PHASE 1
COUNTRY REPORT
MENTAL HEALTH POLICY DEVELOPMENT AND IMPLEMENTATION IN ZAMBIA: A SITUATION ANALYSIS

30\textsuperscript{TH} March 2008
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Acknowledgements

In doing this research over the past couple of years, we have received fabulous help from numerous people. As the long gestation of this report indicates, getting the ideas on paper and seeing to it that everything came out in the end as envisaged, has not been an easy task. We would like to thank our respondents who generated the data in varying ways and pressures. We accord due honour and gratitude to the Permanent Secretary in The Ministry of Health, Dr. Simon Miti, for granting us permission to access the health institutions in the three districts and critical documents.. This is coalesced with all the staff in the directorates and primary care units, who saw to it that we had all that was needed timely and wholesome. Special thanks go to Dr. Victor Mukonka, Director of Public Health and Research, under which Mental Health Services fall, for ensuring that the ministry of health is well represented on the MHAPP project. We pay tribute the Dean of the School of Medicine, Prof Y. Mula, for the critical role that he played in superintending the project. We further extend our gratitude to the Director of Technical Support Services Dr. Velepi Mtonga, the Director of Policy, Dr. Luke Sichone, the Director of Planning and Development Dr. Chimfwembe and the Director of Clinical Care Services, Dr. James Simpungwe, for having been supportive in a manner we could not describe. Over and above, this project could not have taken off had it not been for the financial support from DFID for which we are heavily indebted. To all these, their contributions traverse human understanding.

This work represents the views of the authors and not necessarily those of the organisations they represent. There are indeed weaknesses in our research and the product there of. Some arise from our stretch to incorporate as much as we could to try to give meaning to this piece of research. The other weaknesses arise from the demands of the seven research questions due to insufficient time, resources and probably a lack of ingenuity on our part. The faults are entirely ours.

Dr Mwanza Banda – Principal Investigator
**Executive Summary**

For developing countries, such as Zambia, health services have not been associated with an appropriately designed framework for evaluation of sector performance. A lack of systematic theoretical and evidence based methodologies to resolve emerging constraints in the health systems has existed. Mental health which was a priority at independence is no longer favoured. Zambia’s decentralisation has been embedded in the macro – organisation framework that tried to address financing and principal agent behaviour through performance based accountability for determining health status. Outputs in the health system such as disease burdens have not shown corresponding response to the objectives of improving equity and accessibility, most notably in mental health.

There is growing recognition that mental health is a crucial public health and development issue in Zambia. There is also emerging evidence that a range of clinical, social and economic interventions could have a positive benefit for the mental health of our communities. Yet mental health is not given the priority it deserves. The aim of this study is to examine mental health policy development and implementation in Zambia, with a view to identifying the key barriers to mental health policy development and implementation, and steps that can be taken to strengthen the mental health system in the country. This study forms part of a broader international mental health research consortium based in Ghana, South Africa, Uganda and Zambia, which aims to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries.

**Methodology**

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2, the WHO Mental health policy and plan checklist, and the WHO Mental Health Legislation Checklist as quantitative instruments interfaced with ethnographic methods: observations, interviews, documentary reviews and focus group discussions were used to collect data. The report is guided by critical theory with an ethical responsibility to readers of this analysis to work towards addressing processes of marginalization and unfairness that is evidenced. By “ethical responsibility,” we mean a compelling sense of duty and commitment based on moral principles of human freedom and well –being, and hence a compassion for the suffering of those who are mentally ill and those providing the service.

**Results**

The country has a mental health authority within the directorate of public health and research that ought to coordinate mental health activities in the country. There is currently a national mental health policy, but no strategic plan for mental health. An
integrated structure exists through which mental health care ought to be provided but it serves other disciplines well and not mental health. In addition, the 1951 mental health law that was inherited from the colonial legacy only protects the general public from the perceived dangerous mental patients is not used at all. Financing is mainly oriented towards integrated health care though the budgets in the districts but the proportion of the total budget spent for mental health services by the Ministry of Health was a paltry 0.38% (K 218 1151 743.00) in the year under review. There is no equity of access to mental health care within the present mental health system. Generally we observed that:

- There is low priority given to mental health
- There is need to increase participation of mental health care users in policy making;
- There is widespread stigma for mental illness.
- There is a human rights review body, but it has never inspected any mental health units.
- At the moment, the country is operating on a skeleton of mental health worker staffs that have received no training in human rights and have not had any refresher courses in the last five years.
- There is no equity of access to mental health care as close to the family as possible.
- There is no integration of mental health care at all levels of health care delivery.

Discussion and Conclusion

The mental health needs of the greater majority in our Zambian society are not being met. The needs are not being met because the health system is dysfunctional from a structural level as well as from a regulatory level. There are no interconnections existing within the Ministry of Health and between the ministry and other sectors because there is no mental health policy in action. In addition, the 1951 mental health law that was inherited from the colonial legacy has failed to confer rights and obligations to people living with mental illness and carers. Instead it strives to protect the general public only from perceived dangerous mental patients, while failing to uphold the human rights of people living with mental illness. The mental health law seems to be redundant as it is not used. Noting that the structure within which mental health care ought to be provided is in place, we see that other health disciplines or priority conditions are prominent and well catered for. On the contrary, as for mental health, it is marginalised.

We have established that apart from the systemic problem, the other critical problem is integration and this is financial, structural and/or clinical practice integration. The problems of integration are rooted in the faulty design.

Our conclusions are that Zambia’s mental health system is in dire straights. Our mental health system has no quality standards. All attempts to develop the adopted mental health policy and mental plans have been met with paucities in both evidence and
methodologies inherent of staff lacking of dexterity in public policy theory and practice. It therefore follows that we need to review the policy. It is possible to have the review because there is a high level mandate to develop public policies from the Minister of Health. In this study, we are suggesting the following recommendations:

1. Integrate mental health into routine clinical practice.
2. Provide treatment in primary care units.
3. Develop a Health Management Information System in mental health.
4. Train mental health workers: psychiatrists, psychologists, psychiatric nurses, psychiatric clinical officers.
5. Make psychotropic drugs available.
6. Give care in the community.
7. Educate the public.
8. Involve communities, families and consumers.
9. Review national mental health policies and plans
10. Reform the Mental Service legislation.
11. Link with other sectors.
13. Support more research.
CHAPTER ONE — INTRODUCTION

1.0 Country Description

Zambia derived its name from the Zambezi River, which rises in the northwest and forms the country’s southern boundary. Zambia is a landlocked country with an area of 752,612 square kilometres. It lies between latitudes 8 and 18 degrees South and longitudes 22 and 34 degrees East. The neighbouring countries enveloping her include: Angola, Botswana, the Democratic Republic of Congo, Malawi, Mozambique, Tanzania, Namibia, and Zimbabwe.

The country is home to more than 70 ethnic groups all of them being Bantu-speaking. This creates tremendous diversity- ethnically, racially, linguistically and religiously and we are unlikely to have uniform health behaviours and attitudes towards mental illness. The population is just over 12 million people of whom 40% are rural areas and 20% live in the capital city, Lusaka, while another 40% live in the Copper belt region (north). The population leaves huge tracts of uninhabited land and resulting in one of the smallest land to person ratios in Africa. Apparently, the country’s population growth rate is 3% annually which is very high by African standards (UNDP, 2005; Ndonyo, 2005). One of the reasons for the high growth rate is the very high fertility rate which now stands at 6.1. Zambia currently has the lowest life expectancy of any country in the world averaging 32.7 years and this is mainly due to the HIV/AIDS pandemic. The implication of high population growth rate and low life expectancy for the health sector is that resource allocations to the sector have to grow at a corresponding rate to meet the demand. In Zambia, the percentage literate rates are not satisfactory and stand at 55.3% and have remained unchanged since 1990 (UNDP, 2005).

1.1 Social Economic Profile

Zambia has moved from being a major copper producer and potentially one of the continent's richest countries at independence in 1964, to one of the world's poorest in 2007. A colonial legacy, mismanagement, debt and disease are said to have contributed to the country's tribulations. The country has embarked on wide sector social economic reforms to propel the country on the course to recovery. In spite of these reforms, Zambia’s economy is still largely mirrored by the fortunes of its copper-mining industry. The delay for instance in the privatization of the Zambia Consolidated Copper Mines and its loss making operations presented considerable challenges for the Zambian economy in particular for the period from 1996 to 2000. This acted as a major drag on the economic performance during that period. The performance of the mining sector improved significantly following the privatization of the nation’s largest mining asset, Konkola Copper Mines, which was acquired by Anglo American Corporation in March 2000 enabling the much needed financial and intellectual resources to follow to the sector. However and regrettably, commodity prices have fallen sharply in the face of...
a significant downturn in the world economy and this has impacted not only on the profitability of the mining operations but on social welfare like health (FNDP, 2006).

In order to ensure that government takes a leading role in setting priorities and meeting sector goals, we have been tracking Sector Wide Approaches (SWAPS) since 1993. Within the SWAPS framework Developmental Co-operating Partners are discouraged from supporting projects/programs to supporting sector investment plans through a funding mechanism popularly known as “common basket funding”. This has been responsible for the lack of donor support in mental health\(^1\) (MoH, 1992; Bennett, 1999; Priya, 2000; Walt et al. 1999a, b; FNDP, 2006). A prerequisite to Swaps, which both Government and Co-operating Partners have jointly agreed include:

- Commitment to the Health Vision (Policy) by all stakeholders
- Articulation of a clear, practical medium term National Health Strategic Plan (First plan was developed in 1995-2000 and later 2001 – 2005);
- Defining and updating the cost-effective basic health care package of interventions; (this has not included mental health care\(^2\) to date);
- Pooled Funding Mechanisms (Common basket funding)
- Joint reviews of plans and progress through the biannual Consultative and quarterly Health Sector Committee meetings;
- Joint Management Systems: Common procurement, disbursement reporting, accounting and audit procedures;
- Preparation and signing of a Memorandum of Understanding (code of conduct) with Co-operating Partners. (16 Co-operating Partners have signed except Japan and UNAIDS);
- Costing Annual Action Plans (Ministry of Health and Central Board of Health); (These plans have budgets for mental health for the public health Office and not for Primary Health Care\(^3\));
- Definitions of performance indicators and putting in place the Health Management Information System (HMIS); (These have excluded mental health and mental illness);
- Financial feasibility of health reforms (worked out - National Health Accounts and Resource Envelope); and
- Developed and implementation of the Financial Administrative Management Systems (FAMS).

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\(^1\) In the 2006 to 2011 NHSP, the Ministry of Health intends to lobby CPs to ensure that the Sector Wide Approach (SWAP) plays an important role in ensuring efficient and effective mobilization and utilisation of financial resources. The existing Memorandum of Understanding (MoU) between MOH and the CPs is being amended to address the new demands and priorities including mental health.

\(^2\) Mental health care* includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

\(^3\) However, the Ministry of finance through the Ministry of Health now funds mental health services at micro level.
1.1.1 Poverty

Zambia was once one of the wealthiest countries in sub-Saharan Africa. However, external shocks in the 1970s (such as the oil crisis and the relative commodity price collapse) and a massive recession in the 1990s, coinciding with extensive World Bank and IMF structural adjustment reform programs, have resulted in severe declines. Over the last thirty years instead of progressing in terms of human development, Zambia has gone backwards. In 2004, 63.7% of the Zambian population lived on a $1 a day. Unless there is a radical change, it looks increasingly unlikely that Zambia will achieve most of the Millennium Development Goals by 2015 (FNDP, 2006).

Macro indicators show positive growth trends during the last few years but Zambia is yet to register significant declines in income poverty levels. According to the Living Conditions Monitoring Survey (LCMS) IV of 2004, as much as 68 percent of the population fell below the national poverty line, earning less than K111 747. Figure 1 shows that poverty levels slightly fell in 2004 compared to 1998 when poverty stood at 73 percent. The depth\(^4\) and severity of poverty also remain high despite the slight decline since 1998. At the national level, the depth of poverty dropped to 36 percent from 40 percent in 1998, while the severity of poverty declined to 23 percent from 26 percent in 1998. Extreme\(^5\) poverty (covering people earning less than K78 223 per month) fell from 58 percent in 1998 to 53 percent in 2004. The declining depth and severity of poverty was driven primarily by rising per capita consumption amongst the poorest non-farm households. This represents a deviation from the experiences of 1991-1998, during which time non-farm poverty rose rapidly (FNDP, 2006).

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\(^4\) The ‘incidence’ of poverty (or headcount) measures the number of people falling below the poverty line irrespective of how far from the poverty line they are. So people lying far below the poverty line and those just beneath it are counted equally. In order to adjust for the fact that some people lie far below the poverty line it is necessary calculate the ‘poverty gap’ or what is alternatively referred to as the ‘depth’ of poverty. This measure gives a greater weight to the poorest of the poor. Along similar lines, the ‘severity’ of poverty (or the ‘squared poverty gap’) attaches even greater weight to the poorest of the poor.

\(^5\) Extreme poverty is measured by taking a lower poverty line that reflects the minimum requirements of food spending and excludes some of the items included in the national ‘basic’ poverty line.
Changes in poverty during 1998-2004 were evenly distributed across rural and urban areas. The incidence of poverty in the rural areas fell from 83 percent in 1998 to 78 percent in 2004, while poverty in urban areas declined to 53 percent from 56 percent in 1998. Rural incidence of extreme poverty fell from 71 percent in 1998 to 65 percent in 2004. In urban areas, the incidence of extreme poverty declined by 2 percent from 36 percent to 34 percent. Although almost all provinces recorded some declines in poverty prevalence, important gains were made in certain provinces like the Copper belt and Eastern Provinces. The incidence of human poverty declined the most in Eastern Province, where it fell by 11 percentage points to 70 percent in 2004 from 81 percent in 1998. This was followed by the Copper belt, which recorded a 9 percentage points decline in human poverty incidence to 56 percent in 2004 from 65 percent in 1998 (FNDP, 2006).

The persistently high-income poverty observed in 2004 is in sharp contrast to the rapid acceleration in economic growth experienced since 1999. This implies that the country’s improved economic performance over recent years has not translated into significant declines in human poverty. It has been noted that people living with mental illness are more likely to have a low income, be reliant on a pension, and face greater barriers to education, low employment, and reduced promotion opportunities (Robins et al., 1981), one-third more likely not to have graduated from high school, and 3 times more likely to be divorced (Cohen, 1993). There is in addition evidence to show that they experience many aspects of social deprivation associated with human poverty (Bolton and Oakley, 1987; Kessler and Frank, 1997; Fisher et al., 2007). Given this state of affairs, it is logical to assert that people living with mental illness in Zambia are living a miserable life.
1.1.2 Legislation and/or Regulations:

There is no specific legislation that targets combating human poverty, although generally where legislation exists, it is intended to create an environment conducive for sustainable development. There are however in existence sectoral policies to mitigate human poverty but the ministry of health has not come up with measures looking at the differing disabilities like mental illness. Indeed this scenario has compounding effects on people living with mental illness.

1.1.3 Strategies, Policies and Plans

Little can be achieved to reduce human poverty unless measures are taken to revive Zambia’s economy with the focus on mitigating micro level poverty. Accordingly, Zambia’s Poverty Reduction Strategy focuses on measures to achieve strong sustained economic growth of between five to eight percent per annum. In the short to medium term, uncertainty in the critical mining industry will dampen Zambia’s growth objectives and also threaten the viability of implementing Poverty Reduction Strategies. However, this can be considered to be a temporary setback as the country remains endowed with great mining potential in spite of the low mineral royalties the government is getting from the mining sector.

1.1.4 Health and Sustainable Development

Prior to 1991, the health sector in Zambia was highly centralized. Districts and the lower levels of the health care delivery system played minor roles prior to the decentralisation policy of 1992. In 1995, the National Health Service Act was passed, calling for significant changes in the role and structure of the Ministry of Health and for the establishment of an essentially autonomous health service delivery system. This led to the decentralisation the Ministry Of Health and organization of the health service delivery system based on three distinct levels (Foltz, 1997; Kalumba, 1997; MoH, 1998a,b).

1. The Central Board of Health, operating as the national coordinator of health service delivery being a technical unit responsible for the delivery of health services and implementation of health reform policies and strategies on behalf of the Ministry of Health. In addition Central Board of Health was part of Government’s strategy to ensure that an ordinary Zambian citizen had a legitimate “voice” in the running of health service delivery.

2. The District Health Management Team (DHMT) and first level hospital and secondary and tertiary level major hospitals governed by the District Health Boards and Hospital Management Boards, respectively. Under the coordination of the CBoH, the district and hospital boards act as supervisors of DHMT and hospital management units. The boards are expected to be the employers of both management teams under the planned “delinkage” of personnel from MOH to districts; however, this process has been only partially implemented. The
DHMT was to be responsible for policy implementation and service provision through a network of health facilities.

3. **Health centres** provide services under the supervision of DHMTs and district health boards. There are plans to convert smaller health centres into health posts, each with a single professional staff member. Health Centres have Facility Committees and Neighbourhood Committees to encourage community participation.

Decentralisation of health services was characterised both as delegation of the day to day management responsibilities from the Ministry of Health to a semiautonomous Central Board of Health and deconcentration to the District Health Boards. This involved granting managerial and professional autonomy to these autonomous institutions. Health Boards have a decision space to manage both human and financial resources without interference from the centre whose role was to monitor and evaluate performance and give guidance. Decentralisation has provided the health boards with an exploit budgetary transfer called a “grant” which covers a significant proportion of local expenditure. Decentralisation has also allowed the health boards to make decisions for allocation of resources, user fee levels and expenditures.

