020 are:

- ADHD
- Oppositional Defiant Disorders/Conduct Disorders
- Anxiety Disorders
- Mood Disorders
- Elimination of Disorders; and

[85] MoH (n 16) 17

[86] Ababi Zergaw and others, 'The Burden of Mental Disorders in Ethiopia, from 1990 to 2019: A Systematic Analysis of the Global Burden of Diseases Study 2019' (Ethiop. J. Health Dev.) 2

[87] Sathiya susuman A, (n 83) 715

[88] Zegraw (n 86) 2

[89] MoH (n 16) 12

[90] Ibid 8

- Autism Spectrum Disorders.[91]

Ethiopia's primary healthcare approach prioritizes health promotion, disease prevention, and essential health services delivery.[92] Even though the number of health facilities providing a mental health service is far from being enough to meet the needs on the ground, it is slowly increasing.[93] St Amanuel Specialized Mental Hospital in Addis Ababa has 268 beds and provides mental health services, and the second largest hospital providing in-patient psychiatric care with 150 psychiatric beds is Kotebe General Hospital.[94] An estimated 25% of Ethiopia's hospitals provide mental health services at the outpatient level.[95]

Child and adolescent mental health units are available in only two Hospitals located in Addis Ababa, which are St Paul's and Yekatit 12 hospitals. However, both facilities do not have in-patient services for children and adolescents.[96] The National Mental Health Strategic Plan provides that as of 2020, there were only two child and adolescent psychiatrists.[97] The Strategic Plan mentions that one of the weaknesses of mental health in Ethiopia is the limited focus on childhood developmental disorders.[98]

2.5. Legal Framework of Children's Right to Mental Health

2.5.1. International and Regional Law

2.5.1.1. The Human Right to Health

The Universal Declaration of Human Rights acknowledges everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including medical care

[91] Ibid 13

[92] Ibid 11

[93] Ibid 15

[94] Ibid 15

[95] Ibid

[96] Ibid

[97] Ibid 16

[98] Ibid 19

under Article 25[99], which also encompasses mental well-being and access to necessary healthcare. The Convention on the Rights of the Child and other international human rights frameworks serve as the foundation for the concept of Children's Right to Mental Health. The CRC is ratified by almost every country in the world.[100] Article 24 of the CRC recognizes the right of the child to the enjoyment of the highest attainable standard of health, including mental health.[101] It also emphasizes the importance of providing children with information and support to promote their mental well-being under Article 17.[102]

The World Health Organization's Constitution of 1946 serves as the foundation for international law on the Right to Health.[103] The preamble of the WHO Constitution introduces the idea of the right to the highest attainable standard of health, for the first time into international law.[104] International law provides two approaches to the definition of health. The first is the approach adopted under the WHO Constitution that defines health in its preamble as 'A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.[105] The consensus reached was that a definition of 'health' was unnecessary as no other terms were defined in the ICESCR and that the term 'social health' should be excluded due to its unclear meaning.[106]

Jhon Tobin suggests that health-related issues, such as housing and education, addressed in other human rights instruments, should not be automatically included in the scope of the right to health, despite their potential impact on an individual's health. He suggests that instead, the right

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[99] The Universal Declaration of Human Rights, (United Nations General Assembly, 10 December 1948, General Assembly resolution 217 A), Art. 25.

[100] 'UN Convention On The Rights Of The Child | Save the Children UK' <https://www.savethechildren.org.uk/what-we-do/childrens-rights/united-nations-convention-of-the-rights-of-the-child> accessed 21 February 2024

[101] CRC (n 1) Art. 24

[102] Ibid Art. 17.

[103] Todres J and King SM (eds), *The Oxford Handbook of Children's Rights Law* (Oxford University Press 2020), 371

[104] Jhon Tobin, *The Right to Health in International Law* (Oxford University Press 2012) 27

[105] Ibid 125

[106] Ibid

to health in international instruments like the ICESCR and CRC should be examined within the context of discussing the meaning of health in international law.[107] The relevant international treaties express a moral commitment to recognizing health as a universal human right, with the highest attainable standard of health being the most important concern.[108] Besides the WHO constitution, this standard is also present in the ICESCR[109], and the CRC.[110]

Considered soft law and designed to serve as an interpretative tool, General Comment No. 4 of the CRC states that rapid physical, cognitive, and social changes, including sexual and reproductive maturation, characterize adolescence. It is also a time when the capacity to take on adult tasks, including new responsibilities demanding new knowledge and abilities is gradually increasing.[111] Systematic data collection is necessary for States parties to be able to monitor the health and development of adolescents.[112] It also states that the promotion and enforcement of the provisions and principles of the Convention, especially articles 2-6, 12-17, 24, 28, 29, and 31, are important to guaranteeing adolescents' right to health and development.[113]

Although not binding on states, the Committee on Economic, Social, and Cultural Rights issued General Comment No. 14 to explain how the human right to health can be approached in practice.[114] General Comment No. 14 provides that depending on the conditions prevailing in the

[107] Ibid 132

[108] Ibid 50

[109] ICESCR (n 6) Article 12 (1) reads: The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

[110] CRC (n 1) Article 24 (1) reads: States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

[111] CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, (Adopted at the Thirty-third Session of the Committee on the Rights of the Child, on 1 July 2003)

[112] Ibid, para. 9

[113] Ibid, para. 10

[114] Jonathan Wolff, Freeman M, *The Human Rights to Health*, (New York, W. W. Norton, 2012, 192 Pages, 21 The International Journal of Children's Rights (2013) 11.

State, the right to health in all its forms and at all levels necessitates the state party to ensure availability, accessibility, acceptability, and quality.[115]

Coming to regional human rights treaties, the African Charter on Human and Peoples' Rights recognizes the right to enjoy the best attainable state of physical and mental health.[116] The ACRWC also recognizes in its preamble that children, due to their needs of physical and mental development, require particular care concerning health, physical, mental, moral, and social development, and lists out the different protections regarding a child's right to health.[117]

The right to health has a crucial role in enabling individuals to lead dignified lives and the value of a healthy individual to the broader community.[118] Mental health legislation is crucial for safeguarding the rights of individuals with mental disorders, who are a vulnerable group that often faces stigma, discrimination, and marginalization, which increases the likelihood of their Human Rights being violated.[119]

Human Rights should be an integral consideration in designing, implementing, monitoring, and evaluating mental health policies and programs.[120] Mental health legislation presents a legal framework for addressing critical issues like community integration, the provision of high-quality care, improved access to care, and the protection of civil rights for individuals with mental disorders.[121]

[115] ICESCR General Comment No. 14 The Right to the Highest Attainable Standard of Health (Art. 12) Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000) Para 12

[116] African Charter on Human and Peoples' Rights (Banjul Charter), (OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), 21 October 1986) Article 16 (1) reads: Every individual shall have the right to work under equitable and satisfactory conditions and shall receive equal pay for equal work.

[117] ACRWC (n 2) Art. 14

[118] Tobin (n 104) 124

[119] World Health Organizations (ed), 'Mental Health Legislation, and Human Rights', (WHO, 2003) 2.

[120] Ibid 11

[121] Ibid 2

2.5.1.2. Children's Right to Mental Health

2.5.1.2.1. International and Regional Conventions

The CRC recognizes the right of the child to the highest attainable standard of health and treatment of illness and rehabilitation under Article 24.[122] The right to non-discrimination under the CRC provides that State Parties must uphold the rights of every child within their jurisdiction without discrimination, regardless of their race, color, sex, language, religion, political opinion, nationality, property, disability, or birth status.[123] The principle of the Best Interest of the Child under CRC states that the interests of a child should be the primary focus in all actions involving children, including those by public or private institutions, courts, administrative authorities, and legislative bodies.[124] When children are unable to access the appropriate public mental health facilities due to a lack of sufficient budget and resource allocation by state bodies, it affects their quality of life and overall development, and goes against the Principle of the Best interests of the Child.

State Parties are also required to support parents and legal guardians in fulfilling their duties of bringing up children by developing necessary institutions, facilities, and services for childcare and ensuring to the maximum extent possible the survival and development of the child.[125] Children in poor health, both mentally and physically, who lack timely or effective healthcare, face challenges in enjoying their rights under various CRC provisions, such as the Right to Life, Survival, and Development, the Right to an Adequate Standard of Living, and the Right to Education.[126] The CRC recognizes child health as a universal right because of its importance in all circumstances and emphasizes universal and basic health care for children.[127] Furthermore, Article 3 of the Convention on the Rights of Persons with Disabilities (CRPD) outlines the allocation of resources and development of policies and interventions affecting a child's health,

[122] Lindberg T, 'The Child's Right to Health and Treatment' (1999) 15 Medicine, Conflict and Survival 336 <http://www.tandfonline.com/doi/abs/10.1080/13623699908409474> accessed 08 April 2024

[123] CRC (n 1) Art. 2

[124] Ibid Art. 3

[125] Ibid Art. 18 and 6

[126] Todres (n 103) 371

[127] Ibid

while the Optional Protocol to the CRPD, adopted in 2006, emphasizes the global commitment to the human rights and fundamental freedoms of people with disabilities.[128]

When we come to regional frameworks, the preamble of ACRWC states that it 'acknowledges that children need special care for their physical and mental development as well as legal protection in conditions of freedom, dignity, and security due to their unique needs.'[129] It also states that every child has the right to health and emphasizes the importance of developing primary health care and integrating basic health care programs into national development plans.[130]

2.5.1.2.2. Soft Laws

In 1991, the United Nations General Assembly adopted Resolution 46/119, which outlines principles for safeguarding the human rights of individuals with mental disorders, establishing fundamental rights that the international community considers inviolable.[131] There are 25 Principles in the resolution some of which include:

- Fundamental Freedoms and Basic Rights[132]
- Protection of Minors[133]
- Confidentiality[134]
- Standards of care[135]
- Rights and Conditions in Mental Health Facilities[136]
- Resources for mental health facilities[137]

