about the long-term benefit of antidepressants do not seem to be being communicated by doctors in a way that is convincing for patients.

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I declare that I have no conflict of interest.


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Sexual and reproductive health rights in Africa

Sexual and reproductive rights have been on the international health-policy agenda since the International Conference on Population and Development in 1994.1,2 International laws on human rights provide well-established conceptual frameworks for sexual and reproductive health rights,3,4 but how far are they relevant to the policy debate in eastern and southern Africa? The gulf between legal human rights and the reality in a region is huge, particularly for poor women, men, girls, and boys.1 The obstacles to making sexual and reproductive health rights a reality are multiple and mutually reinforcing, encompassing sociocultural norms, gender inequalities, resource and capacity constraints, and unfavourable legal environments. These are the challenges being explored by a new Research Programme Consortium on Realising Sexual and Reproductive Health Rights. The Realising Rights Consortium is funded by the UK Department for International Development and brings together the African Population and Health Research Center (APHRC), the Bangladesh Rural Advancement Committee, EngenderHealth, the INDEPTH Network, the Institute of Development Studies at the University of Sussex, and the London School of Hygiene and Tropical Medicine in a 5-year programme, which will address shortfalls and constraints in sexual and reproductive health measurement, access to services and technologies, and rights and entitlements, and which will focus on the unmet needs of poor and vulnerable populations.

Although the obstacles to sexual and reproductive health are often daunting, emerging messages from a regional workshop suggest strategies for making the concept of rights more relevant in eastern and southern Africa.

On Nov 9, 2005, APHRC held a consultative meeting in Nairobi, Kenya, under the auspices of the Research Programme Consortium. The meeting brought together 35 policymakers, service providers, activists, and
academics from eight countries to exchange ideas and guide the consortium’s research in the region.

Drawing on previous work, one of us (CN-M), a human rights lawyer and academic, presented a new framework for analysing rights. Rights are defined as legitimate claims that involve three intersecting dimensions: social, legal, and personal. Social rights consist of claims that are legitimised variously by religion, ideology, traditions, culture, and general social assent. Legal rights are defined in international and national law, but interact with customary and religious law and practice. The personal dimension concerns how individuals perceive their rights, based on their experience, knowledge, and multiple influences from the social dimension.

Subsequent discussion among participants explored the intersections and disconnections between the three dimensions. Examples from wide-ranging professional experience showed how the intersection between social and personal aspects of sexual and reproductive health rights is particularly crucial in Africa, in which such rights are often mediated by claimed cultural norms and beliefs and by household and community relationships that are influenced by gender. One government official noted how interventions aiming to empower women to negotiate over sex in western Kenya resulted in gender-based violence because the interventions failed to address social norms and expectations about the roles of men and women in sexual relationships. This discussion resonated with research findings from the region, which highlight how sexual and reproductive health rights are constrained by sexual identities, such as ideas about maleness and femaleness, which themselves are shaped by poverty. Participants concluded that younger and older men should be involved in all research, advocacy, and action on sexual and reproductive health rights.

Many of the examples discussed were about situations in which rights violations are socially legitimised, issues are stigmatised, and marginalised groups lack voice or have internalised their “rightlessness”. Participants noted that language in sexual and reproductive health often shapes the overlap or disparity between the three dimensions of rights. For example, in some languages there is no term for fistula, or there are only derogatory words for the condition. This language barrier makes open discussion difficult and perpetuates stigma and discrimination, thus restricting access to services. Strategies therefore include working on mutual forms of communication between service providers and users, and paying attention to local language and meaning. There may be more scope for contesting social norms that perpetuate rights violations than is often assumed. Participants cited positive examples in which community-based theatre in Malawi enabled discussion on taboo subjects, such as the difficulties faced by women living with HIV. Participants also pointed to opportunities to work creatively to strengthen the social structures that legitimise claims and mediate disputes, and increase accessibility to marginalised groups. Such approaches could include working with religious and community leaders, and mothers-in-law, who often have the authority to define or challenge norms and beliefs.

The consultation drew out implications for contextualising approaches to sexual and reproductive health rights (panel).

The Realising Rights Research Programme Consortium will develop research on these issues over the next 5 years. The consortium’s partners welcome comments, suggestions, and interest in collaboration from other researchers and practitioners. For further information, please contact the Director, Hilary Standing (h.standing@ids.ac.uk) or visit the website.10

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Panel: Implications for contextualising approaches to sexual and reproductive health rights

- Ensure approaches are grounded in local gendered realities, culture, and language
- Look beyond the individual to strengthen collectively defined rights and responsibilities that exist in communities—eg, by working with influential social actors
- Focus on strengthening overlap between personal and social dimensions of rights, including involvement of men in all initiatives in sexual and reproductive health rights
- Lively discussions during workshop revealed potential gains from developing strategic alliances between different professions and sectors
We thank Hilary Standing for her insights and contributions to this Comment. We are all involved in the Consortium. We declare that we have no other conflict of interest.

1 International Women’s Health Coalition. The Cairo consensus: the right of interest. We are all involved in the Consortium. We declare that we have no other conflict of interest.


Recommendations for alcohol-related liver disease

Orthotopic liver transplantation for alcoholic liver disease is well established in the UK. Survival for patients and grafts is similar to that for other causes of liver disease, at least in the first 5 years. Evidence from the USA suggests that survival beyond 5 years is reduced, particularly in people who return to drinking.1 Prediction of who will return to drinking is challenging because few good studies have been published that identify reliable factors.

In the UK, seven units undertake liver transplantations, with transplantation for alcoholic liver disease accounting for around 25% of all procedures although the proportion for each unit varies (17–34%). Because this disease continues to be (probably) the most controversial indication in terms of the attitude of the general public, all units should use a similar approach to assessment, listing for transplantation, and follow-up of patients, and they should standardise advice given about alcohol intake in the liver-transplant setting. The following recommendations were agreed by a working party including representatives from every unit and have been ratified by the UK Liver Advisory Group. Panel 1 summarises these recommendations.

Patients admitted for assessment when alcohol has contributed to their liver disease should be reviewed by a specialist in substance misuse. This process should include careful attention to risk factors associated with prediction of relapse to drinking, and should provide advice for the transplant team on follow-up requirements to prevent relapse into drinking.

At present, evidence that a fixed period of abstinence will predict patients’ adherence after transplantation is conflicting.2–8 However, we should recognise that, with abstinence, many potential patients will improve to such an extent that transplantation is no longer indicated. A period of abstinence is also required to allow the addiction team to assess the individual and organise any support measures that might be needed.

The working party agreed on several factors that all precluded from listing for a liver transplant because a poor outcome for the graft was likely.2–6.9 Panel 2 outlines these factors. If the opinion of the multidisciplinary team is that a patient should be listed, that individual will be asked to sign an agreement that they will not drink after the operation and will adhere to follow-up requirements.

The expectation is that all patients who undergo transplantation for alcoholic liver disease will remain abstinent after the procedure. To encourage this

### Panel 1: Recommendations for liver transplantation in patients with alcoholic liver disease

#### Assessment

- Alcohol specialist

#### Contraindications

- Alcoholic hepatitis
- More than two episodes of medical non-adherence
- Return to drinking after full professional assessment
- Current illicit drug misuse

#### Listing

- Sign agreement indicating intention of abstinence

#### Follow-up

- Alcohol specialist and transplant clinician