**Table 1 Coordination Government/Body Responsible For the Issues Prior to the Repeal of the National Health Services Act**

<table>
<thead>
<tr>
<th>Body / Government</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of health</td>
<td>A policy making body on health for Zambians.</td>
</tr>
<tr>
<td>Central Board Of Heath</td>
<td>A technical unit responsible for the delivery of health services and implementation of health reform policies and strategies on behalf of the Ministry</td>
</tr>
<tr>
<td>District Health Boards</td>
<td>To manage both human and financial resources without interference from the centre whose role is to monitor and evaluate performance and give guidance.</td>
</tr>
</tbody>
</table>

1.1.5 **Legislation and/or Regulations in the Health Sector**

The government has passed many laws and other regulations to drive the governments health vision and they include: Acts concerning regulation of medicines and pharmaceuticals Products; National Health Services Act; Public Health Act; Pharmacy and Poisons Act; Food and Drugs Act; Ionizing Radiation Act; Therapeutic Substance Act; Dangerous Drugs Act; Tropical Diseases Research Act; Human Tissues Act; Termination of Pregnancy Act; and Medical Services Act. Acts concerning public health and health promotion; National Health Services Act; Public Health Act; Food and Drugs Act; Ionizing Radiation Act; Local Government Act; and Extermination of Mosquito Act. Pneumoconiosis Act and National Food and Nutrition Act. Acts Concerning financing of health sector; National Health Services Act; The medical Aid Societies and Nursing Homes (Publication) Act. Acts Concerning Provision of Health Services including Research; National Health Services Act; Tropical Diseases Research Act; Human Tissues Act; Flying Doctors Act; and Mines and Minerals Act.
Of these laws, the National Health Services Act was later repealed in 2005 to pave way for the dissolution of the Central Board of health. The repeal was occasioned by numerous reasons and the notable ones were (i) the excess expenditures incurred by the government on personal emoluments which seemed to gobble funds for utilities at primary level of care and (ii) the worsening picture in the indicators that continue to be registered looking at the overall performance of the public health systems – in terms of access, efficiency, effectiveness, quality and equity.

At the moment, there are areas requiring development of legislation and these include: Traditional Medicine; Forensic Science; Human Embryology and fertilization; the national analytical laboratory services; and HIV/AIDS. It has been argued that there is need for the Mental Health Act of 1951 to be repealed because it lacks a number of numerable rights and obligations.

1.1.6 Major Groups Involvement in Decision-Making:

There are a limited number of stakeholders that play a role in decision making on critical issues in the health sector. In this regard, the Ministry Of Health only considers health staff – professional groups, Ministry of Health’s Cooperating Partners and Communities as its critical partners. However from the data at hand, conspicuously missing at policy development, planning and monitoring workshops are representatives from Finance, Social Welfare and Housing, criminal justice system, family members or representatives of such groups, relevant NGOs, private sector and consumers or representatives of such groups- stakeholders noted as cardinal by the World Heath Organisation (WHO, 2004).

1.1.7 Health Sector Priorities

The Zambian government has noted innumerable health challenges afflicting the nation and to attempt to address these challenges, she has prepared a Basic Health Care Package. This is a set of carefully selected high impact interventions to be offered to the public freely or on a cost-sharing basis at appropriate levels. Interventions outside this package are offered on a full cost recovery basis. Interventions included in the Basic Health Care Package were selected on the basis of an epidemiological analysis of those diseases and conditions that cause the highest burden of disease and death. Currently, ten priority areas for health services have been identified for inclusion in the Basic Health Care Package as indicated in Table 2. Further work is needed to refine the packages and use them in the manner they were intended.
### Table 2 National Health Priorities (FNDP, 2006)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Strategic Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child health and nutrition</td>
<td>To reduce the mortality rate among children under five</td>
</tr>
<tr>
<td>2. Integrated reproductive health</td>
<td>To reduce the Maternal Mortality Ratio</td>
</tr>
<tr>
<td>3. HIV/AIDS, TB, and STIs</td>
<td>To halt and begin to reduce the spread of HIV, TB, and STIs through effective</td>
</tr>
<tr>
<td>4. Malaria</td>
<td>To reduce incidence and mortality due to malaria</td>
</tr>
<tr>
<td>5. Epidemics</td>
<td>To improve public health surveillance and control of epidemics</td>
</tr>
<tr>
<td>6. Hygiene, sanitation, and safer water</td>
<td>To promote and implement appropriate interventions aimed at improving hygiene and access to acceptable sanitation and safer water</td>
</tr>
<tr>
<td>7. Human resources</td>
<td>To train, recruit, and retain appropriate and adequate staff at all levels</td>
</tr>
<tr>
<td>8. Essential drugs and medical supplies</td>
<td>To ensure availability of essential drugs and medical supplies at all levels</td>
</tr>
<tr>
<td>9. Infrastructure and equipment</td>
<td>To ensure availability of appropriate infrastructure and equipment at all levels</td>
</tr>
<tr>
<td>10. Systems strengthening</td>
<td>To strengthen existing operational systems, financing mechanisms, and governance arrangements for effective delivery of health services</td>
</tr>
</tbody>
</table>

### 1.1.8 Mental Health Situation

Since 1992, Zambia’s strategic plans have not sufficiently addressed mental health. The Ministry of Health and its Co-operating Partners have agreed jointly to develop National Health Strategic Plans and to jointly fund these plans and within these is the premise of providing care through basic packages. Since the onset of the health reforms, the focus of the Government has been on Primary Health Care (PHC) which has been identified as the main vehicle for delivering health services. The reasoning behind the PHC approach is that most of the diseases in Zambia can be prevented or managed at primary health care level which in itself can lower the cost of referral curative care by reducing the number of people seeking services. Further, in an attempt to promote allocative efficiency in a climate of limited resources, the Government has developed a Basic Health Care Package (BHCP) (CBoH, 2001: MoF, Transitional National Development Plan, 2002-2005) which is a set of carefully selected high impact interventions that is offered through the public health system freely or on a cost-sharing basis at different levels of the health care delivery system. Interventions outside this package are offered on a full cost recovery basis. Interventions included in the BHCP were selected on the basis of an epidemiological analysis of those diseases and conditions that cause the highest burden of disease and death. Currently, ten priority areas for health services have been identified for inclusion in the BHCP as indicated in Table 3. No further work has been done to refine the packages to include mental health and this may be due to the fact that mental illness is not even among other conditions that cause the highest burden of disease and death (FNDP, 2006:126) and it is no
wonder that it is afforded a low priority rating through a miscalculation as noted by Gleisner (2002) in his article “What causes more destruction, AIDS or AID?"

At the time of the study, three plans had been developed (1995-1998; 1999 – 2000; 2001 -2005). Over the years (1995 -2001) within these plans mental health and clinical care plans have not been reflected until the 2001 -2005 strategic plan when mental health was listed as part of the public health priorities. However, within these earlier plans the following programs were been given priority excluding mental health:

### Table 3 Priority Programs Developed from Assertions in FNDP

<table>
<thead>
<tr>
<th>Programme</th>
<th>Background</th>
<th>Constraints &amp; Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Health Care Package</td>
<td>Zambia has developed and costed an essential basic health care package which gives cost effective core interventions to be undertaken from community, first, second and third levels of care. Public Health Priorities include HIV/AIDS, Malaria, TB, Child Health, Reproductive Health, Environmental Health and health promotion activities</td>
<td>Funding available only meets 1st level of care. HIV/AIDS tying up resources.</td>
</tr>
<tr>
<td>Infrastructure Development Programme</td>
<td>In order to improve access to quality health care, government has since 1992 been rehabilitation health facilities focusing more on rural health centres. Under the infrastructure development program government intends to rehabilitate and expand 520 health centres and hospitals. So far 100 facilities have either been rehabilitated or expanded.</td>
<td>Medical Resources Persons inadequate. Brain drain in sector high. Lack of Medical Equipment and accessories.</td>
</tr>
</tbody>
</table>

Drawing from these variations in the plans, it has been observed that as a country we do not have criteria in placing conditions as public health priorities. Pressure may be a factor in deciding priorities.

1.1.9 Health Care Financing

Per capita total expenditure on health has fallen from US$24 million in 1997 to US $18 million in 2001-5. Consequently, the provision of quality health care has declined. The sector is financed by Government (about 60%) of the total budget while the rest, (40%) is met by development partners. Government finances the sector through grants while the cooperating partners finance through bilateral contributions, tied aid and loans *inter alias*.

1.1.10 Reform Agenda

Zambia embarked on a radical reform process in 1991, which was aimed at creating a well functioning, cost effective and equitable, district, based health care system that could deliver an essential package of care as close to the Zambian family as possible (MoH, 1992). While much progress has been made in improving the health care delivery system especially at the district level, rhetoric does not yet match reality.
1.1.11 Financing Gap

There is a financing gap in the health sector. The estimated per capita expenditure in the year 2000 of USD 10.5 for instance was under the USD 11.5 of the overall basic package. Assuming that the districts were to receive 70% of per capita expenditure ($7.35) the difference of $3.65 was envisaged to be funded by households through purchase of drugs, user fees or by further prioritisation even within the basic package of care. This has equity implications and further on mental health care (FNDP, 2006).

1.1.12 Planning For Health Services

There are also a number of issues that have affected planning, management and provision of services. These include variations between Government of the Republic of Zambia budgets and actual expenditures, variations between donor commitments and actual disbursements (FNDP, 2006).

1.1.13 Human Resources

Human resources are critical to the delivery of quality health services. The lack of adequate professional health workers has contributed to poor health care delivery. The major types of health personnel in Zambia include physicians, nurses, clinical officers and health assistants. To meet the demands of the rapidly expanding health system, a medical school was set up at The University of Zambia in 1966, and the first batch graduated in 1973. However, overall output from this school has remained very low, rising from an initial 26 to about 40 per annum. This has always been clearly inadequate for the requirements of Zambia’s health system, and so in addition to a very low level of physicians nationally, there has been continued reliance on expatriates on contract to fill most physician posts. For certain other types of health personnel, such as pharmacists, Zambia continues to lack training facilities, and remains dependent on overseas training. For other levels of health personnel, training has not been adequate, and there is also a critical shortage. Overall more than two-thirds of the health personnel, including both nurses and doctors, are located in Lusaka and Copper Belt Provinces (Berman et al., 1995). The University of Zambia has however done well in the training of general medical practitioners but has failed to train critical mental health practitioners such as psychiatrists and psychologists mainly due to lack of specialised personnel to provide the training.

At the moment, key constraint to effective and rapid scale-up of health services in Zambia is the worsening human resource situation. Over the past few years, there has been a massive exodus of health workers, especially nurses and doctors going abroad due, primarily, to the low level of wages and benefits in the civil service and also the general poor working environment. The exodus of doctors is critical especially in psychiatry. We have three (3) psychiatrists for a population of 12 million people. A recent assessment of the health workforce in Zambia reported that current workforce
levels are only 50 percent of the required levels. Significant levels of resources will be needed for filling in the vacant posts and for improving the working environment (FNDP, 2006).

1.1.14 Drugs and Supplies

Zambia requires approximately US$38.5 million for procurement of essential drugs but less than half of this is available annually from both Government and cooperating partners. With the policy of free Anti Retroviral Drugs (ARVs), Zambia requires about US$25 million per annum to sustain the 39,000 patients on ARVs. If ART is scaled up to cater for 100,000 eligible patients, approximately US$60 million will be required for procurement of anti retroviral drugs. Zambia also requires approximately US$10 million for the procurement of Coartem for malaria treatment and US$8 million for vaccines and injection supplies (FNDP, 2006). However, there is no mention at all of the estimated costs of psychotropic drugs and this could be occasioned by the lack of empirical data that is necessary in making procurement estimates.

1.1.15 Access to Health Care

Access to basic services shows a wide spatial variation with provinces closer to the 'line of rail' having better access to services. In urban areas, 99 percent of households are within 5km of a health facility while it is only 50 percent of households who are within 5km of a health facility in rural areas. In the Fifth National Development Plan, the priority is to make available at least one first level hospital in each district, which would operate as a referral hospital to a satellite of health centres (FNDP, 2006). While this may be so, there are no plans to build structures that embody mental health care.

1.1.16 Information Systems

Since 1995, The Government has been implementing Health Management Information Systems (HMIS) at district level to ensure a monitoring and evaluation system, which supports the thrust of decentralisation. The system includes routine information monitoring system (HMIS), sentinel surveillance system e.g. monitoring HIV/AIDS sero-prevalence, operations research, and special research such as the Demographic and Health survey. The system has failed in part to institutionalise a culture of quality through quality assurance and hospital accreditation although all of our 72 districts have a functioning HMIS. The failure is premised on reporting which is irregular and further, the data collection tools are inadequate to capture mental illness. More than 30% of the districts now have a computerised HMIS. Districts and hospitals use HMIS data to assess and evaluate the levels of their performance in delivering care. Data from the districts and the hospitals is further processed and analysed at the national level to produce national statistics on health to help policy makers to develop evidence-based policies.
1.1.17 Research and Technologies

Research is irregularly conducted and when it is, the research topics are mainly on the performance of health care sector and policy research. A cursory look in some offices within the Ministry Of Health and The University of Zambia shows the presence of reports commissioned by Partnership for Health Reform, Harvard School of Public Health, and Reports commissioned in collaboration with the School of Humanities in the Department of Economics. There are also some joint reviews conducted and reported bi-annually to assess the performance of programmes and make recommendations. A great deal of research goes unpublished. However, in spite of this data being insignificant, it is a positive feature for Zambia because research could be contracted to the university in case the Ministry of Health lacks capacity.

1.1.18 Organization and Composition of the Health Sector

The composition and organization of Zambia’s national or public health system (by the public health system is meant those services which are either financed by the government or nominally supervised by the Ministry Of Health) include Ministry Of Health facilities, mission hospitals and industry hospitals (mostly mines). This public system for the most part is not coordinated with the services of private-for-profit providers and traditional healers. The public system is organized nationally on the basis of a pyramidal referral structure, consisting of central, provincial and district hospitals and health centres (figure 2).

Zambia has 72 districts and 9 provinces. In each province except for Lusaka which has national referral hospital, there is one general hospital and one mental specialist hospital. In most of the districts (37) there is a district hospital. Doctors are officially located in some of the urban health centres and this is true for the Capital City Lusaka, general and district hospitals. There are also 19 other mission hospitals, and 8 mine hospitals. Mine hospitals and clinics are almost exclusively located in the Copper belt. Missions are located mostly in rural areas of the more peripheral and poorer districts of the country. In addition, there are more than 1,037 health centres. There are 10 hospital beds per 100,000 population and 60 general practitioners per 100,000 population. Forty two percent of all hospital beds are in the private sector. In terms of primary care, there are 3 900 physician-based primary health care clinics in the country (2 000 in the public sector and 1 900 in the private) and 3100 non-physician based primary health care clinics (1500 in the public sector and 1600 in the private).

Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families as close to the family as possible to where people live and work in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination. It refers to care which is based on the needs of the population. It is decentralised and requires active participation of the community and the family (WHO, 1978).
Structurally, non-physician based primary health care clinics in the public sector (called health centres) are staffed by clinical officers, nurses and other ancillary staff. Health centres are designed to be the primary referral points for patients and to provide basic preventive and primary care. In terms of primary care, there are 3900 physician-based primary health care clinics in the country (2000 are in the public sector and 1900 in the private) and 3100 non-physician based primary health care clinics (1500 in the public sector and 1600 in the private). Private facilities are limited to the urban centres and these are located almost exclusively along the line-of-rail. Pharmacies are moderately dispersed. It is important for policy makers to understand the differences in the distribution of health facilities, since this has implications both from an analytical perspective as well as from policy-making and implementation perspectives. The distribution of the various provider types is described below. Figure 2 illustrates the relative distribution of hospitals across province by ownership type.

Figure 2 Distribution of Hospitals in Zambia by provider type

Governance of the health system has been dependent on decentralised, autonomous district units which are responsible for all functions within the responsibilities of purchasing and providing health services. Hence, we see that the fundamental assumptions of improved health care reform being embedded in:

- The financing of health services.
- The autonomy of the health services providers and purchasers.
- Accountability and performance of the agents and principal.

Analysis of decentralisation performance and use of resource inputs in terms of expenditures relate to the interaction of resources that the District Health Management
Team controls. Discretionary funds are available for recurrent and some capital expenditures to the districts which comprise an estimated 30% of total expenditures. Non-discretionary funds include human resource related expenditures commonly called personnel emoluments. These comprise wages, salaries, per diems, and other benefits such as leave allowances and pensions and constitute the remaining 70% of expenditure. The ability of the District Health Management Team to control expenditures of the discretionary funding therefore relates to the degree of performance of the District Health Management Team (MoH, 1992; Bennet 1999; Walt et al. 1999a,b).
Figure 3 Organization Structure of Zambia’s Public Health Care System

Key
- Referral
- Reporting
- Financing
- Policy direction and supervision
1.1.19 Traditional Healers

Nothing can be said definitively about the distribution of this group of providers. Although there are two organizations of traditional healers in the country (The Traditional Health Practitioners Association of Zambia and the National Council of Ng'angas) and the Ministry of Health keeps a register of them, there are no firm estimates of the actual numbers of traditional health practitioners in Zambia. The Ministry of Health estimates that there are 20,000 registered traditional healers in Zambia. Others put this number at about 30,000 (Freund, 1989). Besides, because many of them are itinerant, moving from place to place in search of profitable markets, it is difficult to talk about their distribution. However, the general consensus is that traditional healers are widely available in rural areas, and are often the most accessible source of health care for the rural population.

1.2 The Research Problem

Mental health has emerged as one of the priorities in the field of public health worldwide. It has characteristics which distinguish it from physical health. In fact, according to the World Health Organization (WHO, 2001), mental and behavioural disorders were estimated to account for 12 per cent of the global burden of disease. A 2000 study by Jenkins and Strathdee and a 2004 report by Thornicroft and Tansella found that the greatest opportunity to address the needs of consumers with common mental illnesses resides within primary health care. If mental health care is to be made more accessible, primary and mental health care providers, consumers, families, caregivers, policymakers, governments and other key stakeholders must re-examine the ways in which mental health care services are provided. Collaborative mental health care is one way of improving mental health promotion and prevention, enhancing access to early detection of illness, and making sure that treatment and recovery from mental illness is an integral part of primary health care.

Mental health in Zambia clearly suffers from the lack of a convenient policy model as the dominant ones in public health policies do not seem to fit7. This appears to be an area where research on mental health policy is much needed. Experts in the Ministry are all agreed but one that mental illness is a priority. To become a priority a health issue needs to prove several points. Are the societal costs of the disease high enough? Or what is the face value of its importance and what are the specific needs of the community? If an idea is a newcomer in the field of public health it must not only prove to be evidence-based and cost-effective but also socially and culturally accepted. This is true in Zambia for mental health. For instance, UK’s health strategy “Health of the Nation” of 1992 is a good example of how mental health is recognised in the idea of overall health.