[128] UNICEF (n 61)

[129] ACRWC (n 2) preamble

[130] Ibid Art. 14 (2) (g)

[131] WHO (n 119) 7

[132] United Nations General Assembly Resolution 46/119 The Protection of Persons with Mental Illness and the Improvement of Mental Health Care, (7th Plenary Meeting, 17 December 1991) Principle 1

[133] Ibid Principle 2

[134] Ibid Principle 6

[135] Ibid Principle 8

[136] Ibid Principle 13

[137] Ibid Principle 14

- Access to Information;[138] and
- Complaints[139]

Regarding the Protection of Minors, Principle 2 provides that special care should be given to minors. Principle 14 asserts that mental health services should have access to the same facilities as other health establishments, including qualified medical staff and appropriate professional care. Regarding implementation, Principle 23 provides that states should implement these principles through appropriate legislative, judicial, administrative, educational, and other measures that they review periodically.[140]

On top of the frameworks discussed above, WHO has developed a Comprehensive Mental Health Action Plan that lasts from 2013 -2030. The Action Plan acknowledges the global gap in mental disorder service provision due to inadequate response from health systems.[141] The number of specialized and general health workers addressing mental health in low-income and middle-income countries is significantly low.[142] The goal of the Action Plan is to 'promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights, and reduce mortality, morbidity, and disability for persons with mental disorders.'[143]

The WHO Action Plan aims to enhance mental health leadership and governance, provide comprehensive, community-based mental health and social care services, implement strategies for mental health promotion and prevention, and enhance information systems, evidence, and research for mental health.[144] The Action Plan suggests that the proposed actions for member states set out in the Action Plan should be tailored to national priorities and circumstances.[145]

[138] Ibid Principle 19

[139] Ibid Principle 21

[140] Ibid Principle 23

[141] World Health Organization, Comprehensive Mental Health Action Plan 2013 -2030, (WHO 2013) Para 14

[142] Ibid para 15

[143] Ibid para 21

[144] Ibid para 22

[145] Ibid para 24

The proposed actions for member states include service reorganization and expanded coverage, integrated and responsive care, resource planning, and addressing disparities.[146] Early intervention for children and adolescents with mental disorders is best provided through evidence-based psychosocial and non-pharmacological community-based interventions to avoid institutionalization and medicalization.[147] These interventions should respect children's rights as per the CRC and other international human rights instruments.[148]

2.5.1.3. Core Obligations and Progressive Realization under International Law

The ICESCR acknowledges the challenge of resource constraints and encourages the progressive realization of rights rather than an immediate realization. Article 12 of the ICESCR recognizes the right to enjoy the highest attainable standard of physical and mental health and provides that states must take steps to achieve the full realization of this right.[149] Progressive realization allows a country to make small progress due to limited resources, while the concept of Minimum Core Obligations ensures there will be no excuse for failing to achieve some level of healthcare.[150] Countries are considered to be actively working towards progressive realization if they have developed appropriate plans.[151]

ICESCR's General Comment No. 03 which deals with the nature of State Parties' obligations provides that even where the available resources are noticeably inadequate, State parties must strive to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances.[152] The Committee emphasizes that during severe resource constraints, such as the process of adjustment or economic recession, vulnerable members of society can and must be protected through the adoption of low-cost targeted programs.[153]

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[146] Ibid Para 56- 60

[147] Ibid Para 69

[148] Ibid Para 69

[149] ICESCR (n 13) Art. 12 (2)

[150] Woolf (n 114) 13

[151] Ibid 32

[152] General Comment No. 3 (n 14) para 11

[153] Ibid para 12

General Comment No. 14 also specifies what governments must do in terms of concrete action. State parties must ensure the following:

- **Availability:** Functioning public health and healthcare facilities, goods, and services, as well as programs, must be available in sufficient quantity within the State party.[154]
- **Accessibility:** Health facilities, goods, and services must be accessible to everyone without discrimination, within the jurisdiction of the State party.[155] Accessibility is split into four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility.[156]
- **Acceptability**: Health facilities must uphold cultural values, be gender-sensitive, adhere to medical ethics, and be acceptable to adolescents and their communities, while also adhering to the convention's provisions and meeting medical ethics standards.[157]
- **Quality:** Health facilities must be culturally acceptable, scientifically, and medically appropriate, and of good quality, requiring skilled medical personnel, approved drugs, hospital equipment, safe water, and adequate sanitation, along with safe and potable water.[158]

Additionally, States also have the duty to respect, to protect, and to fulfill.[159] The duty to respect means that governments must respect or refrain from interfering in certain rights, the duty to protect entails preventing third parties from interfering, and the duty to fulfill means States must adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards the full realization of the right to health.[160] Additionally, data collection that is segregated by age, gender, ethnicity, and social status, can highly benefit countries by enabling

[154] ICESER General Comment No. 14 (n 115), para. 12 (a)

[155] Ibid para 12 (b)

[156] Ibid

[157] Ibid 12 (c)

[158] Ibid 12 (D)

[159] Woolf (n 114) 29

[160] ICESER General Comment No. 14 (n 115) para 33

self-monitoring and ensuring the effectiveness of resources, particularly for the most disadvantaged groups.[161]

2.5.2. National Policies and Legislations

In addition to the international and regional human rights treaties, Ethiopia has national policies and legislations that protect the right to health of children. The Ethiopian Federal Constitution provides that the government must allocate ever-increasing resources to provide public health, education, and other social services.[162] The Federal Government also has the duty to establish and implement national standards and basic policy criteria for public health.[163] Also, to the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health.[164]

Mental health problems were included in the Health Sector Development Program (HSDP) as one of the priority areas and this led to the development of the 2012-2016 National Mental Health Strategic Plan.[165] In 2012, the Ethiopian government developed and implemented the first Ethiopian National Mental Health Strategic Plan. The Strategy outlines objectives for training mental health professionals and aims to enhance the quality of mental healthcare provided in primary healthcare settings.[166]

The current Health Sector Transformation Plan (HSTP II) and the National Mental Health Strategic Plan go more in-depth addressing mental health in general, and the mental health of children in particular. In her statement under the HTSP II, the Minister of Health, Dr. Lia Tadesse, admits mental health problems are becoming public health concerns, and need to be given a special focus through integrating these services with the primary health care system.[167]

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[161] Woolf (n 114) 33

[162] FDRE Constitution (n 4) Art. 41 (4)

[163] Ibid Art. 51 (3)

[164] Ibid Art. 90 (1)

[165] MoH (n 16) 14

[166] Hughes TL (n 84) 4

[167] Health Sector Transformation Plan II (HSTP II), (MOH, February 2021)

Ethiopia is dealing with a triple burden of diseases, including mental health diseases, which disproportionately affect children and women in their reproductive age.[168]

The challenges in Ethiopia include the lack of sustainable availability and affordability of psychopharmaceutical agents, as well as limited psychosocial interventions.[169] One of the Targets of HSTP II is increasing treatment coverage of severe mental health disorders (Depression from 5% to 30%; Substance Use Disorders (SUD) from 1% to 20%) by the year 2024/2025.[170] It also provides that Mental health is one of the top priorities in HSTP-II. Mental health promotion, prevention, and management of common mental health problems such as depression, bipolar disorder, and schizophrenia are to be addressed through advocacy, social mobilization, strengthening social support, capacity building, and expansion of access to medication, psychosocial interventions, and rehabilitation.[171] The major strategic initiatives under the HSTP II are:

- Facilitating the development of mental health legislation to protect the rights of people with mental health conditions.[172]
- Ensuring a dependable and affordable supply of essential medicines and diagnostic technologies for mental health and access to psychosocial care at the community level.[173]
- Conducting advocacy, social mobilization, and SBC interventions to create public awareness of mental health and mental illnesses.[174]
- Establish a National Institute of Mental Health and introduce and strengthen the promotion and preventive mental health services in schools, workplaces, health facilities, and religious, and traditional treatment settings.[175]

[168] Ibid 20

[169] Ibid 20

[170] Ibid 45

[171] Ibid 51

[172] Ibid 52

[173] Ibid

[174] Ibid

[175] Ibid

- Ensure the availability of mental health services to vulnerable groups or special populations.[176]

In 2019, about 26% of health facilities had integrated mental health services into their general health services. However, the mental health bed-to-population ratio stood at less than 1%, and inpatient child and adolescent mental health care was nonexistent.[177]

The current National Mental Health Strategic Plan (Strategic Plan) took some inspiration from WHO's Comprehensive Mental Health Action Plan 2013 -2030 and provided several visions, goals, guiding principles, and objectives. The goal of the Strategic Plan is to promote mental well-being, prevent mental disorders, provide care, enhance recovery and integration, promote human rights, and reduce mortality, morbidity, and disability for persons with mental health conditions and psychosocial disability.[178]

The Strategic Plan has the following five major objectives which are strengthening effective leadership and governance for mental health, empowering individuals, families, and the general population to improve their mental health, mitigating risk factors and establishing conducive conditions, meeting mental health human resource standards to enhance the quality and accessibility of mental health service delivery, early detection of mental health conditions, which is necessary for prompt treatment, care, and rehabilitation while promoting inclusion through optimal infrastructure and a sustainable supply of materials such as equipment, medications, and technologies, and establishing and strengthening information systems, evidence, and research for the mental health sector.[179]

Objectives 1 and 5 of the strategic plan are adopted from the objectives set under WHO's comprehensive mental health action plan.[180] The strategic plan also shares the principles provided under WHO's Action Plan. The principles and approaches of the Strategic Plan include universal health coverage, primary health care, a life-course approach, evidence-based practice,

[176] Ibid

[177] Ibid 27

[178] MoH (n 16) 22

[179] Ibid

[180] WHO, Comprehensive Mental Health Action Plan (n 141) Para 22

accessibility and equity, a multi-sectoral approach, inclusion in the community, and a rights-based approach.[181]

Universal health coverage advocates that persons with mental health conditions should have affordable access to basic health and social services, while taking account of health and social needs at all stages of the life course, including infancy, childhood, and adolescence.[182] Accessibility and equity are also included to guarantee mental health services are accessible and available to all, regardless of their geographical location, age, socioeconomic status, religion, or ethnicity.[183] These are also listed as cross-cutting principles in WHO's Action Plan.[184]

Treatment coverage for child and adolescent mental health problems was at 1% when the strategic plan was put in place and the target is to push it up to 20% by 2025.[185] Among the strategic initiatives of the strategic plan are increasing mental health awareness among school children, parents, and neighbors,[186] and to create favorable maternal, social, economic, and environmental conditions for the mental health of infants, children, and adolescents.[187]

Nurturing care in early childhood is important for children's development, and the interaction between them and their primary caregivers significantly influences their overall growth.[188] The early stages of life present an important opportunity to promote mental health and prevent mental disorders since up to 50% of mental disorders in adults begin before the age of 14 years.[189]

Some of the key interventions set in place in the Strategic Plan include

[181] MoH (16) 22.