7 However, there is now a mental health policy in place. The challenge however is its implementation especially that the key criteria used in arriving at priorities is resource versus need.
Epidemiological studies in Zambia have shown that the major public health diseases which are the leading causes of morbidity and mortality in Zambia include Malaria, TB, HIV/AIDS, Respiratory Infection: pneumonia and non-pneumonia, diarrhoea: non-bloody, and Respiratory Infection (MoH, 2007). These conditions are being mapped measured and an assessment strategy exists. This is also reflected in appropriate plans and structures. However, mapping of public health risks and populations at risk is either negligible or completely absent for mental illness. With all of these other health problems prioritized, one could easily overlook mental health problems, and indications are that this is often done at all levels of health care in Zambia. In Zambia, the mental health care system, within the parameters of the overall health care delivery system is visible but the challenge is that priorities are determined by resources available compared to needs. Given this scenario, mental health problems and mental illnesses have not been given priority, especially that the mortality rate in mental institutions is considered to be relatively low. Zambia relies heavily on facility based data to arrive at burden of disease.

Mental disorders account for nearly 12% of the global burden of disease. By 2020 they will account for nearly 15% of disability-adjusted life-years lost to illness. The burden of mental disorders is maximal in young adults, the most productive section of the population (WHO, 2003). In 2001, about 450 million people were estimated to suffer from a mental or behavioural disorder globally. According to WHO’s Global Burden of Disease (2001), 33% of the years lived with disability (YLD) are due to neuropsychiatric disorders, a further 2.1% to intentional injuries. Unipolar depressive disorders alone lead to 12.15% of years lived with disability, and rank as the third leading contributor to the global burden of diseases. Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder) and these diseases are linked viciously and cyclically linked with poverty (WHO, 2003:8, 25). There is increasing evidence of an association between poor mental health and the experience of human poverty whether at the individual level or the ecological level (Burgess et al., 1992; Jarman, 1992; Kammerling and O’Connor, 1993).

![Figure 4 Poverty and Mental Disorders: A Vicious Circle](source: WHO, 2003, Investing In Mental Health)
At the World Economic Forum’s Africa Summit held in Maputo, Mozambique, in June last year, Africa was described as the worst economic tragedy of the twentieth century. This is because Africa is the only continent which registered sustained economic regression in the second half of the century, with the result that most sub-Saharan African countries are poorer today than when they attained independence in the 50s and 60s. It is now estimated that about 52% of African’s population are living on less than the World Bank poverty threshold of one (US$1.00) per day (UNDP, 2005). While sub-Saharan Africa was experiencing a decline, the economies of the rest of the world were growing, and per capita incomes in several East Asian countries were rapidly catching up with levels achieved by developed countries. Nearly half of the world’s 6.6 billion people exist on less than US$2 a day (UN, 2007). Over 1 billion live in “extreme poverty,” defined by the World Bank as US$1 a day or less and nearly every Zambian (63.7%) lives on less than US$1 in Zambia (WHO, Country Health System Fact Sheet 2006). With global population projected to reach 9 billion by 2050, and 95% of that increase occurring in the developing world (UN, 2004), poverty and mental illness will become very burdensome in Zambia if interventions are not designed in tandem with development processes. In most cases, the most appropriate drugs for a mental disorder are not affordable since existing health schemes do not cover them.

It has been noted that people living with mental illness are more likely to have a low income, be reliant on a pension, and face greater barriers to education, low employment, and reduced promotion opportunities. For instance, people with schizophrenia, in comparison with people without mental disorders, are four times more likely to be unemployed or partly employed (Robins et al., 1981), one-third more likely not to have graduated from high school, and 3 times more likely to be divorced (Cohen, 1993). There is in addition evidence to show that they experience many aspects of social deprivation associated with human poverty (Bolton and Oakley, 1987; Kessler and Frank, 1997). People with mental illness also face high costs of health care due to increased need to seek health care, increased costs of specialists, and additional costs of medication. Epidemiological data on human poverty asserts that people with the lowest socioeconomic status (SES) have 8 times more relative risk for schizophrenia than those of the highest SES (Hozer et al., 1986). Research has shown the existence of a cyclic relationship between mental illness and poverty (WHO, 2003). This mutual interaction linking mental health to human poverty and development could work positively with good mental health care plans as long as there is active and successful involvement of individuals and communities in development.

In Zambia, recognition has grown that mental illness is a crucial public health problem and that it impresses a great burden on the family. Family members are often the primary caregivers of people with mental disorders. They provide emotional and physical support, and often have to bear the financial expenses associated with mental health treatment and care. Family members may need to set aside a significant amount of their time and income to care for a beloved one who is living with a mental disorder.

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8 Poverty, from an epidemiological perspective, means low SES, unemployment, and low levels of scholarship and family standing.
Our health institutions are at the moment not able to do this. Where families have failed or may not wish to render direct care, informal care givers may be approached but at a great cost and sacrifice.

The lack of recognition of mental illness in Zambia is characterised by not appearing as a priority in critical policy documents. For instance, the fifth national development plan (table 2) does not list mental illness as a priority. In addition, primary health care units (health centres and psychiatric units) do not have any mental health plans\(^9\) at all. This suggests that people living with a mental illness are either receiving no assistance, or are depending on informal sources of support usually from traditional healers, faith healers, unpaid carers and from beloved ones from impoverished families. The picture of mental illness at the moment is not clear considering that population based epidemiological studies to ascertain the extent of the problem have not been done.

More recently, in spite of the political freedoms and human rights advances brought about by a new democratically elected government in 1992, there has been a growing trend of economic inequality, poverty and unemployment which has marked Zambia’s social, economic and political landscape. The democratic dispensation that was founded by the Second Republican President Frederick Chiluba led to wide spread reforms, policy reviews and development within the public sector. For instance, the advent of the health reforms in 1991 saw a massive revolution in the management of our health care system and mental health workers hoped that mental health was going to be granted priority status withstanding the development of health packages that were designed according to the levels of care. The need for the reforms was caused by the declining resources in the sector while at the same time the demands for health services were increasing. This contributed to a decline in the health status of the population. The main objective of the reforms was expressed by the government’s desire to provide health care with equity of access as close to the family as possible (McLaughlin, 1995; Cassels and Janovsky, 1996). This main objective was intended to be achieved through:

- Decentralisation and creation of autonomous district and hospital management boards and strengthening of local planning, budgeting and managing capacity.
- Improving financial and performance accountability by introducing better procedures, standards for reporting, and improved control systems.
- Re-direction of funding from centrally managed projects towards funding for activities defined by communities and districts.
- Defining essential packages of services and redefinition of roles for the various levels of the health service.

\(^9\) Mental health plan: This is a detailed pre-formulated scheme for implementing strategic actions that favour the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation. Such a plan allows the implementation of the vision, values, principles, and objectives defined in the policy. A plan usually includes strategies, time frames, resources required, targets to be achieved, indicators and activities. In essence, a mental health plan is a detailed pre-formulated scheme for implementing strategic actions (WHO, 2004:12).
- Introduction of fees to share costs and to influence health seeking behaviours to the appropriate referral level.
- Enhancement of private sector involvement including traditional healers.
- Improving the technical competence of staff through training, better supervision and provision of standards and guidelines.
- Increasing community involvement and ownership through establishment of neighbourhood health committees (NHCs).
- Streamlining central bureaucracies and the creation of the Central Board of Health to promote integration of health services.
- Strengthen donor co-ordination in support of the Zambia Health Sector Investment Programme and the common "basketting" of donor funds to support District Action Plans.
- De-linkage of Ministry of Health Personnel from the civil service and retrenchment of surplus Ministry of Health personnel.

Between 1991 and 2005, during which the health reform agenda was rigorously being rolled out, there was no mental health care befitting the health vision which is “to provide equity of access to quality health care as close to the family as possible”. While the health reforms were taking place, only a few people have seen the positive results and yet there are numerable social risks particularly for mental health policy. During and after the reforms, mental health services have suffered marginalisation and this has been worsened by decentralisation through integration which has led to the fragmentation and exclusion of services for people with mental disorders. Integration is the search to connect the health-care system with other human service systems (e.g. long-term care, education, vocational and housing services) in order to improve outcomes (clinical, satisfaction and efficiency). The term 'integration' can mean anything from linkages, through coordination to full integration of services clinically and administratively (Leutz, 1999). Integration is one factor which has been admitted to be problematic by WHO (2003) when health reforms are embarked on. This adversely affects mental health care more than physical health since it already occupies the subordinate position compared with physical health (Lahtinen et al., 1999).

In Zambia, the seeds of neglect and marginalisation of mental health by policy reformists, developers and analysts appear to have been sown in the era of reforming our health system. What we seem to be doing right and yet minimally and failing, is “treating symptoms” of mental illness. The challenges that we have seen are multitudinous and these include (i) failure to implement the existing mental health policy and (ii) failure to review our Mental Health Act so that we could manage people living with mental illness holistically).

Between 2001 to 2005 –within the study period, the mental health unit spear-headed notable improvements. For instance, a direct entry training programme for registered mental health nurses and clinical officers psychiatry was reintroduced and 81 graduands are expected by July 2008. There is also a mental health and HIV/AIDS programme of the global fund. This was commenced in July 2005 and mental patients in psychiatric units have benefited and continue to benefit. During the same period, there was an integration of mental health in the (a) integrated technical guidelines (ITGs), (b) standard treatment guidelines (STGs) and (c) community health workers’ manual. The challenges remain with the operationalisation of these guidelines.
Drawing from the problems enumerated above, this study was premised on the following research questions:

1.3 Research Questions

1. What is the context like within which mental health takes place in Zambia?
2. Within the country what is the current situation regarding mental health care?
3. Generally, what are the policy planning processes in the public sector?
4. How was the mental health policy developed?
5. Who are the critical stakeholders and in what ways do they influence mental health policy making?
6. In what ways is the adopted mental health policy appropriate?
7. How are mental health policies implemented and what is the current status of mental health service provision in Zambia?
8. What alternatives exist to improve and strengthen current mental health policy development in Zambia?

1.4 Research Objectives

The study objectives were:

1. To explore the current situation in Zambia regarding mental health care policy, law and mental health care.
3. To understand the current situation based on social actors’ accounts and the use of extant theory the broad context in which Mental Health policy-making takes place.
4. To understand the general situation regarding mental health needs and priorities.
5. To describe the typical wider policy-making processes in the public sector and most importantly the health sector.
6. To describe and advance a critical appraisal of the development of the mental health policy and mental health law.
7. To assess the appropriateness of the mental health policy and mental health law, including the involvement of stakeholders and their influence on the making of mental health policies and mental health law.

1.5 The Scope of the Study

This study titled “The Mental Health and Poverty Project (MHAPP)” is rooted in the critical perspective and was set to investigate, using rapid appraisal methods, the policy level interventions in Zambia that are required to break the vicious cycle of human poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries. Within the perspective, researchers could frame questions
and promote corrective action. Its eventual purpose is emancipation of cultural members from ideologies that are not to their benefit and not of their creation — an important concept in critical theory. The critical perspective is borne out of the theoretical underpinnings of critical theory and it is premised upon the assumption that cultural institutions can produce a false consciousness in which power and oppression become taken-for-granted ‘realities’ or ideologies. In this way, critical perspective goes beyond a description of the culture to action for change, by challenging the false consciousness and ideologies exposed through the research process. Its methodology entails a constant inter-weaving of inductive and deductive logic (Ilyenkov, 1977; Harvey, 1990).
CHAPTER TWO — METHODOLOGY

2.0 Introduction

This report presents the findings of the first phase of the study, namely a situation analysis of mental health policy development and implementation in Zambia. The findings of this first phase will be used to inform a set of interventions, developed in partnership with the national Directorate of Public Health and Research (Mental Health Unit). The interventions conducted in the second phase will set out to address particular barriers to the successful development and implementation of mental health policy in Zambia. These interventions will be documented and evaluated, with a view to generating lessons that may be of value for future work in this country and in other low- and middle-income countries.

2.1 Research Design

This was a cross sectional mixed study design conducted in the context of a wider international study of mental health policy development and implementation in four African countries: Ghana, South Africa, Uganda and Zambia (Flisher et al., 2007). The study’s methodology was informed mainly by the WHO-AIMS instrument, interpretivism and critical theory. A qualitative paradigm juxtaposed with the quantitative one was chosen so that we could holistically address the problem with mundane realism by attempting to:

i. Explore, describe and understand the state of mental health scenario, the mental health needs and priorities, policy-making practices in the public sector and ;
ii. To assess the appropriateness of the mental health policy and mental health law;
iii. The involvement of stakeholders as a process and their influence on the making of mental health policies and mental health law.

11 Interpretivism is a qualitative approach that holds the view that the world is the creation of mind and that it is also interpreted through the mind (Schütz, 1962). In essence, the social reality about the environment, mental health and mental illness are the products of processes by which social actors (patients, policy makers, health workers inter alia) negotiate the meanings of and for actions and situations.

12 In using the thinking of critical theory, the researchers were driven with a moral obligation to make a contribution toward changing the existing mental health conditions toward greater freedom and equity. In this study, the researchers move from “what is” to “what could be” (Thomas, 1993; Denzin, 2001; Noblit et al., 2004). The researchers probe possibilities that will challenge institutions, regimes of knowledge, and social practices that limit choices, constrain meaning, and denigrate identities of those who are mentally ill and the service providers.

13 To approach or view and show one phenomena from several vantage points.
The fieldwork for the study was conducted between 2005 and 2006. Data was requested from services for the 2005 calendar year. Analysis and writing up was completed on the 24th December 2007.

2.2 Data Collection Sources and Sampling Process

We drew 65 respondents from three study districts (Lusaka, Kabwe and Sinazongwe). These districts were chosen because they had mental health activities appearing in the ministry of health annual budgets suggesting that these districts have mental health plans. From these geographic units we drew a sample from heads of departments of line ministries and units, mental health coordinators, health service managers, lead nurses and clinicians and notable NGOs dealing with mental illnesses (please see figures 5 to 6). The WHO-AIMS Assessment Instrument and two checklists were applied (WHO Checklist for Mental Health Legislation14 (WHO, 2005f) and the WHO Checklists for Assessing Mental Health Policy and Plans15 (WHO, 2006) on respondents who were believed to be very informative and relevant to the study.

2.2.1 Administration of the WHO-AIMS Instrument and Survey Checklists

The WHO-AIMS Assessment Instrument for Mental Health Systems (WHO-AIMS 2.2) was administered by hand to the head of a unit or NGO (society). Each respondent was given a relevant set of questions to answer drawing from the instrument. In addition to The WHO-AIMS Assessment Instrument for Mental Health Systems (WHO-AIMS 2.2) Quantitative data was collected using checklists tailored to measure Mental Health Systems and the WHO-AIMS 2.2 instrument which is a comprehensive assessment tool for mental health systems designed for middle- and low-income countries. The WHO-AIMS 2.2 instrument consists of six domains. These domains address the ten recommendations of the World Health Report 2001 through 28 facets and 155 items. These recommendations (called at times as domains of interest), address essential aspects of mental health system development in resource-poor settings like Zambia. In order to collect the data for this study, we followed each one of the recommendations as enunciated in the WHO-AIMS Excel Data spread sheet which template addresses six domains as enunciated below.

14 The WHO Checklist for Mental Health Legislation is a tool that allows countries to examine the comprehensiveness and adequacy of existing legal provisions and whether they are in line with international human rights standards. Because the checklist covers all the key provisions that potentially should be covered in a mental health law it also allows a country to assess the extent to which key provisions are missing from their current law and need to be included in a new one.

15 The WHO Checklist for Assessing Mental Health Policy also acts as a best practice guide for how policy should be developed from the start. The checklist delineates a number of critical processes that should be followed and content areas that should be considered for inclusion in a policy to enhance its successful implementation.
Checklists were used on the respondents to assess the qualification of parameters. When collecting quantitative data, we found it prudent to impress upon heads of units or supervisors to take responsibility to ensure that the WHO-AIMS Assessment Instrument is complete.

To confer validity to results and particularly improving the response rate and the quality of answers, the use of the WHO-AIMS Assessment Instrument was followed up by visitations. On average four visitations were made to potential respondents averaging sixty minutes. When the data was collected, we checked the data submitted by respondents by sieving through using a round robin. Following a one to one discussion, each item was examined and were possible, evidence was requested for purposes of verification and the feedback we got from the lead team researcher on the project, we can assert that the data collected and processed upon which this report is based are valid.

2.2.1.1 Conducting In-depth Interviews

In depth interviews were conducted mostly with experts at macro level most of whom were unwilling to answer questions based on the adopted structural framework. In order to proceed with the research, we decided to operate from an “I don’t know much about the respondent’s point of view”, so that we could encourage them to set the agenda hoping to see if we could thoroughly understand their point of view as we brought them to our agenda. These interviews where then structured so as to create an open environment to provide freedom to the social actors to say what they considered we needed to know about mental health. The interviews were conducted on the basis of a loose structure consisting of open ended questions that loosely defined the area to be explored, at least initially, and from which the interviewer or interviewee would diverge in order to pursue an idea on a specific issue in more detail (Patton, 1987; Fontana and Frey, 1994). This was done so that we could discover what was important in the social actors’ world as we began to hear words or issues repeated. These were words or issues that represented important categories or themes of knowledge to us (Kvale, 1996; Gold, 1997). Although these social actors desired freedom to discuss and express themselves about the issues, we were able to bring them to the issues interest through directive structured questions.

Interview questions included those that explored the respondents’ background information (including demographic characteristics; education level before moving on to
issues surrounding mental health and mental illness. Generally, interviews began with
general opening questions, which were framed as follows: Please tell me about
yourself? Please describe for me, as completely, clearly as you can an experience of
mental health in Zambia? Please explain to me about the policy making process in this
ministry? From this then, specific experiences were continuously probed for in depth
responses.

2.2.1.2 Conducting Semi-Structured Interviews

We used a general interview guide approach which was intended to ensure that the
same general areas of information are collected from each interviewee; this is because
the researchers wanted respondents to provide more focus than the conversational
approach, while allowing a degree of freedom and adaptability in getting information
from the interviewee. We conducted interviews on the basis of a loose structure
consisting of loosely closed ended questions that defined the area to be explored, at
least initially, and from which the interviewer or interviewee would diverge in order to
pursue an idea on a specific issue in more detail (Patton, 1987; Fontana and Frey,
1994). This was done so that we could understand these specific issues will warrant the
researcher to ask directive or closed ended questions (Kvale, 1996; Gold, 1997).

2.2.2.3 Conducting Focus Group Discussions

Six focus group discussions were conducted with no less than six participants and not
more than eight at the most. A focus group consisted of homogenous participants (with
nurses alone, clinical officers alone and patients alone), although in two instances focus
group discussions were conducted in the company of nurses and clinical officers. Focus
group discussions allowed extraction of data, which could not be collected during the
ethnographic interviews or semi structured interviews a matter that is buttressed by
researchers like Kitzinger (1995); Barbour and Kitzinger (1998) and Krueger and Casey
(2000).

Focus group discussions enabled us to collect data for purposes of obtaining meaning
to some utterances and actions on critical matters of mental illness and mental health.
Respondents who were shy certainly felt uncomfortable talking about their experiences
in the presence of unfamiliar faces. The researchers were also able to observe
interaction that occurred among participants in the group as they queried each other
and explained their viewpoints. This in turn, opened doors for us to identify possible
areas of disagreements and consensus within groups.

So far 65 respondents were drawn from the research pool including inter alia; the
ministry of health and other key related sectors and these included the Ministry of
Justice, Labour, Communities Department, Education, Home Affairs and Local
Government and Housing, and NGOs. The respondents traversed macro, meso and
micro levels. We used purposive, availability and snowball sampling to select typical
respondents that we thought would provide specific data that was deemed necessary to
cover multiple realities so that we could answer our research questions succinctly. The use of multi method triangulation helped us to construct a bricolage that was filled with richness and holism, by revealing the complexities of the mental life-world. In figures 5 and 6 below, we show the size and pattern of our study units.

2.2.2.4 Observations

At the outset of the study, we did not anticipate making any observations, however, we were compelled to do so circumstantially and we were able to take notes on what was audible or what we were able to see. Spradley (1980) and Krenske and McKay (2000) advise qualitative researchers to have a journal where happenings and self to self-interactions could be recorded. Similarly, in this study, we kept journals in which notes about what we observed and heard were kept. The journals were used to jot down ideas, fears, mistakes, confusions, breakthroughs and problems that arose during the fieldwork. The journals helped in further enhancing the data collection process, as well as providing memoirs during data explication, interpretation and report writing.
Figure 5 Profile of respondents by position and job type
Figure 6 Profile of respondents by position and job type

MACRO (Key Line Ministries)

(INTER – SECTORAL COLLABORATION)
Ministry of Local Government & Housing
(Director Planning)
Ministry of Local Government & Housing
Principal – Labour Officer
Ministry of Education
Director – Distance & Open Learning
Ministry of Home Affairs
Director – Human Resource & Development (Deputy Commissioner of Police Prisons – Public Relations Officer)
Ministry of Community Development & Social Welfare
Principal – Community Welfare Officer
Ministry of legal Affairs
Deputy Director – Human rights Commission of Zambia

MICRO
Teacher
Prison Warder
Community & Social Welfare Officer

OTHERS MICRO AND (MACRO)

(NGO’s -Organisations Dealing with the ministry of Health)
NON GOVERNMENTAL ORGANISATION
Care Ministries for the Mentally Ill (CMMI)
Director
Foundation for Community Action (FOCA)
Director
House of Joy for Human Care

Consumer Associations
Mental health users association of Zambia (MHUNZA)
Executive Director
Mental health association of Zambia (MHAZ)
Executive Director

University Of Zambia
Clinical Psychologist
Psychiatrist
Traditional Healers Association of Zambia
Executive Director
Family members
Users
In our study, we did not include the private sector because they provide mental health services to a minority of the population, and are seldom utilised by those who live in conditions of human poverty.

2.3 Data Analysis

Each WHO-AIMS Assessment Instrument was examined for completeness and to learn what the scenario was like in each study unit that was sampled. A separate profile was created for each unit for reference in future. In order to have a country profile providing a single reality, we were able to key in the data onto separate spreadsheets. Data from these spreadsheets were then condensed to form a national spreadsheet. It was possible to produce descriptive statistics befitting a nation. Nationally aggregated responses to items were then entered into the WHO AIMS narrative template.

For the qualitative data, since the qualitative component called for a description of the *lebenswelt* or lived experience in a mental life-world, based on the social actors' accounts, the qualitative report tends to provide an understanding of multiple realities of various social actors at three levels (macro, meso and micro) as they comment on phenomena within Zambia’s natural and authentic context (Maxwell, 1996; Creswell, 2005).

We used two coding frameworks in analysing the roll data. The first one was related to pre-coding, a practice advocated by Ritchie and Spencer (1994) where certain themes are agreed upon by investigators *a priori*. The investigators from the four countries created typologies of themes. These themes were based on the objectives of the study. From these objectives, sub-themes were suggested by partners, and reviewed by all partners through a process of iteration, until a single framework was agreed upon that could be used by all four study countries. The second one is related to post coding where specific themes emerged from the interviews that were not included in the generic cross-country framework; these were added to the coding frame, to adapt the analysis to issues specific to Zambia and to embrace any phenomena that may have been missed in the pre coding phase.

Before post coding, we initially proceeded to code independently to understand how the textual data as a whole was like to apprehend the essential features of each text (a case) so that we could account for the data. This called for being submerged into the data by reading a case several times and part-by-part interpretation of key thoughts throughout to try to elucidate the general meaning of units or substantive statements that really said something. From these interpretations, meaning units and demographic characteristics such as age, education and job profile *inter alia* were captured for each case. To do this, we engaged the phenomenological époché of Edmund Husserl which is a deliberate and purposeful opening to grasping the “real meaning” of the phenomenon “in its own right” as espoused by Fouche (1993) and Hycner (1999) by a suspension or ‘bracketing out’ of all our experiences, presuppositions and not allowing our meanings and interpretations or theoretical concepts to enter the process of
understanding each case (Creswell, 1998: 54, 113; Moustakas, 1994: 90). In this way, no position is taken either for or against (Lauer, 1958:49). This stage was followed by constantly comparing case by case in order to generate tentative categories, subcategories and patterns. We then able to develop a subjective and holistic sense or *lebenswelt* of each case to enable us construct ‘gestalts’ in a context to understand mental life in an undivided manner much more than the sum of their descriptions an approach that Duncker (1974) implores researchers to use.

Transcripts were first independently coded by three researchers on the basis of these themes, with additional themes added to the coding framework as determined by the data. In order to confer veracity to the process of explication, we first exchanged notes on what each one of us had recorded or heard and wrote independently. We then listened to the recordings together and corrected each other’s notes on a round in order to agree and evaluate the characteristics of the data (Tinsley and Weiss, 1975; 2000).

In explicating these texts, we paid attention to both the manifest content as well as the latent content analysis. Manifest content analysis involved looking at what the text said, thus dealing largely on giving a meaningful description of the visible obvious components of the text (Oiler, 1982; Downe-Wamboldt, 1992; Koch, 1995). Manifest content is shown in this study by presenting reality descriptively in verbatim (quotations of parts of speech or the whole speech). This is that part of the data that speaks for itself and allows the reader to make own conclusions from the visible obvious descriptions given in the language of a social actor since reality is constructed in their minds.

In contrast, latent content analysis is shown in this paper by the researchers attempting to offer additional interpretations rooted in *Dasein* by giving a public like underlying meaning of the text. This is achieved by dialoguing with the manifest contents of the text within the hermeneutic circle in attempting to produce a technical account from lay accounts as Blaikie (2000:101) would call it. Latent content is presented, as the researchers’ views complimented by citations of other literature were applicable. This augurs well with Heideggerian hermeneutic phenomenology in that it augments the revelation of the essence of phenomenon, which exists independently of conscious experience, so that issues could also be known through the researchers’ dialectical examination of such experience (Heidegger, 1962; Berger and Luckmann, 1966) in a broader context.

Glaser and Strauss’s (1967) inductive grounded theoretical analytic approach interwoven with Derek Layder’s (1998) adaptive approach were used constructively and interpretively to create an ideal bricolage of new themes, categories and subcategories in piecing together sets of presentations from the discourses and observations. This coding was facilitated by the computer program Non numerical Unstructured Data Indexing Searching and Theorizing (NUD*IST Vivo or N Vivo) software version 2.2.
CHAPTER THREE — RESULTS

In order to present the sought reality of Zambia’s situation analysis of mental health policy development and implementation, we have weaved the qualitative and quantitative data opted to present our results in tandem. The results are arranged in six sections and they appear under the following headings:

I. Policy and legal framework,
II. Mental health services
III. Mental health in Primary health care
IV. Human resources
V. Monitoring Evaluation and research

I Policy and Legislative Framework

This domain answers the question “What are the policy making processes in the public sector generally?” by offering descriptive accounts of policy development prior to the development of policy development standards and after policy development standards. Having said so, it would be prudent to preliminary define what policy is and what health policy is in order to ground this domain. Policy may refer both to a set of specific plans for action and, more generally, to the underlying organizing principles guiding the development of that plan. Heclo (1972: 84) argues that ‘the term policy usually applies to something “bigger” than particular decisions, but ‘smaller’ than general social movements. A second and essential element in most writers’ use of the term is describing it as purposive actions and it ought to include the unintended consequences of purposive actions (Walt, 1994: 41). On the other hand, ‘Health policy’ could therefore be defined as the principles, plans and strategies for action guiding the behaviour of organizations, institutions and professions involved in the field of health, as well as their consequences for the health-care system.

3.0 The General Policy Making Process in Zambia

Policy-making is a core function of government, central to a country’s political and economic life. It is about how governments make choices and manages resources in order to achieve their economic and social objectives. In Zambia, as in many countries, Cabinet is the supreme policy-making body. All major government policy matters are forwarded to it for decision. Cabinet ministers make decisions together, and bear collective responsibility for them.

The Zambian Government, as an ultimate steward of mental health services has strived to assume the responsibility for ensuring that mental health activities are carried out. One critical role in stewardship is policy development and implementation. Before 2002, there were no guidelines or standards to augment public policies in Zambia and ministries went alone to make policies. Now there are standards from Cabinet Office to
augment policymaking that all ministries ought to follow. The Zambian cabinet is a body of high-ranking members of government, typically representing the executive branch and The President heads it. The standards in question hail from the booklet “Guide to writing national policy documents and cabinet memoranda.”

Before addressing the issue of policy making, it is prudent to make a conceptual distinction among policy making, policy formation and policy implementation. We adopt Hill and Hupe’s conceptualization that term ‘policy-making’ be used for the process as a whole, ‘policy formation’ for the early part of policy-making, and ‘policy implementation’ being the operationalisation, for the latter part of the policy-making process (Hill and Hupe, 2003: 8).

In trying to understand how and why policy is formed for the provision of social services, Palfrey (2000) observes that it is often necessary to go to original sources of information such as transcripts of debates, speeches, minutes of official meetings, official reports and government papers. We were unable to obtain information from these sources either because the documents were unavailable or the people who were in custody of them were not available or unwilling to provide them. Below we present excerpts related to policy making drawn from interviews and cabinet office guidelines.

**Availability of Country Policy Process Document**

In Zambia, policy development and implementation is guided by the document that is provided by the cabinet which is the organisation that approves policies because it comprises of the ministers and is headed by the president, so that guide is what gives us the format of the policy.

(Director 1 Ministry Of Health)

The cabinet paper says each time you want to come up with a policy there must be a problem.

(Director from the Ministry of Community Development)

**Policy Formation and Agenda setting**

Policy making generally begins with identifying an agenda according to Cobb and Elder (1972) and Kingdon (1995). The concept of agenda refers to “the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention to at any given time.” Agenda setting is the process that narrows the “set of conceivable subjects to the set that actually becomes the focus of attention” (Kingdon, 1995:3). Starting from this definition, we need to take into account the well-known distinction between two types of agenda\(^\text{16}\) - public and policy agendas. Public agenda generally refers to the interaction

\(^{16}\) Kingdon (1995) add a third type – the decision agenda that consists of matters requiring immediate resolution – proposals considered for legislative enactment, or subjects under review for imminent decision by executives or departmental secretaries.
between public opinion and issue salience in the media that are commonly perceived by members of the community as meriting public attention and as involving matters within the legitimate jurisdiction of existing governmental activity. These salient issues tend to have a high public visibility, and which large sections of the public believe to both important and to require some kind of policy response from government. Ideally, the public agenda is the primary domain of activity for groups and individuals that do not have free access to government. Policy agenda or formal agenda on the other hand concerns the problems authoritative decision makers themselves perceive as significant at a specific moment in time (Cobb and Elder, 1972: 85; Soroka, 2002:7-8). These items are issues that decision-makers accept require their attention in any section or level of government. Although public and policy agendas are related, we should acknowledge their relative autonomy as shall see below.

In Zambia, the bulk of the agenda that generates policy is set by senior bureaucrats in government ministries than the public. Below we show the two sources of policy agenda.

Many of the policies that have been developed in the third republic began with senior bureaucrats in the ministries setting an agenda. Problem identification or agenda setting by senior bureaucrats in the government fits the elitist theory. Elite theory\footnote{Elite theory is a theory of the state which seeks to describe and explain the power relationships in modern society. It argues that a small minority, comprised of members of the economic elite and policy-planning networks, hold the most power no matter what happens in elections in a country. Through positions in corporations or on corporate boards, and influence over the policy-planning networks through financial support of foundations or positions with think tanks or policy-discussion groups, members of the “elite” are able to have significant power over policy decisions of corporations and governments. The theory stands in opposition to pluralism in suggesting that democracy is a utopian ideal. It also stands in opposition to state autonomy theory.} has generally been concerned with top national elites, who make own configurations and actions. In Zambia, these elites happen to be politicians who predominantly direct policies through ruling party manifestos. In contrast to the elite theory, there is the democratic elite theory. The democratic elite theory has emphasized the fact that even among elites, not all are equal: apart from those at the top of the pyramid, there are also medium-level, and even small-scale elites, or sub-elites. These include persons lower in rank on the national level, such as medium level officials in the national government administration, as well as policy makers on the regional or local levels (Schattschneider, 1960: Putnam, 1977; Etzioni-Halevy, 1993).

The first two narratives below fit the elitist approach which typifies what five directors out of the nine we interviewed claimed is the genesis of policy making. The second narrative fits the democratic approach which typifies what four directors out of the nine we interviewed claimed is the genesis of policy making in Zambia.
Senior civil servants identify the problem

OK, the process involved in the policy formulation firstly, as a Ministry or stakeholders in a given area, that need policy, if we identify the need for a policy which by definition is the intent or a chosen direction by a gap of people to address a matter of concern, when you identify such an issue, or issues, we have what we call the idea stage, that is when you have just identified a certain area that you need policy to be formulated. And after that you need to do a situational analysis because in analysis you look on the strength, weaknesses and the gaps and each area needs to be addressed. A situational analysis can take the form of research, in that particular area or you could just combine a desk review of prevailing literature as well as research, on the adequacy on what has already been documented if it is enough, you may use that as you basis for the situational analysis. But if I find gaps, then I need to do some form of research, document and have first hand information on what is obtained on the ground. And after doing that you now, that situation analysis is now…

(Director 1Ministry of Health)

The cabinet paper says each time you want to come up with the policy there must be a problem, and then you go deeper and find out as to why there is that problem and the extent of the same problem and this can be done by surveys or research like you are doing it. You involve people on the ground so that you hear what they are saying and their views and then later you call in other key people who can make contributions and suggestions then stakeholders. The PS (Permanent Secretary) and the minister have to go through it and then the cabinet also comes in and after it has been well edited then we take it to the parliament for adoption. I think that is what I can say as far as the process is…

(Director from Community Development)

There has to be a problem identified by the community

Usually the public and the other institutions stimulate us when they complain about something or certain aspects of an existing policy. What we do is this, we when are reviewing a policy; we first hold a stakeholders workshop. At this workshop, we discuss the policy’s weaknesses, strengths and the proposed changes that can be made to the policy. Then from there, we take different stakeholders like government, private, councils depending on the type of the policy and the people who may or are affected. There is also need to do a lot of research. A comparative study with other countries or other policies could help. Later on, we then present the proposals to our stakeholders for comments or contributions….

Finally after the consultations, the Permanent Secretary and Minister will come in. When it is accepted, you then prepare a cabinet memorandum. You must at this time circulate the draft policy to other ministries to get a comment and from there the policy will be submitted to the cabinet with the kinds of changes that have been suggested by stakeholders. Ideally cabinet will then approve the ..... So that's the procedure and I could have left something maybe.

(Director from Ministry of Local Government and Housing)
Policy Making Process before Cabinet Guidelines and Existing Mental Health Policy

Zambia has a mental health policy that was developed in 2003 and was adopted by Cabinet in 2005. Generally we found that there were varying descriptions of policy development processes among directors. The results provide timely education that the theory and practice of policy development among Directors in the ministry of health remains driven by varying competing ideas and practices and most of them are based on scepticism than the foundations inherent of the science of health or public policy and administration. Except for two directors the failure to account for the policy process is a source of considerable concern. We wish to emphasize that health practitioners and planners need to understand the ideal manner in which health policies are developed, planned, implemented, and monitored and the manner of monitoring and evaluation. Below we provide the tenets of the development of the present mental health policy.

Ok, there is one observation on the mental health policy, it has been approved but the process, at the time of approval was not guided by any government standards. This is different from the new arrangement...and now we have standards from cabinet office....

(Director 2 Ministry of Health)

People could do them (meaning policies) then, but with the guidelines now, it is very strict in fact if you deviate from that, they will send the document back which wasn't the case.....I have a feeling that we may need to make a few adjustments to bring it to the current guides by cabinet's office, so it could be true that some of those things may not be reflected. But when you look at other policies like HIV/AIDS food and nutrition which we have since done, you will see that most of the key components are featuring except that in the new arrangement you don't even have to reflect your names... It is not a prerequisite especially to put individual names, because it doesn't (meaning the draft policy document) belong to an individual but the government. But we have segregating to start mentioning. But if you look at the processes, from the time they started and which people participated, and you can always trace that information but not in the final document.

(Director 3 Ministry of Health)

The above excerpts are a true description of the existence of guidelines. However, when we compared the renditions of one director and all other directors in other line the ministries; there were similarities in terms of process. However, when we took the rendition of one director in the ministry of health that was in consonant with other directors in the line ministries and compared it with the other directors in the ministry of health, from their verbal accounts, we established that the other ministry of health directors gave renditions that departed from the general practice of policy making in public policy theory and practice and government guidelines. Some were at pains in attempting to make their renditions; some seemed not to be aware at all. We are compelled to hypothesise that (i) there was lack of inter directorate integration when it came to policy development in the ministry of health and (ii) a relationship exists
between articulating policy process and content on one hand and lack of knowledge on public policy theory and practice. The excerpts below attest to these claims.