[182] Ibid 21

[183] Ibid

[184] WHO, Comprehensive Mental Health Action Plan (n 141) Para 23

[185] MoH (n 16) 31

[186] Ibid

[187] Ibid

[188] Ibid 32

[189] Ibid

- Collaborating with the Ministry of Peace and other relevant agencies to address the mental health needs of children and adolescents exposed to natural disasters or civil unrest.[190]
- Collaborating with the Ministry of Education and Higher Education Commission to incorporate training that promotes mental health and prevents mental, neurological, and substance use disorders in adolescents and youth,[191]
- Collaborate with national programs like Mother and Child Health, Health Extension Program, School Health Programs, and international programs to integrate promotion, prevention, clinical care, and de-stigmatization aspects of mental health care.[192]

Collaboration among different institutions is set as an option for implementation in WHO's Action Plan[193] and the Strategic Plan seems to follow suit by encouraging collaboration and a multisectoral approach. Furthermore, the Strategic Plan sets out priority areas which include child and adolescent developmental, behavioral, and other mental health problems,[194] outpatient and inpatient services for adults, children, and adolescents, and self-care substance use rehabilitation centers or community-based services for special populations such as trauma victims, children, and adolescents.[195]

The Strategic Plan states program implementation and activities, setting up several targets among which are: inpatient services for adults and children, and specialized clinics for the treatment of specific disorders of children and adolescents.[196]

2.6. Challenges in the implementation of Children's Right to Mental Health

Understanding the barriers to mental health policies and programs is crucial, as legislation can help overcome or break down these barriers, particularly those related to access and equity.[197]

[190] Ibid 35

[191] Ibid

[192] Ibid 34

[193] WHO, Comprehensive Mental Health Action Plan (n 141) 26

[194] MoH (n 16) 43

[195] Ibid 43-44

[196] Ibid 84

There are several prevalent barriers to promoting and protecting mental health and treating mental disorders in children. Some of these barriers are:

Stigma: It prevents children, young people, and caregivers from seeking treatment and participating fully in their families, schools, and communities.[198] Stigma creates misconception, hindering research, funding, and commitment to addressing the mental health needs of children and limiting the understanding of their emotional and psychosocial worlds.[199] Stigma and fear of judgment lead to delays in seeking mental health services and misuse of financial resources by traditional faith healers.[200]

Accessibility and Affordability of Services: Mental health needs are only partially funded by government and international development spending.[201] Mental health services may be lacking in some areas of the country due to unaffordable costs, partial or no coverage in health insurance, and poor care and living conditions in mental hospitals, leading to human rights violations and a potential lack of affordable mental health care.[202]

Inadequate human resources: Mental health human resources are often insufficient. However, more specialists in mental health are essential, and general knowledge about mental health across multiple professional fields must increase to provide critical promotion and protection.[203]

Lack of coordination between sectors: The complex needs of mental health across the life course require coordination between health, education, early childhood development, child protection, and social protection sectors.[204]

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[197] World Health Organization (n 59) 14

[198] UNICEF (n 61) 123

[199] Ibid

[200] Mubeen Z and others, 'Barriers and Facilitators to Accessing Adolescents' Mental Health Services in Karachi: Users and Providers Perspectives' (2024) 24 BMC Health Services Research 157 <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-10593-0> accessed 9 April 2024

[201] UNICEF (n 61) 123

[202] World Health Organization (n 59) 114

[203] UNICEF (n 61) 123

[204] Ibid 123

CHAPTER THREE

DISCUSSIONS AND FINDINGS

3.1.Introduction

This chapter begins by explaining the method of analysis used to interpret the findings. It then proceeds to present the data gathered from the mental health professionals, and parents or caregivers[205] at the Child and Adolescent Psychiatry Outpatient Department (OPD) of St. Paul Hospital through IDIs and KIIs, as well as the information gathered through the Observation Checklist in light of the international and national legal and policy frameworks that have been discussed in chapter two, literature review. The key themes in this chapter include accessibility, affordability, quality of the service, common challenges, feedback mechanisms and collaborations, and positive outcomes.

There are private psychiatric clinics that offer outpatient psychiatric services to children and adolescents such as Lebeza Psychiatric Clinic, Setota Center for Mental Health Care, and Canopy Child and Family Mental Health Services. However, St. Paul Hospital is one of the two public hospitals that offer mental health services to children and adolescents. It was founded in 1968 by the late Emperor Haile Selassie but St. Paul's Millennium Medical College, as it is known today, was established through a decree of the Council of Ministers in 2010 and governed by a board under the Federal Ministry of Health.[206] The Child and Adolescent Psychiatry Outpatient Department (OPD) has been functional for over a decade.[207]

To ensure the comfort of the IDI respondents and increase their willingness to participate, their names have been kept anonymous. Instead, identifiers such as Participants (P) 1,2,3… are used and their background information is summarized in a table. (See Appendix I)

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[205] Parents have a biological or legal relationship with a child and are mostly considered the primary caregivers. Whereas Caregivers provide care and support to children who need assistance. These terms overlap because the caregivers might be parents or other individuals who may not necessarily have a biological or legal relationship with the child such as relatives, nannies, or neighbors.

[206] Saint Paul's Millennium Medical College – OUR SPECIALITY, YOUR WELL-BEING <https://sphmmc.edu.et/> accessed 23 May 2024.

[207] Interview with Sister Fikerte, May 10, 2024

3.2.Method of Data Analysis

Thematic Analysis was used to analyze the data gathered through the KII and IDI tools as well as the Observation Checklist. Thematic analysis is a qualitative research method that researchers use to systematically organize and analyze data.[208] It involves an identification of themes that can capture the narratives through careful reading and re-reading of the transcribed data.[209]

The first step after collecting data was transcribing each interview and organizing the field notes. After transcribing the interview, the researcher read through the transcriptions to become familiar with the information. Then the researcher identified the thematic framework by identifying key themes, issues, and discussion points. After arranging the data and thematic framework, the researcher presented the findings in this Discussion and Findings chapter.

3.3. Availability

3.3.1. Available Resources and Services

This sub-section will give an overview of the available resources, which include human resources, physical facilities, treatments provided to children, and additional services before delving into the findings.

Regarding Human Resources, the Child and Adolescent Psychiatry Outpatient Department (OPD) of St. Paul Hospital has a staff of one psychiatrist, two psychiatric nurses, two psychiatry residents, two clinical psychologists, one runner, and one Child and Adolescent Psychiatry sub-specialist. When it comes to treatments, the OPD provides most mental health services, including treatment for substance abuse in children and adolescents, except speech therapy. Psychotherapy is provided two days a week by two clinical psychologists. Other than the psychiatric residents who rotate every two months, the rest of the staff has been working at the OPD for at least two years. Every psychiatric resident treats fifteen children per day on average, and one psychologist treats five children per day.[210]

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[208] Dawadi S, 'Thematic Analysis Approach: A Step by Step Guide for ELT Research Practitioners' (2020) 25 Journal of NELTA 62 <https://www.nepjol.info/index.php/NELTA/article/view/49731> accessed 16 April 2024

[209] Ibid

[210] Interview with Sister Adey, May 9, 2024

Through observation, the researcher was able to see that the OPD has three rooms in total, including the waiting room/reception area, which only has three seats. The OPD shares a hallway with another medical clinic, and there are only two shared bathrooms located outside for all who come to the compound, including children. During the time of data collection, there was no running water available to wash hands. The OPD has a room with toys to serve as a playroom when the room is not used for psychotherapy. On those days, the children can take out the toys and play with them as they wait for their appointments. The researcher also observed that new patients who were coming in did not know which building the OPD was located in and had to ask around the compound for directions because there was no clear sign to provide directions when they entered the compound.

When children first come to the OPD, the psychiatric nurses screen them to determine the mental disorder. If necessary, they are sent for an additional laboratory test. The screening process is cost-free, and if what the child has is indeed a mental disorder, the parents are told to get a patient card to start treatment. Sister Adey who has worked at the OPD as a psychiatric nurse for over four years mentioned that since there isn't much awareness regarding mental illness, most parents struggle to come to terms with their child's diagnosis, especially if the child has autism spectrum disorder (ASD) or an intellectual disability. When this happens, the psychiatric nurses usually calm the parents down by explaining what they can about the disorder and treatment. They are also in charge of scheduling a follow-up appointment for the children.[211]

Besides the mental health treatment given to children, the OPD offers caregiver skill training (CST) for children with neurodevelopmental disorders to teach parents how to interact with and understand a child who has ASD, or developmental delay. This training is offered three times a week to three separate groups of caregivers. One group consists of twelve caregivers and the training lasts nine weeks.[212] Once a group completes the training, another group takes their place. This training is given by the resident psychiatrists, who are first trained by the subspecialist. The training has been provided at the OPD for many years now and has proven to be effective according to the key informants. In addition, a caregiver meeting is held once every month to serve as a support group for them and allow them to share their experiences and challenges.