**Problem identification heralds policy making**

OK, the process involved in the policy formulation firstly, as a Ministry or stakeholders in a given area, that need policy, if we identify the need for a policy which by definition is the intent or a chosen direction by a gap of people to address a matter of concern, when you identify such an issue, or issues, we have what we call the idea stage, that is when you have just identified a certain area that you need policy to be formulated. And after that you need to do a situational analysis because in analysis you look on the strength, weaknesses and the gaps and each area needs to be addressed. A situational analysis can take the form of research, in that particular area or you could just combine a desk review of prevailing literature as well as research, on the adequacy on what has already been documented if it is enough, you may use that as you basis for the situational analysis. But if I find gaps, then I need to do some form of research, document and have first hand information on what is obtained on the ground.

(Director 1 Ministry of Health)

**Problem description or analysis**

There are many stages some of them are external and some of them are internal. But the most important stages are:

First of all (you have) to identify the problem and this means that you have to do situation analysis. If I may put it in mathematics terms it means you do an epidemiological survey to know the extent of the problem or the issue in the population. You then you look at the resources you have to tackle that particular issue. And the resources I am talking about here, the most important resource is human resource. Whether trained people are available or not and at what level of training have they achieved in order for them to be useful. And then of course you look at other resources such as the money and if you have got the resources or man power then not trained as you would like them to be trained then you think about capacity building so then you bring them to the particular level, that correspond to the facility you want to give to the people at hand. Where you can not meet all the resources that you require then we look for collaborating partners also to come in and assist both in terms of knowledge in terms of actual physical assistance there are times when the partners might just bring their know how may be just bring their equipment or actual cash.

Then next stage is consulting the community you are going to deal with. You may choose a few people that you may want to meet. It may be at a workshop or talk to traditional leaders who know the peoples needs.

(Director 1 Ministry of Health)

**3.1 Mental Health Policy Making Process**

The present mental health policy process that began in 2003 and finalised by cabinet in 2005 was a departure from normative theory of policy making and practice. The following show this departure:
1. There was total absence of stakeholders participating outside of the ministry of health. This indicates that there was absence of a stakeholder framework. WHO (2004) considers an ideal framework ought to embrace: Stakeholders with responsibility for funding: ministry of finance, social and private insurance, donor agencies and charitable organizations, Stakeholders with responsibility for provision: national organizations of providers, people with mental disorders and families, mutual aid groups, professional NGOs, health workers and traditional health workers and Stakeholders with responsibility for regulation: professional associations and advocacy groups, ministry of Justice, consumer associations, human rights associations, international organizations, non governmental organizations and other line ministries.

2. There was no evidence that tangible epidemiological data was used in conceptualising the policy.

3. Social, political and economic realities were not recognized at local, regional and national levels in grounding the conceptualisation. This implies that the ministry failed and most importantly to identify the broad psychosocial determinants of mental problems, as well as to provide verifiable and tangible quantitative information on the extent and type of problems that were in the community. In essence, the document entitled “Situational Analysis\(^\text{18}\) of Mental Health Services in Zambia” which was used to structure the approved mental health policy could not have formed the basis of its development. It should be stated at the outset that the two types of policy making activities did not take place sequentially or in parallel and these are policy-making and policy operationalisation. As it may happen not all policies come “fully designed” at the end of the policy making process (having the two components as outputs), in our case, the mental policy formulators just made a policy but without operationalising it. Policy operationalisation was performed three years later by virtue of developing a strategic plan.

4. Another important observation was failure by the Ministry of Health to carry out a comprehensive survey of existing resources and structures within our communities, along with a critical analysis of the extent to which our existing resources and structures then were fulfilling the defined needs. Inference is therefore being made that the ministry was not interested in social learning. Among the theoretical tools associated with evidence based policy development, the concept of social learning. This favours the most direct reference to the role of evidence in policy-making. Lack of epidemiological data is a critical challenge that needs to be addressed in any subsequent policy review or reformulation. It was observed that research that addresses disease burdens to identify the broad psychosocial determinants of mental problems, as well as to provide information

\(^{18}\) A situational analysis identifies \textit{inter alias}, the population to be served, reviewing the local context of mental health care, consulting with all relevant stakeholders, identifying who is responsible for mental health budgeting and planning, and reviewing current mental health resources and service utilization.
on the extent and type of problems in the community was lacking citing the available data in the ministry to be not very informative.

Director 1 Ministry of Health alluded to the policy development stages and five stages were identified as enunciated below.

**Process of Defining Content of Policy (Stage 1)**

Ok, this is the process involved in the policy formulation. As a ministry, when we need a policy, and by the way, a policy by definition is the intent or a chosen direction by a group of people to address a matter of concern, when you identify such.

(Director 1 Ministry of Health)

**Situational Analysis**

…..and after that you need to do a situational analysis because in analysis you look on the strength, weaknesses and the gaps and each area needs to be addressed. A situational analysis can take the form of research, in that particular area or you could just combine a desk review of prevailing literature as well as research, on the adequacy on what has already been documented if it is enough, you may use that as you basis for the situational analysis. But if you find some gaps, then you need to do some form of research, a document review of some sort and have first hand information on what is obtaining on the ground. And after doing that you now have a situation analysis.

(Director 1 Ministry of Health)

**Content of Policy Document**

Usually the key components of the policy document are as follows: (i) You have the foreword by the minister, (ii) then you have the acknowledgements by the Permanent Secretary who is the controlling officer, the minister is a policy maker (iii) then you look at the situation analysis after the situation analysis, (iii) First you look at the vision (iv) then you look at the rationale (v) then you look at the goals, usually we use objectives. (vi) After the objectives, you have the measures, (vii) then after measures you look at the implementation framework, (viii) the monitoring and evaluation and (x) financing of the given policy.

(Director 1 Ministry of Health)

**Emphasising Stakeholder Involvement**

Yes we also invite the stakeholders, from all the levels including NGO’s, international organisations that is Multi-lateral and bilateral organisations and during this stage, that is when now we build consensus, the document is given to the participants and each one goes through it and they make their observations so that you build consensus to say yes, this is what the situation and this is what we are supposed to do, and after you agree, you now include the comments from various stakeholders and come up with the final draft.

(Director 1 Ministry of Health)
When asked what follows stage one, the director’s response described the second stage which involves writing a policy memorandum to cabinet:

... you do a cabinet memorandum ...... This is the covering letter that goes together with the document to the cabinet for approval. If it is adopted, they say (meaning cabinet) you can now start the implementation and inform us on how you are going to proceed.

(Director 1 Ministry of Health)

Essentially cabinet expects policy implementation to be effected after cabinet has nodded that the policy ought to proceed. This is when strategic planning will be done and it is the third stage in policy formulation.

you need a strategic plan which is done more less like policy but it is less tedious..... I think, (not sure) we have a standard format and we usually have guidance of Cabinet Office. The strategic plan is drawn for a period of 5 years. Now that gives general strategies on how you are going to operationalise your plan. Now to actually do the implementation that is when now you have the annual plans. The districts, hospitals, NGO's and so on are now supposed to tackle from the start. This is from the objectives that were in the policy. Then you have the measures and then you now put them into action, those are now the annual budgets and actions plans, and that completes the whole thing but now, to assess and ensure that you are in line with the thing, you have to do some monitoring and evaluation. Monitoring is continuous and evaluation is periodic.

(Director 1 Ministry of Health)

While this process was emphasized, it was riddled with process problems and the following stand out.

*Lack of Epidemiological Data as a Challenge*

We have a little bit of information on ministry of health in the HMIS (Health Management Information System. But the information that we have is not comprehensive because only thing that is mentioned in the HMIS is mental health the ages above 5 and below 5 and deaths inpatients and out patients it doesn't talk about anything else. It doesn't talk about age related or drug related or whatever former related or anything is it drugs, is it mental health? It doesn't go beyond mental health then we suggested to HIMS that they should actually make it comprehensive, so that we are able to capture all the activities that are happening in mental health. Because just mental health is not telling us enough for us to say we got psychosis, we got schizophrenia no is this mental health? Internationally we say you have no data.

But with the data that we have, we can't go any where in policy practice. May be with the study that you are doing we will get something....You can imagine they couldn't come out with like the number of psychiatrists that we have in the country not even psychologists you see?

(Director 1 Ministry of Health)

*Lack of Stakeholder Involvement*

Literature has shown the need to have stakeholders being involved throughout the public policy process. Stakeholders attempt to influence, and even control, the decisions, particularly during the emergence, formulation and adoption phases. Thus,
the development of public policies is influenced by the dynamics of power among the policy actors. According to Lemieux (2002), we can categorize these players into four groups: private individuals, interested parties, officials and elected people. Within government we find the officials and the elected. The officials are the bureaucrats, the content specialists whereas the elected are formally representing their constituencies and have executive and legislative capacities. Outside of government are the interested parties and private individuals. Interested parties are usually experts, interest groups and other content specialists whereas private individuals refer to the general population directly or indirectly affected by the policy. Public health organizations and individuals may be part of the interested parties or of the private individuals. In fact, they may play the roles of expert and/or of representative of the population. The ideal of having stakeholders coming from other government departments, NGOs, users family, donors and professional professions inter alia was not entrenched when developing the current mental health policy but only staff within the ministry of health according to interests groups were considered vital to be party to policy development. These were the only groups that were described as “critical stakeholders”.

It must be emphasised that an active compromise of the majority of the key stakeholders may be required in order to develop and implement a mental health policy. It is very important to obtain political support (WHO, 2004:3) through consensus building. Indeed building consensus is ideal as long as it is done through out the stages of policy development and implementation. This is because an active compromise of the majority of the key stakeholders at all levels (macro, meso and micro) and at all stages may be required in order to develop and implement a sound and acceptable mental health policy. Many well-intentioned service plans experience setbacks because they do not obtain “political” approval from local communities, people with mental disorders, carers, politicians, service providers and administrators (WHO, 2003:16). This may happen in Zambia because there are disquiets about the policy document.

We present the disquiets involving stakeholder involvement.

But you people involved in the system do not involve us, where do we start from? You have a mental policy and act which involves the prisons, but have you ever invited one of us to represent our commission? All what we hear is you conducting workshops, travelling abroad and you don't even count on us when initially we are supposed to work hand in hand, so how do you expect us to get serious with mental health work?

(Senior Officer Prisons)

Mental health can only be integrated in our system if you people invite us in your activities. You should organise workshops where you invite us and discuss as to how we can work together in dealing with these people, and I am not just saying you invite the prisons alone, but all the stakeholders who seem to be playing a role in managing these people. In that case, mental health can even be specialised in our act, unlike falling under the general health which is stated in our act.

(PRO Prisons)

The ministry of health inviting us to review a policy or a law you mean? No never. They have never, Many times, we have opted our colleagues from the MOH when we are doing
Ours. I for one I remember coming up with an idea of bringing in people from Chainama and
to do that, we introduced the aspect of screening our officers from Chainama all the way
from Lilayi college and that was done deliberately in order to see or articulate the interest of
the management that side, from my observation, in a way, the police in certain sectors, we
were being marginalized because we are considered to be un educated, corrupt, brutal and
so on.

(A commissioner in the Ministry Of Home Affairs)

But in terms of housing, we were not included, because you see, the experts in the field
were not involved, because we may not understand how they behave (the mentally ill) and
the kind of assistance that they might need, to receive, so you find that you may go ahead,
like the physically disabled who are present in the policy, if we didn’t understand their
needs, it was going to be difficult to incorporate them, so even the mentally ill, if we are not
aware of their needs, and how they can be dealt with, them we may develop a policy that
you completely leave them out, so that’s the kind of problem that maybe we had when we
were developing the policy. So we need, experts, and that’s why there is stakeholders like I
said, so that experts in different fields who are affected by what you are trying to plan and
coming up with, can bring on their own observations and suggestions so that you can
include them in the development of a policy.

(A Director in the Ministry Of Local Government and Housing)

…….you have vulnerable groups of people for example the women themselves, there is
somewhere were thy are mentioning the women but is not even clear, for what reason are
they mentioned in the policy, we have a lot of civil societies and NGOs that are concerned
with women welfare I don’t remember one of them being consulted or taking part. So really
we are playing with words here as far as aim concerned .if you are talking about the mental
health policy which should encompass all walks of life in the country, therefore the
consultation and the involvement should be wide or wider than it has been before.

(NGO leader 1)

First of all, like you pointed out, the people who contributed to the development of that
policy were not cross sectional stakeholders who know something about mental health…

......the question of line ministries involved was also inadequate coz we have a lot of gaps.
I can mention them if you want for example if you look at the present policy, you have the
ministry of justice and these people are 100% stakeholders in the policy of the mental
health coz, the justice system, needs to be representative of the mental health strategies
like for treatment in criminal patients, prison systems and even the Judiciary itself, there is
no direction in policy as to how people experiencing mental health policy by law are going
to be handled, the second example, even the ministry of community development and
social w welfare, I don’t think even the involvement if at all was there, was at the
professional level…..,

(NGO leader 3)

But I saw the list and yes I agree with you that not all the ministries were captured and that
was the concern also that was raised much earlier, but why is it that we are not capturing
the other ministries and all people are involved starting from the grass root up to the top
because mental health is for is the whole country. So that was an issue that was raised
and unfortunately the policy has already been approved. And we are supposed to go ahead
with whatever we had on that policy and see what we can do. The involvement of the
stakeholders is very important because it will tell us what other problems other people have
in their own settings. And this we many do only by capturing them again in this strategic planning as we plan for activities in mental health we should bring them on board.

(Director 2)

Factors Responsible for Lack of Involvement of Stake Holders

The problem of non-involvement of a broad array of stakeholders was due to the teething problems of the health reforms. The Central Board of Health failed at the time due to lack of standard processes to identify critical stakeholders. The adherence to the methodologies of selecting stakeholders and developing policy documents that were applied then was merely situational, personal and mere conjectural some directors claimed.

Central Board’s Definitions of Stakeholders

I think that the reason is the time mental health was being drafted central board was in existence and central board was not working with the ministry of health. Their stakeholders (central board of health) were still lately different from ministry stakeholders. The process of stakeholder identification was supposed to capture all the 21 line ministries and 22 if we add the new one- the Ministry of Gender.

(Director 3)

Personalisation

Mr. X will be able to answer that what I know is that he was involved in the policy at the central board then I went out, but that one really a probe Mr X I am sure will give you the up date where we are….. His selection criteria all that you know…of stakeholders.

So for people mental health is X. I was at that meeting and we were told (not stated who) what we were supposed to do and X (or Mr. X) did the budget for mental health.

(Director 1)

Noting that the ministry does not have a definite framework and manner of relating with stakeholders, in terms of areas of action, it will be discreet to conduct a social system analysis to identify people, groups and organizations that are important to take into account when developing and implementing policies. If this is done and where possible a list of stakeholders may be drawn. It would be discreet too to enter into some form of memorandum of understanding. A social system analysis of stakeholders using the

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19 A mental health plan is a pre-formulated detailed scheme to implement the vision and objectives defined in the policy. A plan should include the concrete strategies and activities that will be implemented to tackle mental disorders and associated disability, as well as specifying the targets to be achieved by the government. It should also clarify the roles of the different stakeholders in implementing the activities of the mental health plan (see information sheet for more on mental health policy and plans).
SWOT analysis model may be handy to identify potential stakeholders who have more comparative advantages to the ministry of health for particular development policies.

A comment worth making from the descriptions of the development policy process and an examination of the adopted mental health policy is that this process and content of the policy are at great variance from Knoepfel and others (2001) model and the WHO (2003; 2005b) enunciations describing the policy development process. We note the following departures from the WHO ideal anchoring on five key phases: (i) the emergence of a problem that requires the attention of the public and decision makers, (ii) placing this problem on the government’s agenda in order to find a solution; (iii) the formulation of various alternatives to resolve the problem, (iv) the adoption of a policy, and (v) the implementation and the evaluation of a policy. Bearing on these, WHO (2003) advises that a sound policy process ought to embrace seven steps as enunciated below.

**Step 1:**

To assess the population’s mental health needs by gathering information and data for policy development.

A good policy is dependent on information about the mental health needs of the population (public agenda as Kingdon, 1995 would like to call it) and the mental health system and services offered. The needs of the population can be determined from, for example, prevalence and incidence studies, determining what communities identify as problems and an understanding of help seeking behaviour. Establishing priorities for mental health must also be done. In addition, the current system for delivering mental health care must be well understood and documented. Knowing who delivers mental health, to whom and with what resources is an important starting point for developing a reasonable and feasible mental health policy. Our policy developers did not determine the needs at all. As a matter of policy prudence, needs could have been determined by the following methods *inter alia*:

**Conducting formal research:** Epidemiological studies in the general population and in special populations (e.g. schools and workplaces), simple epidemiological studies of people visiting health facilities, burden of disease studies involving the use of disability-adjusted life-years (DALYs), in-depth interviews and focus groups. This was not done.

**Conducting a rapid appraisal:** Secondary analysis of data from existing information systems, brief interviews with key informants and discussion groups involving people with mental disorders, families, carers and health staff.
One respondent in support of a needs analysis remarked:

I have worked long enough there are always fashions in everything including medicine and closing mental hospitals. But these fashions ought to embrace a number of elements: The first element is the recognized need. The second one, they must be more than three I think …. so that second one must be the over all policy designed to meet that need. The third one should be the strategies needed to implement the policy and connected with the rest of strategies there should be an implementing body. It’s easy to write down this and that...

(Psychiatrist)

Step 2:

To gather evidence for effective policy

Gathering evidence prior to and after policy development is cardinal for purposes of monitoring. WHO (2003, 2004) advises that visiting local services and reviewing the national and international literature could provide the much needed evidence. However, some directors claimed that there was epidemiological data that was used in policy making and yet there was no evidence to these claims. In the current Zambian policy document there was no evidence adduced from any country or within the region and there was no literature cited to buttress the key variables in the policy.

Vital use of Health Information Statistics

So when it comes to a number of policies the health sector is trying to formulate and implement, we rely heavily on the HMIS statistics. We have several directorates here and they rely heavily on data gathered from the HMIS.

(HMIS Specialist)

But when challenged that the present mental health policy was developed devoid of any HMIS, the director gave a self contradictory statement. The excerpt below further attests to the neglect of sound public health policy development and planning theory which emphasises the use epidemiological and other data as pertinent to policy making.

The neglected category (mental health)

Ok, first of all, in the HMIS, there are certain indicators that we put under the neglected category (mental health) and these are not given the attention that they deserve and mental health is one of them, but what we have done now under the revised HMIS, we are revising the indicators (without any baseline data) which need to be included into the HMIS and Mental health indicators have not been left un attended to, and the review process which is being done by our consultants, actually interviewed a number of programme officers in their respective specialised fields and mental health . One of the programme officer was interviewed and Mr X (Who happens to be repository on mental health policy) actually submitted a number of indicators on mental health but we were advised (by powers that be) that we only get a few (no justification for these few and which ones are these) that are really key to the sector.

(HMIS Specialist)
Lack of indicators

One director stated with dismay the lack of indicators in mental health that could be used in policy development and monitoring.

The monitoring system at the Ministry is very poor and the reasons are the current indicators we are using were just dictated (by some power). There are no mental health indicators to speak about and what are there were developed mentally by one person (mentions Mr X). So it is true to say that the mental health policy is there but at the same time we have to admit that indeed, mental health indicators are not being given that prominence and attention ….. But it is never too late because the revision of HMIS gives that opportunity to incinerate these indicators so that you are also monitored just like we monitor these other indicators.

(HMIS Specialist)

The descriptions above attest that Mental Healthy Policy development process was described invariably by key officers in the ministry of health. For instance, two officers claimed at the outset that epidemiological data (HMIS) was informative when developing the mental health policy when one said it was non existent in mental health. In terms of process, one director unlike others provided a French or elitist approach of policy making which is a top down approach whereby policies are not cooperatively developed by the broader community (Kingdon, 1995). The top down approach used by the ministry is approach negates the benefits of consultation and consensus building where senior bureaucrats take a moderator role. By opting to use the French approach, the role of the health ministry was solely to author the draft document as it willed. The ministry was not expected to listen to the various stakeholders at the outset. Stakeholders were not concurrently involved from the needs analysis stage onwards so as to allow them make proposals. According to WHO (2004), such proposals blend different views of stakeholders, groups and individuals into the design of the policy.

When asked what the problems were behind this scenario, one director catalogued a number of them and the following stand out.

Use of inappropriate data collection forms affects planning

I think prior to the reforms, even when they say we are using MF7?? I think it was more informative than what we are using now. Because the reforms came up with what they call 6 thrusts and that is what has affected the whole system because they just think of TB, water sanitation, child health HIV/AIDS but the rest are not featuring prominently and that is why we lost direction. Because in the ministry of these things the unit which is supposed to spearhead is the directorate of planning and when you look at planning currently, we are not doing a very good job.

(Director 1 Ministry of Health)

Consultation refers to seeking input (i.e., advice, reactions, clarifications, etc.) during the policy development process from individuals within government and those external to government.
Lack of proper trained manpower

One explanation for us not doing a good job is that most of the planners have never practiced and they don't know what is obtaining on the ground and some have the background of economics and the likes. So they don't understand these things. We need to hybridise that directorate in such a way that they are some people, yes we need economist as planners, but the hybridisation or interaction between various players I think is very critical.

(Director 1 Ministry of Health)

Lack of coordination

Because currently it looks like things are in isolation so we need co-ordination between the clinicians, planners, I think it is a bit weak, and we need to work on that if we are to improve on the monitoring issue.

(Director 1 Ministry of Health)

Use Of DALYs as Inappropriate Indicators

So definitely when you look at monitoring in mental health, it was delayed at that time when they concentrated on the 6 months and I don't know whether it is some economist, they said no we look at the dailies and the things, mental diseases don't read these dailies those are purely and in fact the.... Ethically we are not supposed to use dailies in the management of health sector because it is totally in ethical. So when you concentrate on dailies you may end up picking the wrong things and leave some of the key things that might be killing people; because in public health, there are those that we call public goods non is willing to, for different reasons "may be economic and thinking that if I do this, there is as many and such. So those are some of the things we need to look at. We have a big problem it comes the monitoring and evaluation on the health sector.

(Director 1 Ministry of Health)

Data Scarcity

One director admitted the problem of data scarcity or unavailability. It should be acknowledged from the outset that this state of affairs negatively affects the whole process of policy development and implementation. His observation was that:

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21 The DALY measures the overall burden of a disease by combining, on the one hand, the years of potential life lost due to premature death from the disease and, on the other, the years of productive life lost due to the disability produced by the condition. "For mental health, the DALY (which is being castigated by the specialist) has brought a critical reality to light and showed that psychiatric disorders and neurological diseases are amongst the most important contributors to the global burden of disease." In 1998, these disorders were estimated to account for almost 12% of the deaths and lost productivity due to all diseases and injuries globally, with an estimated 23% in high-income countries and approximately 11% in middle and low-income nations. In 2020, their share is projected to increase to 15%, if urgent action is not taken," Dr Brundtland said (WHO home page http://www.who.ch/)
We have a little bit of information on ministry of health in the HIMS (Health Information Management System). But the information that we have is not comprehensive because only data that is covered relates to in-patients and it doesn't talk about anything else. It doesn't talk about age related or drug related problems .... We suggested to the HIMS directorate that they should actually make it comprehensive, so that we are able to capture all the activities that are happening in mental health. Because just 'saying' mental health, it tells does not tell us enough to say we got psychosis, we got schizophrenia......

So we only hope that when they do (does not suggest who) the new system (meaning reviewing the HMIS) will comprehensively capture mental health so that the data can be used in developing policies. But with the data that we have, we can do very little may be with the study that you are doing we may get something.

(Policy analyst)

We don't have the figures

Director 2 in the Ministry of Health made the following observation on the scarce data:

But I think the data that will come out from the head count that is being done on human resource will give us the proper readings about the staff that we need and the deficit areas. We don't have the figures telling us what the impact is on mental health. The release of funds for a certain activity has also become a little bit tricky because of scarce data. Why should we spend money on this (meaning mental health) when we have a problem like this? We also don't have mental health documented as a problem. Even when you go to these meetings, (International conferences) Zambia has no figures. If you had come at the right time, I would have shown you where we have written. We have no figures for mental health.

(Policy analyst)

From the excerpts, one is likely to envisage that we have a problem of mental health resource planning arising from unreliable or absent data. A key impediment to – but vital ingredient for – mental health resource planning concerns the availability of comprehensive and reliable data on existing levels of mental health service provision. However, development of a WHO Assessment Instrument for Mental Health Systems (WHO–AIMS) and its subsequent application in a number of low- and middle-income countries has significantly improved the situation and Zambia could rely on this instrument to overcome the impediments. There is need to come up with mental health staffing norms and staffs mixes in order to run our mental health system effectively and efficiently. These norms need to be trended over each development plan and we have to factor in population growth and staff turnover factors.

Lack of Evidence to Support Claims

One director laboured to show the process of policy making heralding from a situation analysis. When asked repetitively to provide evidence and where they got the evidence upon which the present mental policy was developed, the response was rather quick and hidden in what is cognitively known about situation analysis:
We just got the situational analysis and you will agree with me (begging the question) that it is evidence based. We did a lot of analysis in terms of epidemiology, finances, human resource, transport and infrastructure.

In answering (the research question); where am I? That is the first thing in the policy. So it gave us all these important areas in mental health. Now thus a beginning, so we can either go to primary information, but you start with secondary information there is a lot of literature around us look at the information and supplement it with primary information. Then you do a bit of interviews these structured interviews you can do a bit of research and what have you (Seemed to have been speaking rather generally and not only for mental health). So it should give you really evidence to say here we have got a problem. So our evidence was very strong…. You mean you want to have a copy of the situation analysis? You can see Mr X he will give you. There is data to verify.

(Policy Advisor)

What seems to come out from the interviews are facts that in the absence of data and failure to provide evidence on the spot implies that the ministry of health develops policy which is not evidence based. There are no prevalence, incidence, severity or priority mental conditions data for Zambia any where in the ministry of health. In the absence of epidemiological data on mental health, we cannot as a country make any proxy needs, and not even service requirements in mental care. This behaviour by the key health actors shows an absolute failure fails to meet the benchmarks of the essentials of mental health policy development. We wish to reiterate that an explicit evidence based mental health policy is an essential and powerful tool for the mental health division in any ministry of health (WHO, 2004:2). Noting the absence of critical foundational evidence, we have serious reservations to the usefulness of the present mental health policy.

Other than the above challenges, there were compounding factors militating sound public policy practice and a number stood out ranging from gate keeping, avoidance, evasion of questions and buck passing. An enumeration of these challenges is presented below.

Gate keeping

The lack of availability of the mental health policy and mental health data in each of the key offices and the library in the ministry of health had a negative effect on attempting to verify verbal accounts. This was compounded by gate keeping with persistent reference by directors to a Mr. X. This shows how gate keeping could thwart or challenge mental health research in Zambia.

If you want more details, see the policy. It should be ready by now (meaning the developed mental health policy) check with Mr. X I think it’s complete. The challenge will be of course will be the implementation. In the last round 6 for global funds, we had a small working group and mental health and we had given them a lot of money.

(Director 4 Ministry of Health)
Avoidance, Evasion of Questions and Buck Passing

The problem of verification of claims these directors made was further compounded by evasion of questions and buck passing clarifications to another person. The illustrations from two directors below attest a very unfortunate situation in research.

I wouldn't be very specific on that as I said I have been out I have just coming in the ministry, but my good colleague Mr. X will be able to answer that what I know is that he was involved in the policy then I went out, but that one really a probe Mr X I am sure will give you the up date on where we are....You can also see just now Mr. C is a director and Dr. M I think was director of policy then you should talk to him also.

(Director 2 Ministry of Health)

So for people mental health is X. I was at that meeting and we were told (not stated who) what we were supposed to do and X (or Mr. X) did the budget for mental health. The allocation I don't know I can't comment because what he wrote on those papers.... I don't know the only thing I saw it's when we were doing... we were looking at the budget before it was presented at parliament I saw mental health reflected there.

(Policy Analyst)

But I am sorry I wasn't there when the thing was done. I just found myself working with X after it had gone through, but these are the things that we have to work with because we found them and we only have to correct them at the end of the day, because we have already done it, we have already eaten government money we can not go back and say is not done we have to do it. Those are facts we have just to do it. I wasn't there when the document was done, but I have been working with X (meaning Mr. X)

(Director 1 Ministry of Health)

Step 3

To consult and negotiate

The process of formulating and implementing a mental health policy is mainly political. To a lesser degree it is a matter of technical actions and resource building. The role of the health ministry at the time should have been to listen to the various stakeholders and to make proposals that blend their different views with the evidence derived from national and international experience. This was not done.

Step 4

To exchange information with other countries

Sharing experiences with other countries may help a country to learn about both the latest advances in more developed countries and about creative experiences and lower-cost interventions in less developed countries. International experts may also be helpful in this connection. When information has been gathered from a variety of sources
through steps 1 to 4 describing the vision, values, principles and objectives for mental health. When this is done, it is possible to set out the substance of the policy. However, the policy document has a vision “To provide all Zambians with equity of access to cost-effective, quality mental health care as close to the family as possible through use of comprehensive promotive, preventive, curative and rehabilitative mental health services.” This vision sets high expectations for mental health, describing what is desirable for Zambia. The mental health policy has no core mental health objectives that are applicable to mental health policy (WHO, 2000) and particularly those relating to.

- Improving the health of the population. Our mental health policy fails to outline the objectives for improving our population’s mental health status. Ideally, mental health outcome indicators should be used, such as quality of life, mental functioning, disability, morbidity and mortality. If this is not possible, process indicators can also be used, such as access and service utilization.
- Responding to people’s expectations. In mental health this objective includes respect for persons and a client-focused orientation.
- Providing financial protection against the cost of ill health. Among the issues of relevance to mental health are: equity in resource distribution between geographical regions; availability of basic psychotropic drugs; parity of mental health services with those of general health; allocation of an appropriate percentage of the total health budget to mental health.

**Step 6**

**To determine areas for action**

In the event that objectives are developed, the imperative is to translate them into areas for action and the fact that objectives are conspicuously missing it therefore follows that the following could not be covered:

- Coordinating Unit,
- Financing;
- Legislation and human rights;
- Organization of services;
- Human resources and training;
- Promotion, prevention, treatment and rehabilitation
- Essential drug procurement and distribution;
- Advocacy;
- Quality improvement;
- Information systems
- Research and evaluation of policies and services and;
- Intersectoral collaboration.
Step 7

To identify the major roles and responsibilities of different sectors

The main sectors that are required to take on specific roles and responsibilities in the policy formulation and planning process were uninvited inadvertently or advertently.

Policy Review

When it was discovered that the existing mental health policy was not developed as desired in policy practice and in spite of the fact that there are noted serious flaws in its conception and content, the ministry has resigned from reviewing it. There is need to revisit the policy, but from the descriptive accounts of the key Directors, there is nothing easy about the process of mental health policy change. If we are to succeed in having sound mental health policies, nowhere is this more the case than changing the perception at macro level and considering advocacy. Due to political tensions, policy developers seem to be confronted with contradictory views on how to proceed with the review. This is evident from the following illustrations:

Need To Review the Policy

Well, first of all I want to state that, the current policy should be reviewed in the same way the current legislation is reviewed, it will be wrong to assume that the current policy in itself, does meet the requirement of promoting mental health services in the country.

(NGO leader 1)

......last time when I was looking at it (current mental health policy) it has not much of what it is supposed to be expected, especially after doing these other policies on the basis of the guidelines, and I think we may have to make a fewer adjustments to them to reach the recommended standards. We need more stakeholders than we did by going outside of those in the ministry.

(Director 1 Ministry of Health)

No it was not adequate definitely inter ministerial consultation is very important because most of the so called disease problems are actually multi-faceted and multidisciplinary and it is important to consult other line ministries however the consolation is that policies could be reviewed and how often they are reviewed depends upon the needs. If is found that the policy that was made our mental health has left out some areas undressed it can be brought back to the drawing board and be looked at again once again let me emphasis its very, very cardinal to have consultations with other ministries and other stakeholders.

(Director 3 Ministry of Health)

But it is never too late because the revision of HMIS gives that opportunity to incorporate these indicators so that you are also monitored just like we monitor these other indicators.

(HMIS Specialist)
Those of us who are the main stakeholders don’t have the official capacity of doing thing other than having seeing the drafts flying around, so for our organisation. We are being convinced that this is the policy, and to say a little further again, because public awareness lack of knowledge about mental health in general, it would appear that there are very few people who would want to be interests to wanting to know what this policy us all about and come up with suggestions as to how it should be.

(NGO leader 2’)

**Time Constraint as a Factor to Review the Mental Health Policy**

But the only thing that we have is this mental health policy, which is supposed to be printed. And there was a strategic plan that was done and after this strategic plan, we are suppose to implement what is in that policy and then assess it to see if what is in that policy has worked or not. We have to develop indicators and all for that for assessment only then can we review it. Because we cannot just have a policy which has taken us ten years and then start reviewing it. It will take us another ten years when we have actually not implemented anything it’s the cost to the government, so we have to implement whatever little is there see if its going to work? If it doesn't what we need to do is look for funds. We have to do whatever was recommended there because the government wasted money to come up with the document but if we just throw it away then we are not doing justice to ourselves. Let us see were we can find a programme to do and where we cannot because at the end of the day we will say we will review the policy the implementation will be like this only 2% was done can now we do a proper policy? Then the government will agree. The government is us the people, because we are spending money everyday were and then at the end of the day we just throw away the document, but you had cried you want this policy where did the cry came from?

(Policy Analyst)

**Money matters as a Factor to Review the Mental Health Policy**

People become so concerned with money and accounting for it but they forgot the core business of taking care of patients, which is the centre of the service. They are not interested in reviewing what went wrong…. Some people take things into their own hands and do them as if they are theirs, they should allow full participation of various stakeholders so that we come up with something that is workable and then the co-ordination amongst various stakeholders is very critical for the proper performance of our institutions.

(Director 1 Ministry of Health)

If we are committed to addressing the overall question of how much it will cost to scale up the review of the policy and mental legislation that could spur the development of a core mental healthcare package, there is need to define the cost of the policy review if it will be considered. This may have to be extended to cover the package (in terms of health conditions and interventions to be included), estimate current target levels of treatment needs and coverage in the populations of interest. In this vein, we may be in a position to calculate the year-on-year resource costs required over a specified
investment period to reach the desired coverage. The investment period may be set say 10 years (2006–2015) to be consistent with the Millennium Development Goals.

The need for policy review is an interesting starting point for the elaboration of a public policy driven agenda than a professional or policy driven agenda (idealistic non evidence based policy). By calling for a review of the policy, these social and political actors cited above are calling for a redefining of policy development processes in a rigorous manner to accommodate public agenda that was missing from the situation analysis.

3.2 Contents of the mental health policy

Zambia’s mental health policy was developed in 2003 and passed by Cabinet Office in 2005. The present version of the mental health policy was formulated as one of the many out puts of the health reform agenda that began in 1991. A cursory look at the contents of the mental policy reviews that it is poorly written and not evidence based. It will be a fallacy to further examine or comment its contents.

There is wide disagreement that the policy reform document is losing momentum because of the constant attack on it by stakeholders on very profound grounds that it was not cooperatively developed and that Zambia is still behind in terms of its commitment to developing mental care plans and funding of mental health services. The excerpts below relate to people’s constructions and interpretations of the shortfalls of the mental health policy.

Yes, I have had a chance of looking at a mental health policy and as a country Zambia this is a progress as far as I am concerned. I think it does though there is some inadequacy as far as implementation is concerned. And it doesn't seem to meet our current challenges of the country so I believe that it is very important for us to retrace the mental health policy in our country.....

(Clinical psychologist)

In fact the system in Zambia that is being used to nominate key people that should sit for this/talk about mental health issues isn't alright; it doesn't seem to be representative.

(Social Worker)

...... remember there are always fashions. I have worked long enough there are always fashions in everything including medicine and closing mental hospitals into fashions they are building more facilities because they are close to money. But these fashions ought to embrace a number of elements: The first element is the recognized need. The second one, they must be more than three I think ..., so that second one must be the over all policy designed to meet that need. The third one should be the strategies needed to increment the policy and connected with the rest of strategies there should be an implementing body. It's easy to write down this and that... we think that Zambia should have a country wide mental health service, nonsense if you call that policy.