[211] Ibid

[212] Interview with Dr. Selenat Gebru, May 10, 2024

3.3.2. Patient Card

Six out of nine respondents found the process of getting a patient card tiresome and frustrating. Everyone who comes to St. Paul Hospital gets their patient cards from the same front desk. St. Paul's, being a large hospital, receives hundreds of patients daily. Most of the parents and caregivers that come to the OPD come there routinely because of appointments which means every time they come, they go through a process of activating the patient card. That requires them to wait in line for 30 minutes or more and costs them 100 birr a month.

P4 who has been bringing her thirteen-year-old daughter to the OPD for five years now due to ASD and Epilepsy declared in frustration:

> *"When I come here and have to go here and there and wait so long, it makes me want to stop coming."*[213].

In addition to the long wait, parents who do not use community-based health insurance (CBHI) which covers all essential health service packages at the health center and hospital level,[214] or get support from an NGO find that paying 100 birr each month to activate their card is excessive.

3.3.3. Medication

Prescribed medications are usually not readily available for patients at the OPD. There is only one pharmacy for the entire hospital, and the pharmacy has a long line of people waiting to get their medication daily. The price at the pharmacy is relatively cheaper than at other pharmacies in town. So, people wait as long as it takes to get their medication. However, just because they wait in line does not always mean they will get the medication. They might wait an hour or more to be told it is sold out.

P4, expressed her frustration when it comes to accessing medication:

> *"When I go to get my daughter the medication, the line is always very long at the pharmacy because everyone who comes to the hospital gets the medication from the same*

[213] Interview with Participant 4, May 9, 2024

[214] 'Ethiopia Scales Up Community-Based Health Insurance | HFG' <https://www.hfgproject.org/ethiopia-scales-community-based-health-insurance/> accessed 23 May 2024

pharmacy. And sometimes you wait so long to be told they don't have it. For someone who has severe anxiety and stress like me, it is very difficult."[215]

Providing mental health patients with access to medication is set out as a priority area under HSTP II.[216] The Mental Health Strategic Plan also sets access to the necessary medical equipment and medications as an objective.[217] The strategic plan is the main policy framework that serves as a blueprint for mental health protection and promotion in Ethiopia. However, this finding suggests that when it comes to implementation, access to medication is mostly limited.

The respondents who used CBHI described finding it harder to get medications than those who paid in cash. Three of the respondents who had health insurance expressed they felt they were being turned away while medications were sold to people who paid in cash. The respondents don't know why this happens, but it forces them to pay for the medication from their pockets which defeats the purpose of having health insurance. This contradicts Article 2 of the CRC which declares that State Parties must uphold the rights of every child within their jurisdiction without discrimination, regardless of their property or disability.[218] General Comment No. 14 also recommends that accessibility of goods and services must be free of discrimination within the jurisdiction of a State Party.[219]

P8 who is the mother of a 17-year-old boy with ASD who has been using this service for the past nine years described how she was forced to decrease the dose that is prescribed to her son when she could not access the medication:

"I wait in line at the pharmacy if I can get it here. But sometimes they tell me it's sold out, so I break the pill that's left into different pieces to give it to him." [220]

Not only are these medications not accessible at the hospital's pharmacy, but some medications are not available in Ethiopia at all, once more contradicting objective 4 of the strategic plan

[215] Ibid

[216] Health Sector Transformation Plan II, (n 167) 51

[217] MoH (n 16) 22

[218] CRC (n 1) Art. 2

[219] ICESER General Comment No. 14 (n 115) para 12 (b)

[220] Interview with Participant 8, May 10, 2024

which sets a goal to promote inclusion through optimal infrastructure and a sustainable supply of materials such as medications.[221] Dr. Eleni who is a Psychiatry Resident at the OPD discussed how challenging it is to give these kids prescription drugs when some medications are unavailable. These medications include stimulants used to treat ADHD such as Adderall, Ritalin, and Concerta. Because the medications are not found locally, the doctors are forced to prescribe alternate medications.

The improvement of the children and adolescents who are prescribed medications depends on taking the right dosage. When they can't, it delays the process and causes them harm. Merely providing these kids with access to mental health facilities won't be helpful if they can't receive the prescription drugs they need.

3.3.4. In-patient Service

The Child and Adolescent Psychiatry Department at St. Paul doesn't provide inpatient care to children. This is due to the facility not having enough space for this service. According to the key informants, there were many attempts to start inpatient care for children. But no matter how much they advocated to be given the space, they weren't given an appropriate place. At one point, the department was provided with a few rooms, but they found it to be unsafe for children.

Sister Fikerte attributed this to the department not being seen in the same light as others. She stated:

"We are not seen as equal with other departments. The medical pediatric department has beds. But for psychiatry patients that is not available. We asked many times, and they gave us a few rooms. But they were on high floors and unsafe for our patients in general. We are still asking to start inpatient services."[222]

This finding goes against Principle 14 of United Nations Resolution 46/119 which recommends that mental health services should have access to the same facilities as other health establishments.[223] Dr. Selenat shared similar views as she explained that they, as mental health

[221] MoH (n 16) 22

[222] Interview with (n 207)

[223] United Nations General Assembly Resolution 46/119 (n 132), Principle 14

professionals and the department in general, are stigmatized even by other health care workers. And this stigma has caused them and the department to be looked down on and not given priority. She explained:

"I think it is a matter of willingness. There are many rooms in this hospital. It is not hard to allocate at least five rooms for child psychiatry patients. I think they don't understand the gravity of the issue. When they build buildings, we already know we will not be moved there. Even as mental health professionals we are stigmatized. The department is looked down on.[224]*"*

This highly impacts the quality of the service and can even be a matter of life and death at times. When children and adolescents with eating disorders or anxiety are treated in the emergency room and brought to the OPD after self-harming or attempting suicide, these children not only need counseling services, but they also need to be admitted and supervised until the doctors decide they are well enough to be discharged. However, because they don't have beds, they are forced to medicate them, give them brief counseling, and send them home.[225]

The CRC[226] and ACRWC[227] recognize the right of the child to the enjoyment of the highest attainable standard of health, including mental health. CRC also sets the Best Interest of the Child as a principle that should guide decision-making regarding children.[228] This principle should be taken into consideration while allocating a budget to provide inpatient services for children with mental disorders to ensure they receive the highest attainable standard of treatment. The mental health strategic plan mentions inpatient services for children and adolescents as a priority area and target goal throughout the document. However, the findings suggest that it has yet to be implemented.

When children with behavioral disturbances or psychosis come to the OPD, the doctors beg for beds at the medical pediatric ward to admit these children. If that is not possible, they sometimes admit them to the adult ward, which is not ideal because children need special treatment, and the environment is not child-appropriate. The key informants explained that when none of this is

[224] Interview with (n 212)

[225] Interview with (n 207)

[226] CRC (n 1) 24

[227] ACRWC (n 2) Art. 16 (1)

[228] CRC (n 1) Art. 3

possible, they are forced to refer them to Ammanuel Hospital, which admits adolescents above the age of fifteen, or to other hospitals that can admit them with adult psychiatry patients, as there are no inpatient mental health services for children in Ethiopia as of now.

This finding goes against international standards. The ACRWC in its preamble states that children, due to their needs of physical and mental development, require particular care concerning health, physical, mental, moral, and social development,[229] while principle 2 of United Nations Resolution 46/119 suggests that special care should be given to minors.[230]

3.4. Accessibility

3.4.1. Access to Information

Seven of the nine respondents stated they were referred to St. Paul from another health facility. These respondents said they were not aware that mental health services were provided to children at St. Paul. Parents from different parts of Ethiopia bring their children to the OPD because the service is given only at two hospitals. These parents are usually referred to the OPD by another health facility. The respondents, as well as the key informants, unanimously agreed that the service is not widely known. Sister Adey elaborated on this by saying:

> *"Even people in Addis Ababa don't know we give the service here. They go to private hospitals that are too expensive or go to church before coming here. Considering the lack of awareness, new patients do come in every day. But considering there are not many public hospitals that give this service, we expect a lot more than the number of patients we have."*[231]

This view was shared by P1 who brought her sixteen-year-old son to be screened. She spoke on the lack of information by saying:

[229] Ibid 14

[230] United Nations General Assembly Resolution 46/119 (n 132), Principle 14

[231] Interview with (n 210)

> *"I live here in Addis Ababa but didn't know there were other facilities other than Amannuel Hospital which provide mental health care. And that shows most people don't know where to access these services."*[232]

If parents here in Addis Ababa are not aware of where to find this service, it is not hard to imagine that parents and caregivers in other regions and rural areas would not know where to access mental health care for their children unless they are referred by a clinic or hospital. This information gap can truly impact the accessibility of mental health services and prevent children who need them from having access.

Access to information from mass media through national sources as a way of promoting a child's well-being and physical and mental health is provided under the CRC.[233] It is also included as a principle under the United Nations General Assembly Resolution 46/119.[234] Additionally, conducting advocacy and social mobilization to create public awareness of mental health and mental illnesses is one of the major strategic initiatives under the HSTP II.[235] The Mental Health Strategic Plan also put increasing mental health awareness among school children and parents as one of its strategic initiatives.[236] However, the findings indicate that the current state of public awareness and information accessibility has not successfully met the goal set out in international human rights conventions and national policy documents.

The researcher was also able to observe that at the OPD in St. Paul, there were no brochures that parents could take home to help them understand the services given at the hospital and spread the information to other people. However, to ensure that the people who need these services know they exist and where to access them, information needs to be disseminated through different outlets, be it through the mass media, schools, or health facilities. However, there needs to be enough public hospitals that provide the services, and their capacity needs to be strengthened beforehand, so they can accommodate the number of patients they might get once information is more accessible.

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[232] Interview with Participant 1, May 9, 2024

[233] CRC (n 1) Art. 2

[234] United Nations General Assembly Resolution 46/119 (n 132) principle 19

[235] Health Sector Transformation Plan II, (n 167) 52

[236] MoH (n 16) 31

3.4.2. Proximity to Mental Health Services

The distance people travel to access mental health services is detrimental to assessing whether the service is accessible or not. Since only two hospitals provide these services, many people travel long and far to access them. By looking through the OPD register, the researcher was able to observe that the OPD had many patients coming from different regions such as Tigray, Oromia, Amhara, Dire Dawa, Harrari, and so on. This highly limits the accessibility of the service, especially considering that mental health care requires repeated appointments that may go on for years. Children and adolescents from low economic status and rural areas who need mental health care will have difficulty accessing it due to the distance and costs related to long travel.

Five of the nine respondents expressed that they found the distance to the hospital a challenge. P2 who came from Guten, in the Oromia region, with her 6-year-old daughter who has ASD described this challenge with emotion by saying:

> *"Everything is a challenge for me. When I come here, I stay with relatives. I travel long, and money is always a challenge. The distance is a challenge. It is all a challenge."*[237]

Not all patients have families in Addis Ababa that help them with their stay. In some cases, these parents bring their children and pay for cheap rooms for their entire stay. Besides the cost of this, traveling long distances and staying in an unfamiliar environment with a child who has a mental illness is very challenging. Sister Fikerte, who is a clinical nurse who has been working in child psychiatry for five years and coordinates the child and adult OPD, described the burden of the parents who bring their children to the OPD from other regions. She narrated:

> *"There is a father who brings his child here from Dire Dawa. The child is 13 years old and he can't go to the bathroom by himself. So, the father carries a Potty and other sanitary products the child needs whenever they travel. He uses public transport and usually can't find a room to rent because of his child. People refuse him. When I think of*

[237] Interview with Participant 2, May 9, 2024

that father, I always become sad. If he had a facility in his hometown, he wouldn't have to face this challenge."[238]

Physical accessibility is one element of the accessibility of health care services. Health facilities and services should be within safe physical reach, especially for vulnerable or marginalized groups, such as children and adolescents.[239] The Ethiopian federal constitution also provides that to the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health.[240] However, the distance factor not only affects those who live in other regions but is shared by parents in Addis Ababa. Another respondent who lives near Gefersa said she leaves her 17-year-old son at home to come to his appointments alone because the travel is long, and she takes multiple buses. She comes alone, gives the doctors updates on his condition, and takes his medication even though this is not a conventional way for her son to get treatment.

This also affects the quality of the service as three of the key informants mentioned that most parents ask them to give their children appointments once every two to four months because they either live far away, can't afford the transportation fee, or struggle to bring a sick child using public transport regularly. This greatly affects the treatment the children receive. According to Dr. Eden Hussen who works as a clinical psychologist at the OPD, the further apart the appointments are, the lesser the chances of the child showing progress quickly, which can cause the treatment to take years.

The Mental Health Strategic Plan states that there needs to be equity in accessing mental health services available to all, regardless of their geographical location.[241] Even if the available resources in the state are noticeably scarce, state parties must strive to ensure the widest possible enjoyment of the right through low-cost targeted programs.[242] The HSTP II also sets ensuring the availability of mental health services to vulnerable groups as a strategic initiative.[243] Although physical accessibility of mental health services is guaranteed under International Human Rights

[238] Interview with (n 207)

[239] ICESER General Comment No. 14 (n 115) Para 12 (b)

[240] FDRE Constitution (n 4) Art. 90 (1)

[241] MoH (n 16) 21

[242] General Comment No. 3 (n 14) para 12

[243] Health Sector Transformation Plan II, (n 167) 52

Conventions, recommendations, and national policy frameworks, the findings indicate it has not been successfully implemented.

3.5.Affordability

Patients are not charged for the mental health services they receive at the OPD. The only payment they make is 100 birr to initially get the patient card and an additional 100 birr every month to activate it unless they have health insurance or get support from an NGO. In addition to this card price, the patients pay for any requested laboratory testing or prescription drugs. Medications are mostly unavailable at the hospital or other public pharmacies like Kenema because they are imported in small amounts and usually sold out or not imported at all. When it is sold out, patients are forced to buy them at private pharmacies at a high price. Medications found in small numbers with high prices include Epilim, Lamotrigine, and Lonazep, which are used to treat epilepsy, anxiety disorder, bipolar disorder, and more.[244] Four of the nine respondents mentioned that they struggled to afford the prescribed medications due to their economic background.

Considering that most of these children and adolescents are from an economically disadvantaged background, their parents also struggle to pay to activate the card every month. As the nature of mental health treatment requires repeated appointments, the cost can become unbearable for most. In some cases, it might even cause them to stop the treatment altogether. The key informants explained that the hospital was repeatedly requested by the OPD to let the parents pay for only half the fee but refused it. Mastewal, who has worked as a runner at the OPD for four years narrated the effect this has had on parents stating:

> *"Some parents leave without letting their child see a doctor when we tell them to activate their card because they usually don't have the money. They say they don't even have money for transport let alone to activate the card every month. They also struggle to buy medication. We have asked the hospital to at least reduce the card fee by half and allow*

[244] Interview with (n 210)

the psychiatry patients to pay 50 birr because they have repeated appointments. But they said it will remain the same for everyone."[245]

One of the strategic initiatives of the HSTP II is ensuring a dependable and affordable supply of essential medicines for mental health.[246] The principles and approaches of the mental health strategic plan also include universal health coverage to ensure affordable access to basic health and social services for children and adolescents.[247] From the findings, it can't be denied that the service at the OPD is more affordable than private mental health facilities. However, because of the economic status of these parents, for those who have no health insurance, paying to activate a card every month and purchasing medications at private pharmacies has remained a challenge.

3.6.Quality of the Service

3.6.1. Hospital Facility

The OPD is located in a large villa that has been converted into a clinic. There is another clinic on the same floor as the OPD and the researcher was able to observe patients of all ages coming and going. There aren't enough seats for patients in the waiting area, which has three chairs in total. Most patients waiting for their turn to see a doctor wait outside, sitting on either the six chairs outside that are shared with the other clinic or on the grass and pavement in the compound. The entire facility of the OPD is small because it is a large room that has been converted into three separate rooms through partitions.

Sister Adey mentioned that on Mondays and Thursdays when the clinical psychologists come for scheduled psychotherapy, they beg for rooms from other departments so the two psychiatrists wouldn't have to share a single room. Psychotherapy is a process that needs a quiet environment, and one appointment can last for over an hour.[248] But on the Thursday the researcher was present, there was no room available for the psychotherapists, and the two psychiatrists had to share a single room while the psychotherapist was treating children in the playroom. This has a great impact on the quality of the service because therapy, by nature, requires long conversations

[245] Interview with Mastewal on May 10, 2024

[246] Health Sector Transformation Plan II, (n 167) 52

[247] MoH (n 16) 21

[248] Interview with Dr. Eden Hussen, May 9, 2024

and privacy. However, the two psychiatrists treating these children did it in close proximity where the other family could hear the conversations being had.

The CRC requires State Parties to support parents and legal guardians in fulfilling their duties of bringing up children by developing necessary institutions, facilities, and services for childcare and ensuring to the maximum extent possible the survival and development of the child.[249] This includes making sure these necessary institutions and facilities have the necessary resources to deliver quality services. General Comment No. 14 also recommends that health facilities should be, scientifically, and medically appropriate, and of good quality, which includes adequate sanitation, along with safe and clean water.[250]

However, in contradiction with these legal and policy frameworks, the OPD does not have its own laboratory or pharmacy. It also does not have a separate bathroom or running water. Everyone who comes to the compound, including the children and parents at the OPD, has to share the same two bathrooms that have no running water, which is unhygienic. However, the OPD functions with as much efficiency as possible with the resources it has, and the playroom and toys keep the children busy and somewhat entertained as they wait for their appointments, which contributes to the quality of the service.

3.6.2. Hospital Services

The training given at the OPD is one of the services that has shown great results.[251] Training parents and giving them the skills to teach and communicate with their children helps speed up the process of learning for the children and contributes highly to the quality of the service. Sister Fikerte explained that there are circumstances where the parents and children do not understand each other because some children with ASD do not communicate verbally. But once parents receive the training, they are able to understand their children.

Though the OPD offers most mental health services, it does not offer speech therapy. When Children need the service, they are referred to Yekatit 12, which, according to Dr. Selenat Gebru who works as a psychiatry resident at the OPD, now has a waiting list of about 4 years. There are

[249] CRC (n 1) Art. 18

[250] ICESER General Comment No. 14 (n 115) Para 12 (D)

[251] Interview with (n 207)

private facilities that offer speech therapy, but they are too expensive for these parents. The OPD also does not provide inpatient services.

The staff's interaction with patients and their parents is professional and somewhat pleasant. The researcher was able to observe that the nurses treat them with respect and explain things to them with as much patience as they can when parents become agitated due to the long waiting time. All nine respondents said that they felt like they were being treated well and that their children are taken care of when they came to the OPD. P6 who brought her 13-year-old autistic child explained how well she felt her child was being treated by stating:

> *"They treat him very well like he is their child. I may be the one who gave birth to him, but they are the ones who take good care of him."*[252]

Since these parents are used to stigmatization while accessing most public services, the OPD is their safe space, and they feel they are treated fairly, which shows the good quality of service.[253] Overall, the OPD delivers most mental health services with the resources available, and the training program it provides goes beyond expectations in garnering positive outcomes.

3.6.3. Human Resource

The mental health professionals at the OPD are few, and the number of patients that they have is far too many. By looking through the OPD register, the researcher was able to see that from February 7, 2024, to April 10, 2024, the OPD received 602 patients. Because of the lack of human resources and rooms, patients are usually forced to wait over an hour to see a doctor. The key informants also described how they felt like they were overworked and burnt out due to this. Sister Adey spoke on it by stating:

> *"As a department, we don't have enough staff. We also go on night duties to the adult and elderly psychiatry wards. We don't get rest and we suffer from burnout."*[254]

Dr. Selenat validated this experience by explaining that they usually suffered from exhaustion.