(Psychiatrist)
Well, first of all I want to state that, the current policy should be reviewed in the same way the current legislation is reviewed, it will be wrong to assume that the current policy in itself, does meet the requirement of promoting mental health services in the country. First of all...the people who contributed to the development of that policy are by and large were not cross sectional of the people in Zambia, later on, various stakeholders who know something about mental health are......the question of line ministries involved was also inadequate ...

(NGO leader 3)

Absence of Mental Health Plan

A critical examination of all mental health units revealed that they do not have any strategies related to facilitating the development of mental health plans. This implies that as a country we have not prepared any detailed schemes for action on mental health that usually include setting priorities for strategies and establishing timelines and resource requirements.

3.3. Development of Mental Health Legislation

The fundamental aim of developing mental health legislation is to protect, promote and improve the lives and mental well being of citizens. In the undeniable context that every society needs laws to achieve its objectives, mental health legislation is no different from any other legislation. People with mental disorders are, or can be, particularly vulnerable to abuse and violation of rights. Legislation that protects vulnerable citizens (including people with mental disorders) reflects a society that respects and cares for its people. Progressive legislation can be an effective tool to promote access to mental health care as well as to promote and protect the rights of persons with mental disorders (WHO, 2005f).

Zambia is part of 15% of those countries on the globe that have legislation dating back to the pre-1960s (WHO, 2001). We have in place a colonial legislation “The Mental Health Disorders Act of 1951” which is outdated. This law is not used at all in dealing with people living with mental illness. This is because much of this mental health legislation was initially drafted to safeguarding members of the public from “dangerous” patients and isolating them from the public, rather than promoting the rights of persons with mental disorders as people and citizens. The law further does not confer human rights guarantees to people living with mental illness like; the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. However, there are a number of areas in the constitution (The Bill Of Rights) and other legislation (e.g., the penal code) that are used to guarantee due process and civil liberties. In order to confer wider liberties that may not be embraced by all existing legislation, the ministry of health is expected to submit to cabinet a Mental Health Service Draft Bill draft bill. This bill is intended to repeal the 1951 Act and it is waiting for a consensus meeting. Following this meeting, the bill shall be submitted to
the Attorney General for refining. There are misgivings about the 1951 Act from several quarters.

**Legislation uses very derogatory terms**

We had the 1951 act which is under the process of being repealed, up to now it has only reached the level of a bill, yaa but if you look at that they still use very derogatory terms like imbecile and idiot, immoral so in that it has been repealed up to now it hasn't and why its taking time and if you can think of 1951 to date why has it taken so much time because I mean even the parliamentarians themselves they have very little knowledge of psychiatry and mental health.

(Medical doctor)

Yaa, like in my area of interest is the way law describes me. Who am I? The identity that I am given by the law, it is unfortunate for the law to call me an imbecile an idiot. Yaa, this is very critical to me because immediately you just label me as an idiot, that in itself has got a lot of repercussions up there, because every one you will be looking at me us an idiot then attract the very negative attitude that we receive from the community. Because the community is meant to believe that S is an idiot. An idiot is one person who is not worth staying with and maybe the better place is being out there at the edge of society. That I think is where I really find the law in adequate and very cruel to people with mental health problems.

(User 1)

**Need of law embracing human rights**

Yes I think what we would want to see in the law, number one, is to start looking at mental health from the human rights point of view let the law spell out exactly the rights of persons with mental health problems as far as treatment is concerned and as far as the type of like one should lead in the community I would want to believe mental illness is an illness like any other illness and I don’t have actually to apply to my heavenly father in heaven to actually give me this illness no.

(User 1)

**Colour bar**

That was a colonial act and it had protected most of the whites not the blacks if you can think of 1951 up to now there is very little. Why I say so you hear of expatriates coming for surgery apart from the paediatrics and doctors we had here probably in 2000. We have never had people coming as psychiatrists it’s just recently that we have seen doctor X doing a lot of changes around. But otherwise before that, there was very little.

(Medical doctor)
Dire need for repeal

I think the policy was just launched, and I don’t know if it has been taken to the cabinet policy gives way to a bill which gives way to an act and acts can be amended from time to time. In other countries like UK, every 2 years they amend their act. Mental health Act is amended depending on how they review their situations in the past two years. So if this act was in place when we started in 1991, when we started discussing this bill, and it is 16 years now and we are just discussing, workshops and workshops, so if this act was in place you review it in what transpired in the past few years that’s the only way you can’t come up with the act and operates for ever. That is why it is supposed to be amended.

(Director Clinical Care at A district)

3.3.1 The Process of Law Development

We have observed that there is in Zambia an established process of enacting legislation. However, the process of developing the existing 1951 colonial law is unknown. Therefore analysis of law development in this report will focus on the pending legislation to repeal the 1951 one. However we cannot vouch the process that was used to enact the existing 1951 colonial law. In essence, proposals to introduce new legislation or to amend or repeal existing legislation should be referred to the Attorney General’s chambers through the permanent secretary responsible for legal affairs. This is to ensure that the proposals are in line with the overall government policy and that it is necessary. A three-stage process ensures the development of a bill to be presented to parliament. Stage one is related to approval by cabinet office of the draft in principle that is sent by the proposing ministry. Approval comes after the Attorney General’s Chambers has refined it. The second stage is related to approval by the legislation committee of cabinet for the Bill to be sent to the main cabinet for approval prior to presentation to parliament (Cabinet Paper, 2003).The third stage relates to parliamentary proceedings which end up with the Republican President accenting the bill.

In 2006, a new legislation the “Mental Health Service Bill” was drafted by the ministry of health. A number of stakeholders and mainly practitioners within the ministry where called to draft the bill. Ideally, the task of drafting legislation should be delegated to a specially constituted committee. It is a common practice that a draft of proposed legislation is presented for consultation to all the key stakeholders in the mental health field. Consultation plays a key part in identifying weaknesses in proposed legislation, potential conflicts with existing laws, vital issues inadvertently omitted from the draft legislation, and possible practical difficulties in implementation (WHO, 2003:33). However, this is being arranged. A cursory look at the draft Bill shows that it does not contain among others the following essentials according to WHO Checklist on Mental Health Legislation and as enunciated by WHO (2005e):

- Fundamental freedoms and rights of mental health service consumers, family members, and other care givers;
- Facilities;
- Mechanisms to implement the provisions of mental health legislation.
- Oversight and review mechanisms.

The draft Bill has very notable improvements over the 1951 Act in the sense that it intends to ensure both *de jure*\textsuperscript{22} and *de facto* compliance with international human rights law. In addition to developing legislation that meets the requirements of international human rights law on paper, this legislation could be used to reform mental health policies and practices to bring mental health and social service systems into compliance with international standards. In the process of drafting legislation and planning for its implementation, the drafters took heed of the requirement of the Standard Rules on Equalization of Opportunities for Persons with Disabilities for the meaningful involvement of people with mental disabilities and their families in setting priorities, developing legislation and action plans, and creating methods of monitoring their progress. The draft bill further guarantees the following:

- Equity of access to mental health care.
- Voluntary and involuntary mental health care.
- Special treatments.
- Seclusion and restraint.
- Police responsibilities with respect to persons with mental disorders

What needs to be done at the consensus stage is to ensure that fundamental human rights are provided for.

### 3.4 Monitoring and Training On Human Rights

In Zambia, we do have an institution that monitors human rights, namely the Human Rights Commission. It was set up primarily for the protection and promotion of Human rights in Zambia. It is a national institution set up under the act of parliament. It mainly monitors government activities but it does so only when a complaint is launched. However, no mental institution has ever been visited. The excerpt below describes what it stands for and areas of concern in human rights.

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\textsuperscript{22}This is an expression that means "based on law", as contrasted with *de facto*, which means "in fact". The terms *de jure* and *de facto* are used instead of "in principle" and "in practice", respectively, when one is describing political situations. *De jure* is also translated as "by law". A practice may exist *de facto*, where for example the people obey a contract as though there were laws enforcing it yet there is no such law. A process known as "desuetude" may allow *de facto* practices to replace obsolete laws. On the other hand, practices may exist *de jure* and not be obeyed or observed by the people.
**Functions of the Human Rights Commission**

One of our functions again as a national institution is to advise the government on what it is doing or not in terms of protection and promotion of human rights. We are also supposed to monitor what government is doing in terms of implementation of Human Rights treaties that it has signed. We are also supposed to, according to our act, carry out the function of rehabilitation of the victims of human rights and this is one function we feel we haven’t carried out as a commission....there are issues of capacity, in terms of human capacity and financial resources which have hindered us in carrying out particular function. So basically that’s what the commission does.

(Human Rights Commissioner)

**No Inspections**

Inspecting Chainama? Heeeey.....aaaaaa I would say yes...and No, the unfortunate thing for us is that, with the visitation that the commission has carried out, previously the thinking had been that, strictly, it must be prisons....last year we made a move of visiting places where people can be held or people who are being kept. Well that of course does not mean we have to ignore mental places, we have a general mandate to protect and promote human rights and since we have these other areas of detention like Chainama, which is one place we should visit.

(Human Rights Commissioner)

**Visitations but not on purpose**

I remember visiting Chainama on women’s day last year, we made contributions to Chainama and it was used as an opportunity to speak with the female patients and I believe we didn’t get to the male wards of the hospital. Then we had also scheduled 2 visits and it was actually this time to the children section and was supposed to go with visiting orphanages as well to view how children are being kept in those facilities. But unfortunately, for us resource constraints didn’t allow us to proceed with those visits. We are largely a government funded institution even if our function is to oversee and monitor government activities; we are funded by government.

(Senior Officer Human Rights Commission)

**3.4.1 Human Rights Abuses**

We were interested to establish whether people living with a mental illness suffer abuses and discrimination due to the peculiarities of mental disorders. We observed that people with mental disabilities experience some of the harshest conditions of living that exist in any society- akin to the way children – or worse, animals – are treated. Much of the hardship experienced by people with mental disabilities was beating, isolation and deprivation of liberty for prolonged periods of time without legal process. In a number of circumstances these people are subjected to peonage and forced labour in institutions. In addition, they are subjected to neglect in harsh institutional environments and deprived of basic health care and they are victimized by physical abuse and
exposed to cruel, inhuman or degrading treatment. These abuses and discriminations were compounded by the absence of legal protections against improper and abusive treatment. The excerpts below attest to the need for human rights training of mental health workers and a review of legislation to confer protection from abuses and discrimination.

**Job losses**

You know mentally ill people don't enjoy the same rights because of the stigma, which is still there. Because we get for example: if you work with a person who has a history of mental illness if she does anything wrong there are very few people who would go there maybe to give advice, but instead they would say she has started again she is mad and do all sorts of things on you even losing your job.

(Enrolled Psychiatry Nurse)

**Forced Treatment**

Human rights are needed for us and forcing people to receive treatment is not right. I think that in itself to some extent is the violation of someone's human rights as far as maybe forcing someone to receive treatment, and at times we have had situation were people think that a person with mental health problems should not actually get annoyed or upset.

...........I think I know haloperidol better than my doctor, because I am the one who swallows, it is me who undergoes all the side effects, it is me who understands better the medication that I swallow so my experience plays a very important role in actually designing mental health system so to speak. My experience needs to be brought on board and to some extent psychiatrists so to speak should actually and especially the government should take on board family members on issues of mental health and I believe that actually they can play a very very important role in as far as recovery is concerned and I would love to see them brought on board.

(User 2)

The excerpt of user 2 indicating prowess in the management of a mental illness is in consonance with the articles by Rochefort and Pezza (1991) and Rochefort (1993). These articles emphasise the **special need to embrace significant people in the mental health** population in the management of mental illness. Rochefort for instance discusses involvement with a view to integrate a variety of programmatic resources to the benefit of the client population. This has been attempted more in the area of the delivery of mental health services for children than in any other type of care.

There were other human rights affects that were highlighted by people living with mental illness like:

**Isolation**

.... To me what I have actually seen as another biggest problem in as far as recovery is concerned is loneliness. Because then the room for you to receive proper treatment, proper care was some how compromised by such kind of issues, pushing you to seclusion, you can't argue out.....

(User 3)
**Loss of freedoms**

I am sorry I haven’t been brought in that way but I have seen people who have been brought in a very very cruel manner tied in chains, handicap police with guns and all that kind of stuff. Someone coming in as a patient to me I would say this is the time when your human rights are actually taken away form you......Even just transporting you from filter clinic to any ward the way you are taken is such tricky once to the point that you even devalue yourself, you are pushed in as if you are a criminal you have committed a great crime and all that kind of stuff. I would like to confess like in my first experience that in itself ate me up.

(User 1)

**Lack of Social Welfare**

There is this thing about human rights and patients welfare you know. The psychiatry unit should really be taken care of like any other hospital, because what they have in there...... They don’t have even enough blankets. The type of environment you know what types of people are in that environment. They need to have a lot of recreation and the place should be clean. Sometimes you find these guys lying down in faeces so they can easily contract any disease. The place is not clean. There was this time.... when she was discharged (meaning a sister) she had a lot of lice in her clothes. When she was discharged here, when I reached home, I had to tell her to take off her clothes and went in the bathroom and took her to the saloon and put on these other clothes..... So there was a lot of lice in the hot water after washing her clothes. Now she says when I am discharged I want to go to your home because make me change my clothes wash them in hot water and take me to the saloon.

(Extended Family Member)

**Capital Punishment**

......the kind of treatment you would receive oh!!! When you suffer from mental illness its all about your behaviour, your thinking, the way you carry yourself. You see that behaviour is somehow an accepted not normal so to speak so many that you expect the patients to be have in what is so called a not normal way but the response from professional again becomes tricky because its an extent there was the use of beating weeping forcing you to the seclusion and that kind of stuff

(User 1)

**Some respondents described incidents of corporal punishment**

Sometimes you are beaten for no apparent reason. It is just of the late that they stopped beating me otherwise we were being beaten and insulted you can't like it.

(User 2)

yes, coz if parents or relatives are called in, we are the people facing hurdles for the patient, we are there as a family who see what we are going through and have the information of how these people are being treated. For instance, he told me how he was being beaten when he was admitted. I wanted to follow up a case but I couldn’t, you know these people who work with the patients should be more knowledgeable and understand that patients don’t do nothings deliberately but it is because of the sickness, so if our voices can be heard as parents or relatives to the patients, we will be very grateful. If us relatives
can understand their behaviour why not the people who are trained in that field? why don’t we beat them up when at home but being beaten at the hospital and you expect more pts like that at your hospital? So at least it is important for us to be brought on board to air our views on behalf of our patients and other citizens out there.

(Family member)

II Mental Health Services

A cursory look at the organizational integration of services in Zambia shows that there is a mental health authority in the country. The authority within the directorate of public health and research is expected to coordinate mental health activities in the country. The authority fails to plan and monitor mental health services (coordinating without any mental plans). A program officer who has not been ascribed with decision-making powers heads the authority. The authority has however failed to coordinate mental health activities. At the time study was being done, a strategic plan was not developed but it has since been developed. However, it could not be assessed because it has not been accessible. Generally, mental health services show lack of integration, poor referral system and lack of referral lack of feedback. Below are testimonies due to lack of integration.

Referral

Yah, there are cases where these pupils are referred to this school as “rejectees” because of being mentally ill.

(Teacher specialized in dealing with teenage pupils with special needs)

Basically, if that money was there, I was definitely going to try and revive the referral and register system which we used to have.

(District Supervisor)

You will find quite alright in the mental health facility they do this but at the health centre no one is there and everyone is being referred to Chainama, I don’t know.

(Clinical Officer Psychiatry)

And all the 27 clinics in Lusaka refer cases to Chainama. You know we have fluctuating drug stocks. Sometimes the balances usually go down. But most of the sometimes we have because the pharmacy at the hospital supplements.

(Registered Nurse and Sister-In charge)

Because currently it looks like things are in isolation so we need co-ordination between the clinicians, planners, I think it is a bit weak, and we need to work on that if we are to improve on the monitoring issue.

(Director)
So let the clinics start to do something as 1st aid or first handling of a case. Before that case is referred to Chainama. So – work is important, but also the leaders must know as to when they can refer to Chainama and do you people really know the difference between – demons and the real madness? Because if somebody goes in a trance, they start speaking in tongues, that are not madness but spirituality, that is demon possession, if someone is being haunted by a ghost, it set by JUJU, it is not madness, if somebody starts speaking in Swahili the language he/she has never spoken before, then you know that the spirits is speaking through him. It is not madness.

(Traditional healer)

Lack of feedback

But it seems, Chainama is operating like an island in isolation, because even at clinic six in UTH, where I am working I refer patients to Chainama without feedback.

3.6 Services Rendered

The mental facilities that we studied provided a range of mental health services and these included: (i) Mental health outpatient facilities in all district hospitals, (ii) day treatment within the health centres and (iii) one occupational therapy in one community-based psychiatric inpatient unit. All mental facilities except Chainama Hills Hospital provide non-physician-based primary health care. Nurses and clinical officer category type of staff are responsible for the delivery of mental health care instead. They also provide education for the differentially able.

The types of services rendered to people living with mental illness are determined by institutional ranking and staff placement. The following are exemplars of roles and services that are provided. Some services were not integrated within facilities and across line ministries:

Rehabilitation

To rehabilitate patients with a view to help them learn new skills, so the treatment process of occupation therapy. Starting point if it means traditional baskets, we offer them enough materials so that when they go in the community they can make something and sell and then purchase some more materials. But if they have problems in their skill they still come back.

(Occupational therapist)

Community mental health

I have been here since 1990 and my main aim actually is to do with the people who are outside that is the outpatient and I make sure that those who were admitted in the mental hospital and discharged comply with the prescriptions. In short I can say that I am a community health worker sort of. Sometimes I do follow them up to their places, though nowadays to be frank, I don’t do it as I used to some time back due to lack of manpower, transportation to go to the community most people come from very far where you can’t reach them if there is no transport apart from very few who come from within our catchment area.

(Clinical officer Psychiatry)
Nursing

As Nurse, when a patient comes I have to look at the hygiene because they come in very dirty. I have to make sure that the patient is kept clean and have their hair cut. Then I have to look at the nutrition status of the patient and we also look at the bedding where the patient is going to be sleeping, we also look at the nutrition, what type of food the patient is going to eat on top of that we also look at the medication.