[252] Interview with Participant 6, May 9, 2024

[253] Interview with (n 210)

[254] Ibid

> *"Psychiatry needs lots of human contact. We don't just prescribe patients medications and send them home. Therapy requires talking one-on-one and these therapies could take an hour or two. If that is the case, how many patients can a psychiatrist see in one day? We don't have a lot of psychiatrists, so it's exhausting. It can be draining. The psychiatrist needs a break in between sessions to refresh, if possible. Because it is difficult to stay energetic."*[255]

This is also a concern for parents. Even though there is a long waiting time and not enough professionals, every child that comes during working hours, which is from 8:00 a.m. to 3:00 p.m., gets to see a doctor. Though the key informants claim this doesn't affect the quality of the service, P3 who brought his four-year-old son who has a speech delay disagreed. He mentioned that he fears this could affect the quality of the sessions because the doctors might be in a hurry to get to the next session and exhausted from the previous session. He described his fears, saying:

> *"I wish there were more doctors so our son could spend enough time with the doctor. I am afraid that in order to see all these children, they will rush the process. And as you know, mental health issues need time. I don't think it is considered how many patients a doctor should see a day. Everyone gets to see a doctor when they come. However, it should be limited to a few patients a day so the doctors can have enough time and energy."*[256]

Qualified medical and other professional staff should be available in sufficient numbers and with adequate space to provide each patient with privacy and appropriate therapy.[257] However, the findings show that there is a lack of adequate mental health professionals at the hospital and in Ethiopia in general. This could be a result of the stigma that exists around mental health, according to Dr. Selenat. But unless more professionals are trained in the field, it will be difficult to meet the demand that exists in society.

[255] Interview with (n 212)

[256] Interview with Participant 3, May 9, 2024

[257] United Nations General Assembly Resolution 46/119 (n 132) 14 (a)

3.6.4. Appointments and Waiting Time

The OPD has limited space and professionals, so the patient waiting time is usually long. The researcher observed that sometimes this waiting time would go up to over an hour, which frustrates parents. Mastewal explained that in some cases, parents get up and leave before their child sees a doctor due to the long wait. The parents wait to activate their card, then wait for the appointment, and again wait in line to get medication at the pharmacy. They do all this while catering to their sick child. Dr. Selenat explained this challenge by narrating:

> *"There is a woman who is here now. She comes from Holeta. She brings her 17-year-old child who has an intellectual disability, but there is no one home so she brings her 7-year-old daughter and 6-month-old child who breastfeeds. She waits till her daughter gets prescriptions and then waits for hours to get the medication because we don't have a separate pharmacy. She spends all day here while watching over her two daughters and breastfeeding."*[258]

This is not just a challenge that is faced by just one mother. Dr. Selenat mentioned that most children are brought by single moms who do not have anyone home to watch their other children. They also miss a day of work to come here which could cost them money they can't afford to lose.

Patient flow also differs from season to season which affects waiting time. Parents tend to focus on their child's education during the school year. However, once summer break rolls around, parents start to notice behaviors in their children that they may have overlooked during the school year. This forces them to seek mental health services and the number of patients peaks this time of year which could mean longer waiting time for patients.

Sister Adey spoke on this seasonal change in patient flow by stating:

"When there is school, parents usually focus on education. But when school is out, they start noticing some behaviors in their children and bring them here. During school breaks and in the wintertime, we have many more patients."[259]

[258] Interview with (n 212)

[259] Interview with (n 210)

When it comes to scheduling appointments, due to the distance some patients travel to come to the OPD, there seems to be a trend of negotiating an appointment date. So rather than giving them appointments based on the diagnosis and medication, the doctors are forced to give them appointments that are suitable for long travel, which affects the effectiveness and quality of the services.

3.7.Feedback Mechanism and Collaborations

At the OPD, the researcher was able to observe a feedback box set on a bookshelf to allow parents as well as children and adolescents to leave their feedback. However, according to the key informants, people rarely use the feedback box, instead choosing to bring their complaints directly to the nurses and doctors. The common complaints are related to long waiting time, scheduling appointments, and the resident doctors being replaced every two months.

Parents feel frustrated when they come and find that the doctor, they are familiar with has been replaced. The nurses communicate to them that their child's medical history is transferred to the new doctors. But Sister Adey explained that even if it is explained to them, they still think they must explain everything they have shared with the previous doctor all over again. Sometimes, if they believe the previous doctor had a good bond with their child and made them feel comfortable, they get extremely upset and threaten to stop the treatment. This has been an ongoing complaint and challenge at the OPD.

Regarding collaborations, all six key informants explained that they were not aware of St. Paul collaborating with other organizations to assist the OPD. However, the subspecialist at the OPD has a consultancy office, and she helps children attend school, gets them in contact with other services, and tries to bring in speech therapists on her own accord. Additionally, there are individuals who come to the OPD for research or other purposes and donate toys. Training focused on child psychiatry is also not provided to mental health professionals. Dr. Eden said that they personally seek out training in child psychiatry because it is not offered by the hospital or other government health offices even though specialty training for mental health workers is included as a key intervention area under the strategic plan.[260]

[260] MoH (n 16) 37

Sister Fekrete explained that the only time the hospital gets involved and collaborates with the OPD is during the caregiver skill training. The hospital prepares a room for the training, provides refreshments such as water and kolo, and prepares and prints the training manuals. This indicates that coordination and collaboration with other governmental and non-governmental organizations is not a common practice.

Collaborations among government ministries and different sectors as well as international and domestic partners are included as a key intervention area and strategic initiative throughout the mental health strategic plan to ensure the best outcome.[261] The findings indicate that St. Paul's OPD has not been a part of such collaborations though this can help make the service more efficient and allow these different bodies to work together towards a common goal.

3.8.Common Challenges

The challenges these children and their parents face are far too wide and far too many. Dr. Eden Hussen explains them as challenges that need multidisciplinary interventions that cannot just be addressed through the provision of mental health care. Because these children are from a disadvantaged economic background and are marginalized, they are usually let down by most systems designed to serve society. Besides the financial challenges, long travel, and lack of information, all nine of the respondents and all six of the key informants mentioned that one of the biggest challenges they face is being unable to find schools for their children.

The respondents explained their wish to enroll their children in school so they could receive the type of education they need. However, most schools are not inclusive and don't have the resources to enroll children with special needs. The public schools that have resources are usually fully booked and have long waiting lists. And private schools are too expensive for these parents to afford.

Sister Fikerte shared the challenge of parents being unable to find schools for their children by stating:

> *"Not finding schools for children with ASD and developmental delays is a big challenge for parents. This is an issue that the government or anyone else has not looked at. When asked,*

[261] MoH (n 16)

they give us answers like "We don't even have enough school for the healthy ones." They don't consider these children as citizens."[262]

These children are not only prevented from accessing schools but the ones that have somehow managed to enroll are also kicked out in the name of disciplinary measures.[263] Though these children have mental disorders, they have unique abilities. Autism does not show up in the same way in all children. Sister Fikerte mentioned that these children are particularly good with electronics and can express their emotions through drawings or music. If they could have access to special needs schools that could cater to their needs, they would have a chance of being successful.

The CRC provides that States Parties recognize the right of the child to education with a view to achieving this right progressively based on equal opportunity.[264] In conformity with this, the Ethiopian constitution declares that the State is obligated to allocate a continually increasing resource to provide education.[265] Additionally, improving access to education is set as an initiative under the strategic plan.[266] The lack of school for children with special needs denies them their human rights to education and goes against the principle of the best interests of the child provided under the CRC.[267]

Another common challenge is stigma. Due to the lack of awareness that is rampant even here in the capital, Addis Ababa, these children face difficulties in their day-to-day lives. Not only the children, but their parents also face this stigma. Five of the nine respondents who use public transportation mentioned having unpleasant experiences. P7 who brought her seven-year-old autistic son spoke about her experience using public transport.

"When I use public transport, my son might scream or clap in the middle and express his emotions. People's reactions to this make me feel ashamed. They say "Why doesn't she

[262] Interview with (n 207)

[263] Interview with (n 212)

[264] CRC (n 1) Art. 28 (1)

[265] FDRE Constitution (n 4) Art. 41 (4)

[266] MoH (n 16) 51

[267] CRC (n 1) Art. 3

discipline him? Why does she spoil him like this?" even people who know he is sick turn their backs on me."[268]

Sister Fikerte corroborated this by explaining that sometimes these parents are questioned on public transport about whether they stole their child because of the noise the children make. Another key informant, Mastewal, mentioned she knows a mother who had to change houses five times in a year because the owners kept asking her to leave due to her son's condition. This greatly impacts the environment of children with mental disorders. But this is only the tip of the iceberg of the challenges they face. Because of the stress of taking care of a child with a mental disorder while also taking care of their other children, some mothers start suffering from a mental illness themselves. Dr. Eleni explained that when they see the signs of mental illness in these mothers, they refer them to the adult psychiatry ward to be evaluated and start treatment.

Though the findings don't indicate success in implementation, the strategic plan proposes a multi-sectoral approach to address the challenges by requesting the engagement of multiple sectors, such as health, education, justice, housing, social, and other relevant sectors, as well as NGOs.[269] The strategic initiative mentions that schools are a good place to increase community awareness about mental health because teaching school children will also increase awareness among parents.[270] Coordinating with the Ministry of Education to include mental health in school curricula and awareness creation activities is one method provided under the strategic plan to achieve this goal.[271]

3.9.Positive Outcomes

Though the OPD has many challenges of its own, ranging from a lack of space and professionals to not having inpatient services, there are many success stories and children that have had positive outcomes because of the treatments. Many children who were unable to perform basic tasks like changing their clothes and feeding themselves were able to learn these skills from their parents, who received training or counseling. The medications given to them help them manage

[268] Interview with Participant 7 on May 10, 2024

[269] MoH (n 16) 21

[270] Ibid 31

[271] Ibid

behavioral disturbances as well as illnesses related to epilepsy. Sister Adey shared a narrated success story:

> *"There was a girl with an intellectual disability. When she first came, she couldn't even do basic things. Her dad was the one taking care of her. He received the training here and through him, she was able to learn how to do all the basic things and he even started homeschooling her."*[272]

The caregiver skill training is another reason for the positive outcomes and success stories. Parents are often able to understand their children better, which helps the children have their needs met. Besides the training, parents are consulted by the psychiatrists and join in on therapy sessions. P7 explained the difference this has made for her by saying:

> *"I used to think that beating him was the solution because I thought it was a matter of discipline. I didn't understand his needs. But when I stopped all that and started understanding him, he also began to get better."*[273]

Helping children with mental illnesses begins with understanding them. Even though they receive care at the OPD, they spend most of their time at home with their parents or caregivers. The training has helped many parents improve their communication with their children. Sister Fikerte explained how mothers used to come to her crying:

> *"After they take the training, the parents say I now understand my child. He was communicating with me all along, I just didn't understand. But before, mothers used to come to us crying saying, 'I don't understand what my child wants, he screams, he falls, and he bites his hand.' But now they can understand these nonverbal communications."*[274]

In addition to the training, parents have a meeting once a month where they share challenges and stories. This meeting serves as a support system for these parents, and sometimes a challenge shared by a parent is noted by the subspecialist at the OPD who calls the meeting. Positive

[272] Interview with (n 210)

[273] Interview with (n 268)

[274] Interview with (n 207)

outcomes come from these meetings, and Sister Adey shared a success story that shows just how much this meeting is helping parents in need.

> *"I know one woman who has a child with a mild intellectual disability. The girl made it to grade eight but was not allowed to take the national exam. Her mother shared it at one of the meetings. And the subspecialist helped her get back to school and take the exam. So yes, we hear their challenges and try to help them."*[275]

This goes to show that it is not only the children who need these counseling sessions, but parents also need to be actively involved in counseling and taking the training to help their children get better and manage their emotions. The caregiver meetings also help parents exchange experiences and challenges and find a way to resolve them. However, the training has a long waitlist, and both the training and parent meetings are not easily accessible to those who live in other regions and rural areas.

[275] Interview with (n 210)

CHAPTER FOUR

CONCLUSION AND RECOMMENDATIONS

4.1.Conclusion

Ethiopia only has two Public Hospitals that give mental health and psychiatric services to children, which are St. Paul's Hospital and Yekatit 12 Hospital, both located in Addis Ababa. Ethiopia is a state party to the CRC, ACRWC, and other International Human Rights Conventions that uphold the rights of children. Children's right to health, including mental health, is a fundamental human right. ICESCR's General Comment No. 03 imposes obligations on states to fulfill the widest possible rights even when available resources are noticeably inadequate, through progressive realization. This includes ensuring the availability, accessibility, and quality of mental health institutions for children in Ethiopia. In addition, Ethiopia has adopted a National Mental Health Strategic Plan that sets out various objectives, target goals, initiatives, and interventions to improve the mental health of children.

St. Paul's Child and Adolescent Psychiatry (OPD) has patients who come from different parts of Ethiopia. These children and their parents travel far and long to use the service, which is a major barrier to accessing mental health care for children. Because there is a huge lack of access to information about mental health services, most parents may not even know the service exists and where to find it.

There is no in-patient service in Ethiopia for children, which forces doctors to admit children who need intensive psychiatric care with other pediatric patients or in adult psychiatry wards. This is due to a lack of space resulting from poor resource allocation and stigma. At the OPD, parents are asked to activate their child's patient card every month which affects the affordability of the service because mental health care requires repeated sessions and several appointments. Since these parents are from economically disadvantaged backgrounds, the cost can add up and cause them to ask for appointments that are far apart or stop their child's treatment altogether.

The mental health professionals that work with children are few in number and unable to meet the demand which results in long patient waiting times as well as burnout among mental health professionals. Additionally, children can't access their prescribed medications either due to

unavailability or because it is sold out at public pharmacies. They stop taking their prescribed medications or take half the dosage because their parents can't afford to buy medications at private pharmacies. Due to all these factors, even for those who have access to mental health care, the quality of the service is greatly affected.

Overall, though the OPD is functioning with as much efficiency as it can with the resources it has, it can be determined that major barriers to mental health services exist in Ethiopia. Despite having a National Mental Health Strategic Plan that has set several targets, interventions, and initiatives, there is a gap in implementation that indicates due to reasons such as resource constraints and not giving the issue enough importance the Ethiopian government has not been able to fulfill, protect, and promote children's right to mental health to the extent necessary.

4.2. Recommendations

Following the analyses made and conclusions drawn in this study, the researcher recommends the following:

1. Ethiopia should develop a rights-based child-specific mental health policy that is in line with international and regional human rights law. This will aid in promoting and protecting the mental health of children and adolescents by providing initiatives, target goals, interventions, specific programs, and services that accommodate their needs.
2. The Federal Government should prioritize the allocation of budget towards integrating the service within more existing public hospitals, to offer children and adolescents both in-patient and out-patient mental health services that are affordable and of quality. At least one public hospital should integrate the service in each region to make sure the service is more accessible to children across the country. And in the long run, opening specialized public mental health hospitals can help make the service more accessible.
3. The Government of Ethiopia should ensure the availability of appropriate medications at public pharmacies at an affordable price to promote equity and make sure more children have access to affordable prescribed medications.
4. The government of Ethiopia should allocate the necessary budget to allow the existing public schools to be more inclusive of children with special needs by dedicating specific classrooms paired with the necessary facilities and resources as well as staff that cater to

their specific needs. These schools should be affordable and accessible to more children than they serve now. Training and resources should also be available for teachers and school staff to give the children appropriate support.

5. After making the service more accessible by integrating it into more public hospitals, the Ethiopian government should use different awareness-raising mechanisms such as public education, including mental health education in school curricula, disseminating information through media outlets, mental health awareness campaigns, and programs at community levels in different parts of the country to improve mental health awareness, to let people know where to access the service and decrease the stigma around children who have a mental disorder.
6. The Ministry of Health should promote and facilitate the provision of child-specific capacity-building training to develop mental health professional's ability to deliver age-responsive mental health care.
7. The government of Ethiopia should conduct nationwide assessments and research within the appropriate interval on the prevalence of mental disorders in children across the regions to identify the specific needs of different regions to help in effective resource allocation and early intervention. The research findings should be publicly available to researchers, and anyone interested in accessing the information to encourage more research in the area and raise awareness.

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APPENDICES

Appendix I

IDI Respondent Characteristics

Participant Code	Sex	Current Residence	Age of the Child	Sex of the Child	Diagnoses	Years in treatment
P 1	F	Burayu, AA	16	M	Being Screened	-
P 2	F	Guten, Oromia	6	F	ASD and Developmental Delay	One year
P 3	M	Gulele, AA	3	M	Speech Delay	Two weeks
P 4	F	Kara Kore, AA	13	F	ASD and Epilepsy	Five Years
P 5	F	Ferencai delegación, AA	11	F	Anxiety and Depression	One Year
P 6	F	Mriyam. AA	13	M	ASD	One Year
P 7	F	Ferencai delegación, AA	7	M	ASD	Two Years
P 8	F	Gefersa, AA	17	M	ASD	Nine Years
P 9	F	Rufael, AA	8	M	ASD	First Appointment

Appendix II

Key Informant Interview (KII)

Consent

My name is Rebka Kassaye and I am a student at Addis Ababa University, School of Law. I am doing my thesis on Children's Right to Mental Health in Ethiopia: The Law and the Practice. I am talking to you to hear your expert opinions as well as experiences on the Mental Health services being provided to children by St. Paul Hospital.

Your participation in this interview is voluntary. If you choose to participate, you may refuse to answer certain questions, or you may stop participating at any time. There is no foreseen risk to your participation in this interview except for the half an hour you will spend on our interview.

I ask for your support in responding to the questions as honestly and fully as possible. Your responses will be kept completely confidential. This is not an assessment of your efforts, and there are no right or wrong answers. I just want to know the actual practices and the challenges you face in order to understand how it can be improved and provide recommendations. Your answers will be very useful for this study and hopefully policymakers in improving what is lacking.

With your permission, I would like to audio-record the interview.

Identification/background information

1. Date and time:
2. Name of respondent:
3. Work Position:
4. What diagnosis do you treat and how many children?
5. What are their ages?

Mental Health Services at St. Paul Hospital

6. What types of mental health services are available for children at St. Paul Hospital?
7. How accessible are these services to children in need of mental health support in your opinion?

Probing: Do you know how far your patients travel?

8. How many professionals work with children?
9. How many children are receiving care at St. Paul right now?
10. Can you provide information about the affordability of mental health services for children at the hospital?

11. What is the reason there is no in-patient service for children?
12. Are children prescribed medications? If so, are they provided at the hospital?
13. Are referral services provided for additional support if needed?
14. Are there support systems in place for families or caregivers?
15. How are government assistance and budgeting allocated to support mental health services for children at St. Paul Hospital?
16. What are the challenges the Hospital faces in regards to treating children?

Probing: Budgetary, Institutional, lack of equipment, lack of human resources?

17. What common challenges do children face when trying to access mental health services at the hospital?

Probing: Distance, Money issues, Discrimination, fear of stigma

18. How is the quality of mental health services for children ensured at the hospital? What special treatments are given to children as opposed to adults?
19. Does the hospital collaborate with external organizations or agencies to enhance mental health services for children?
20. Can you share any success stories or positive outcomes achieved through the mental health services provided to children at the hospital?

Recommendations

21. Based on your experience, what strategies do you recommend to improve the affordability of mental health services for children?
22. How can government assistance and budgeting be optimized to better support mental health services for children?
23. What initiatives or programs do you suggest implementing to enhance the accessibility of mental health services for children?
24. Are there any specific changes or improvements you believe would positively impact the accessibility and quality of mental health services for children at St. Paul Hospital and throughout other public hospitals?

Thank you for your participation.

Appendix III

In-depth Interview (IDI Tool)

Consent

My name is Rebka Kassaye, and I am a student at Addis Ababa University, School of Law. I am doing my thesis on Children's Right to Mental Health in Ethiopia: The Law and the Practice. I am talking to you to hear you're your personal experiences regarding the Mental Health services being provided to your child by St. Paul Hospital.

Your participation in this interview is voluntary. If you choose to participate, you may refuse to answer certain questions, or you may stop participating at any time. There is no foreseen risk to your participation in this interview except for the half an hour you will spend on our interview.

I ask for your support in responding to the questions as honestly and fully as possible. Your responses will be kept completely confidential. Your name will not be asked or shared. There are no right or wrong answers. You will not receive any direct benefits for participating in this interview. However, your experience and the challenges you face will contribute to informing how it can be improved. Your answers will be very useful for this study and hopefully policymakers in improving what is lacking.

With your permission, I would like to audio-record the interview.

Background information

1. Date and Time:
2. Where are you from?
3. How old is your child?
4. What is the mental disorder your child has been diagnosed with?

Mental Health Services at St. Paul Hospital

5. How did you learn about the mental health services offered at St. Paul Hospital?
6. Can you describe the process of accessing mental health services for your child at the hospital? How far do you travel to come here?
7. How many times a week do you come? How long has your child been receiving care?
8. What has been your experience with scheduling appointments or obtaining follow-up care at St. Paul Hospital?
9. Have you encountered any challenges in accessing the mental health services for your child at the hospital? If yes, what were they?

Probing: Discrimination, the distance of the hospital, finding the right mental health professional, stigma

10. Do you feel like you and your child are treated well when you come to St. Paul?
11. Did you face any financial barriers when seeking mental health services for your child at St. Paul Hospital?
12. How much do the services cost? How affordable would you say these services are? **(Optional)**
13. In your opinion, how would you rate the quality of care and support your child received from the mental health services at St. Paul Hospital?
14. Have you noticed any improvements or changes in your child's mental health since utilizing the services at the hospital?
15. How satisfied are you with the overall experience of your child receiving mental health services at St. Paul Hospital?
16. Are there any additional services or resources you feel should be made available to improve the mental health services for children at the hospital?
17. Anything else you want to discuss or inform me?

Thank you for your participation.

Appendix IV

Observation Checklist

Accessibility

1. Is there clear signage for directions within the facility?

Interactions

2. Courtesy and professionalism of staff towards patients and parents/caretakers?
3. Communication style used by staff when interacting with individuals (e.g., respectful language, active listening)

Quality of Services

4. Is there adequate seating in the waiting area?
5. Wait times for appointments: how long do people wait in general to see doctors?
6. Is there a client feedback mechanism in place to gather opinions on services provided?

Sanitation and Safety

7. How are the cleanliness and tidiness of the reception area and waiting rooms?
8. Are the waiting rooms child-appropriate and child-friendly?

Privacy and Confidentiality

9. Is there confidentiality of client records and information?

Resources and Support

10. Is there availability of informational materials about mental health services and resources? Eg: pamphlets, brocheures, posters, banner
11. Is there an information desk?

Appendix V

Support Letter from Addis Ababa University, School of Law

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ADDIS ABABA UNIVERSITY
School of Law

Date: April 30, 2024
Ref. SL/ ነ6ዓ /016/024

To: St. Paul's Hospital Millenium Medical College

Subject: Request for Cooperation

Our LL.M Graduate Student, Ms. Rebka Kassaye, is working on a thesis titled 'Children's Right to Mental Health in Ethiopia: The Law and the Practice," gathering primary data from respondents, particularly of your esteemed organization. While the School writes letter of cooperation to you to assist the student in data gathering, student Rebka has brought to our attention that your organization wishes to get either an ethical clearance or a letter indicating its absence.

This is to kindly inform you that the AAU School of Law currently does not have an ethical clearance procedure, leaving the ethical considerations to judgements of the thesis advisors and examiners. We kindly request you to note this and assist her in the data gathering process for the completion of her thesis.

Best Regards,

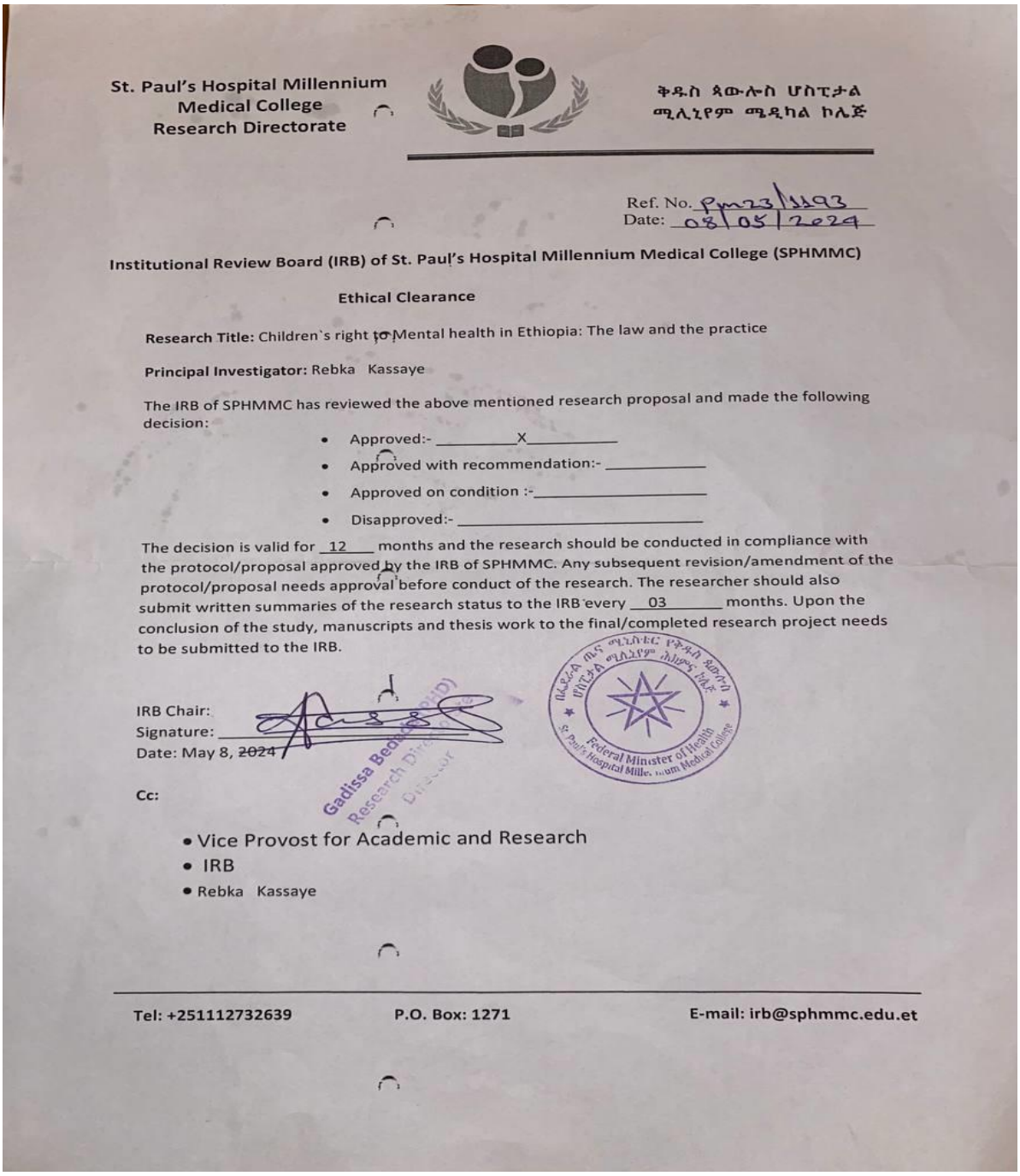
College of Law and Governance Studies
School of Law

Solomon Abay (PhD)
A/Head, School of Law
Addis Ababa University

☎ Tel. + 251+251-118-695648 P.O.B 1176

Appendix VI

St. Paul's Hospital Ethical Clearance Letter



St. Paul's Hospital Millennium
Medical College
Research Directorate

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Ref. No. PM23/1193
Date: 08/05/2024

Institutional Review Board (IRB) of St. Paul's Hospital Millennium Medical College (SPHMMC)

Ethical Clearance

Research Title: Children`s right to Mental health in Ethiopia: The law and the practice

Principal Investigator: Rebka Kassaye

The IRB of SPHMMC has reviewed the above mentioned research proposal and made the following decision:

- Approved:- _____X_____
- Approved with recommendation:- _____
- Approved on condition :-_____
- Disapproved:- _____

The decision is valid for 12 months and the research should be conducted in compliance with the protocol/proposal approved by the IRB of SPHMMC. Any subsequent revision/amendment of the protocol/proposal needs approval before conduct of the research. The researcher should also submit written summaries of the research status to the IRB every 03 months. Upon the conclusion of the study, manuscripts and thesis work to the final/completed research project needs to be submitted to the IRB.

IRB Chair:
Signature: _____
Date: May 8, 2024

Gadissa Beyene (PhD)
Research Director

Federal Minister of Health
St. Paul's Hospital Millennium Medical College

Cc:

- Vice Provost for Academic and Research
- IRB
- Rebka Kassaye

Tel: +251112732639 P.O. Box: 1271 E-mail: irb@sphmmc.edu.et