(Enrolled Psychiatry Nurse)

Operational management

I do day to day running of the hospital, the care of patients in terms of food, upkeep and drugs and other activities and it also involves looking after personnel, supervising personnel and not only doctors but the general personnel at large.

(Director Clinical care)

Occupational Therapy

We try to identify and mobilize resources to meet patients' needs and when we do, we coordinate with other departments and the family and the community in the over all management of the patients by collecting and providing information concerning patients needs and progress. We also impart knowledge through teaching, enhancing skills in patients and encouraging independence in clients' life style while promoting quick recovery from illness. But we have difficulties in some of the material resources because some of them we get them from very far as far as Luangwa district..... We have a bit of a problem because we don’t have NGO's that supports this department. We only depend on funds from the sell of what we produce which are very minimal.

(Occupational therapist)

Psychotherapy

.... As I said, not even community mental health and usually, they don't like being dependent on drugs so much because the availability to start with, especially nowadays. So we really try to focus very much on psychotherapy and counselling.

(Clinical Officer General)

Psychodiagnostic testing

I carry out what is known as psychodiagnostic testing where we use psychological testing to determine the disorders in at good number of patients. Now these disorders are either dependent upon what the doctor has requested in a referral letter. So, from there, I assess, then the findings help; in diagnosis of the patient, management of the patient and even where the physician feels to change the drug.

(Psychologist)

In choosing health priorities, funding and manpower development, mental health especially has suffered from this tradition. The excerpts below paints a gloomy picture of the future of mental health.
Priority

Well! Mental health I think, I consider it to be a critical part in the health service, but to date it hasn't been given the priority it deserves and it is my hope that in the near future we see the situation where mental health is put back to where it belongs as opposed to what is obtaining now...We had someone who was dealing with that (mental health), but unfortunately, he died in 2005. But I am the one representing mental health. Basically, to tell you the truth we are not doing much.

(Clinical Director)

Lack of Influence

How can I be influential when the mental health specialist himself at national level is voiceless? I don't even remember that "relative" of mine the last time he visited me to discuss mental health issues. We just meet at Ndeke (MOH) but basically he is a person who is supposed to be pushing for the nation. His department should push.

(Clinical Director)

3.6 Other Services available

There are limited services that are provided to people living with mental illness. The percentage of patients who received one or more psychosocial interventions in the mental hospital in the past year was in the majority (51 - 80%). Psychosocial interventions sessions are those that last a minimum of twenty minutes. Examples of psychosocial treatments include psychotherapy, provision of social support, counselling, rehabilitation activities, interpersonal and social skills training, and psycho-educational treatments. However, none of the patients received one or more psychosocial interventions in the year prior to this study. It was noted that mental health institutions in Zambia rendered pharmacologic care more often than any other forms of therapy. Counselling, occupational therapy, clinical psychological assessment and therapy, social welfare and guaranteeing human rights (like government providing economic support to families or mental health associations for mental health initiatives and human poverty mitigation) being cross cutting issues were least rendered to the mentally ill. Below we show these claims.

Occupational Therapy

We try to identify and mobilize resources to meet patients’ needs and when we do, we coordinate with other departments and the family and the community in the over-all management of the patients by collecting and providing information concerning patients’ needs and progress. We also impart knowledge through teaching, enhancing skills in patients and encouraging independence in clients’ lifestyle while promoting quick recovery from illness. But we have difficulties in some of the material resources because some of them we get them from very far as far as Luangwa district..... We have a bit of a problem because we don't have NGO's that supports this department. We only depend on funds from the sale of what we produce which are very minimal.

(Assistant Occupational therapist)
While such services as outlined above were noted, they were only rendered at the only mental health hospital but limited services were rendered in 9 mental health outpatient facilities. What we did not see in our 10 mental health outpatient facilities providing is failing to focus on the management of mental disorders and the clinical and social problems related to it on an outpatient basis. We were particularly unable to observe or document any mental health outpatient care involving rape survivors or homeless people. Mental health outpatient facilities for children and adolescents only and mental health outpatient facilities for other specific groups (e.g. elderly) were not seen. These outpatient facilities do not have any data regarding the cases they treat or refer. Only Chainama Hills Hospital has data but no nomenclature is used for purposes of classification. Out of the ten Mental health outpatient facilities, nine do not have facilities such as psychotropic drugs, infrastructure, and human resources and above all lack a direct funding for mental health services. We do not have any data on provision of follow-up community care. In addition, there are no mental health mobile clinic teams.

It was interesting to note that users and mental health workers were able to construct mental illness from the social perspective. The construction ranged from mental health priority conditions (looking at disease types and distribution) definition, causes and below we present the social construction of mental illness and these are described below.

### 3.7 Mental Health Priority Conditions

Making mental health conditions as a priority in our society is a far-fetched dream. This creates a challenge in service delivery. According to in patient data from Chainama hills Hospital, the following are the major mental illnesses: schizophrenia (57%), mental and behavioural disorders due to psychoactive substance use (27%), Mood disorders (12%) and other related cases (4%). However on a one to one basis, mental health workers are ambivalent on the aetiology, what conditions have the greatest burden and not even the most occurring. Mental health workers were not agreeing on definition of mental illness and the pattern of distribution either and the profiles below attests to this claim.

**Aetiology**

Our respondents believe the following to be linked to the aetiology of mental illness.

Well there are many reasons people develop mental problems some is inherited in the family, some its poverty as you have said when there is poverty in a home you do not expect anybody to function well, with hunger no food. The brain to develop well it needs food. So if there is no food even some body reasoning becomes a problem. A person also who is stressed is prone to mental illness. Problems in a home make a woman end up with a depression. Stress also contributes to mental illness, accidents people come out with epilepsy. Even malaria, which is commonly found, persistent attack of malaria, could also damage the brain. According to our culture we usually think of witchcraft when in the family, there is mental illness or if there is in the family a sign that one of the relatives did some thing which is supposed not to be done... like an omen or an abomination, so God punishes them through poor mental health.

(Enrolled Psychiatry Nurse)
I think the most common thing people would think they are bewitched thus the common thing and the merging thing now is Satanism. So is the issue of Satanism and witchcraft some people just think that they are cursed.

(Clinical Officer General)

Just to add on I think if we look at our culture there is an explanation in most causes you find those who are mentally ill they will find an explanation to that illness they would either say its witchcraft or may be that person had maybe done something wrong to the community and then because of the causes that person has been caused or sometimes they just say maybe that person was a well to do family he has just been bewitched. And then if we come to religious explanation they will talk about demons they will tell you that this person is possessed thus why is behaving like this and then nowadays there is a new phenomenal which has come up of Satanism, they will say this person has been involved in Satanism thus why is behaving like this. So there are a lot of explanations depending on which angle you look at. Then if we look at our medical explanations they would say it could be some chemicals in the body like the neuro-transmitters some times they would say this person is reacting to stress sometimes they would say its because of infections which could be HIV related or other infections like syphilis, so there are a lot of explanations to mental illness, but it depends at which angle you look at.

(Mental Health Nurse)

You know there a lot of connections probably with witchcraft. These children were unwanted some years back before people could accept.

(Secondary school teacher for the differentially able)

At times it depends on the level of education a patient has attained. So those who come strength from the villages they would say its witch craft and for those who have gone to school and they have red books and they have come to understand that there so many problems, economic...social etc so many of them would understand, but somebody from the village would say I was bewitched.

(Mental Health Nurse)

**Disease distribution by age**

There are problems that only affect the children, women and the elderly. You know children come with their own problems, also women come up presenting their own problems, the elderly again there are child abuse, and rape cases ... At this institution I have seen many children admitted with mental retardation and epilepsy and for the most of the women are those with the manic cases and dimension are very common.

(Enrolled Psychiatry Nurse)

I can’t really specify because certain conditions have a different age range say drug abuse. When I say drug abuse I am talking about clients that abuse dagga. Usually we have the young ones, adolescents; then old, old guys like 55. But otherwise if I can be honest with you, we deal with a range of clients from the range of 18-55.

(Registered Mental Health Nurse)
Most of the young men I have met stay alone in the compound where rentals are cheap. Like Chibolya, John lenge. They just wake up in the morning go and wash cars in the streets of Lusaka or carry loads for people and they get that little money and they just spend on rentals and drinking. They have not time to sit down and cook .....  

(Clinical officer General)

Disease types

The conditions that were noted to be significant varied from one mental health worker to another. Below we provide a profile of mental illnesses:

We have those with schizophrenia, those who come in with depression, those who came in with mania and those who come in with mentally retired. Those who come in with alcohol related delusions, drug abuse, the epileptic so many of them.

(Enrolled Psychiatry Nurse)

Presently like in our male patients the most prominent cause of their problems is alcohol and drugs. Amongst the young men who are being admitted to this hospital. So if you went to one of our male wards and asked “what is the cause of the problems most of the young men as the age group which is there its alcohol”. Because they abuse alcohol like Chibuku they temporarily feel satisfied and when the metabolism stops or effects stops then they hunger once again and you see they spend most of their time when they are there (meaning night clubs) they have no homes.

(Clinical officer General)

It’s a wide range we have clients with schizophrenia, depression, neurosis, let me just say major psychosis and minor psychosis. We even handle clients with epilepsy and at times, clients with physical problems they present with mental disorder. I can’t really specify because certain conditions have a different age range like for drug abuse, when I say drug abuse I am talking about clients that abuse dagga. Usually we have the young ones, adolescents; these are the ones that usually abuse dagga. Then for other conditions like, dementia, those are the old, old guys like 55. But otherwise if I can be honest with you we deal with range of clients from the range of 18-55.

(Registered Mental Health Nurse)

We have spectrum of patients, we have what we call the mentally ill which they fall into different categories, most of them, we have got schizophrenic patients, we got what we call affective orders and depression, we have equally what we call substance abuse retarded cases which are on the raise too. There is alcohol, nicotine and heroine those are some of the cases you see. Apart from that we are also seeing a lot of epileptic patients which being referred to Chainama, very few patients come as child psychiatry, but we attend to them. So basically the other category that we see is forensic psychiatry I am coming to that we talk about.

(Clinical officer Psychiatry)

Yaa sometimes you find that person has adult malnutrition because of poor diet yaa it could lead to mental illness as usual you see, because the brain may need about 80% of nutrients food nutrients for it to function properly and 20% is distributed to the next parts of the body, because it does most work for the body.

(Clinical officer Psychiatry)
Defining mental illness

An attempt to define mental illness was made and it was evident that the definitions of mental illness reflect a continuum from the broad definition of mental health care problems to the narrower clinical definitions. The understanding of mental illness among the care providers is variable, with some staff reporting that the clinical terminology used within the clinical mental health sector is judgmental in nature or ‘blames’ the victim. The users viewed it from a labelling perspective conferring mental illness with the attributes of felt and enacted stigma. As seen from the definitions, there is however, no one single comprehensive definition of mental illness, as definitions were varying across professions, social, cultural, economic and legal contexts and this was observed in the studies by Giosan et al., 2001; Perring (2005) and Gazzaniga and Heatherton (2006). Generally what we noted is that mental illness refers to a range of cognitive, emotional and behavioural disorders that seem to interfere with the lives and productivity of people. It was interesting to find a unitary definition, as the few exemplars of the renditions below seem to infer.

Yah, there are cases where these pupils are referred to this school as “rejectees” because of being mentally ill. And stigmatisation normally come from the community and not within the school, as you can see, this is an integrated school and we are proud that the normal pupils have accepted their fellows. So really stigmatisation is only experienced in the community.

(Teacher specialized in dealing with teenage pupils with special needs)

Mental illness is all about your behaviour, your thinking, the way you carry yourself. You see that behaviour is somehow an accepted not normal so to speak so many that you expect the patients to be have in what is so called a not normal way but the response from professional again becomes tricky because its an extent there was the use of beating weeping forcing you to the seclusion and that kind of staff.

(User 2)

Mental illness is just going crazy

It is an illness that affects the mind which led to the person start behaving strangely or abnormal.

(Family member)

This is an illness that affects the mind and brings about different aspects in thinking capability of an individual.

(Social worker)

3.8 Day Treatment Facilities

There is only one-day treatment facility in the country and it is at the main mental hospital - Chainama Hills Hospital Were care is provided during the day. People living with mental illness access this facility during the day and more than one patient are
seen. There is a day care centre for children who are differentially able and a sheltered workshop for adults. However, we do not have data on children and adolescents treated in day treatment facilities.

<table>
<thead>
<tr>
<th>Parameter of mental activity</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of users treated in mental health day treatment facilities</td>
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</tr>
<tr>
<td>Availability of day treatment facilities that are for children and adolescents only</td>
<td>Data do not exist</td>
</tr>
<tr>
<td>Diagnosis of admissions to community-based psychiatric inpatient units</td>
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</tr>
<tr>
<td>Involuntary admissions to community-based psychiatric inpatient units</td>
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<tr>
<td>Time spent in community-based psychiatric inpatient units per discharge</td>
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</tr>
<tr>
<td>Physical restraint and seclusion in community-based psychiatric inpatient units</td>
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<tr>
<td>Child and adolescent admissions to community-based psychiatric inpatient units</td>
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<tr>
<td>Community-based psychiatric inpatient beds that are for children and adolescents</td>
<td>This does not exist</td>
</tr>
<tr>
<td>Community residential facilities</td>
<td>Data do not exist</td>
</tr>
</tbody>
</table>

### 3.9 Mental Hospitals

Chainama hills hospital is the only specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. The hospital is independent, although it has some links with the rest of the health care system. The hospital offers long-stay and short stay custodial services (rehabilitation services, for children and the elderly). The Number of beds in this hospital totals 210 only and noting that there are floor beds (167) which do not enter the ministry of health budgeting equation, the proportion of beds per 1000 000 is taken as 1.75 and not 0.0021 as would be the case. Eleven percent (23) of these beds in this mental hospital are reserved for children and adolescents only. The number of beds has not increased but decreased in the last five years. In terms of sex ratio use Females account for (59%) of those receiving treatment.

The excerpt below shows the effects of exceeding institutional capacity.

**Over crowding**

I have seen a lot of changes here and there, but at that particular time the living conditions were horrible we were so crowded that you can bear it. When you talk of care man oh! You are talking maybe of the nurse, 2 to 3 attendants against eighty to ninety patients in one ward.

(User 1)
Admission and requisites

Oh dear me for God’s sake! People with mental health problems are the least respected people on that one. Least in the sense that... eh I would like to start from the point of admission itself. It is so horrible in the sense that all the necessary requirements and necessary procedures that are supposed to be put in place are not there at all.

(User 2)

The number of patients admitted to the mental hospital and psychiatry units was 2667 per 100,000 population in the year prior to this review. The average length of stay in 2005 was 104.94 days. Eighty five percent of patients spent less than one year, 8% of patients spent 1-4 years, 7% of patients spent more than 10 years and an unknown percentage of patients spent 5-10 (figure 7).

![Figure 7 Duration of stay in mental health hospital](image)

Fifty one to 80 percent of patients in the mental hospital and psychiatric units received one or more psychosocial interventions in the last year. 100% of mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. The patient count of those aged 17 years and younger treated in both adult and specialized child and adolescents facilities was only 5% suggesting that this population group may not be vulnerable. In addition to beds in mental health facilities, there are also 70 beds per 100,000 population for persons with mental health disorders in forensic inpatient units accounting for a proportion 0.0007 and 6 in other residential facilities such as homes for persons with mental retardation. In our forensic inpatient units, 77 % of patients spend time in the hospital amounting to less than one year and only 23% of patients spend more than 10 years. The percentage for those who spend 1-4 and 5-10 years is not known.
3.10 Effective availability of medicines at mental health facilities at all times.

In the mental hospital, we noted that the availability of medicines all year long stood at 100% and this was attainable and this is not a surprising occurrence because this is the only mental hospital in the country. In this mental hospital, at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) was available. This scenario was different when we examined outpatient facilities. The number of mental health outpatient facilities in which at least one psychotropic medicine of each therapeutic category was available in the facility or in a nearby pharmacy stood at 10%.

3.11 Equity of access

The data shows inequity of access to mental health care across all facets suggesting the existence of what could be called the “poverty of services” in mental health. This reflects a lack of an ideal organization of services dealing with mental health, their comprehensiveness in a given catchment area, their intersectoriality, and their integration with the community. To borrow from Strathdee and Thornicroft (1993:1996) "Services should be local and accessible . . . comprehensive . . . flexible . . . consumer orientated . . . racially and culturally appropriate . . . should empower clients . . . focus on strengths . . . should be normalized and incorporate natural supports by being in the least restrictive, most natural setting possible . . . should meet special needs and be accountable to the consumers and carers."

Equity of access to mental health services across different population groups was quantified as 0% because there was no data. This indicates that the type of care is not available or inaccessible. For instance, the density of psychiatric beds in or around the largest city is 3.28 times less than the density of beds in the entire country. Such a distribution of beds prevents access for rural users. A number of numerable reasons account for this use rate of 0% and some appear below.

Lack of Mental Health Care Services In the Community

I am sure I can confess many people do travel all the way from Kasama from Mongu, from Eastern Province from Ndola, Southern Province to come here for a review. And my government is saying their policy is to take this service closer to the family as possible. Which is not happening in the case of mental health instead we are seeing people flocking or coming all the way...... in Kamwala I felt unwell I wanted some attention. I went to Kamwala clinic Oh dear me! A nurse came out so strong and told me “baba kansi kuno ni ku chainama” (man is this Chainama?) he said whoo sure at aa ndani ana kuuzu ife kuno ti stokinga minkwala yo ofuntha? She said whoo sure aaa who told you that here we stock medicines for mad people.

(User 2)
Distance and Drugs

A patient from Shangombo who is referred to Chainama hospital, if they don't have the money definitely they will not have access to good treatment. If they don't have anybody to support them, they will not have access, therefore we could say the social economic impact is there on mental health, because even here in Lusaka, very few people have access to come to the hospital. And all the 27 clinics in Lusaka refer cases to Chainama. You know we have fluctuating drug stocks. Sometimes the balances usually go down. But most of the sometimes we have because the pharmacy at the hospital supplements.

(Registered Nurse and Sister-In charge)

III Mental Health in Primary Health Care

Mental health in primary health care has many facets and these include: financing, service delivery, human resource and training, infrastructure and research *inter alia*. What we found generally in this area is that mental health is poorly integrated in the mainstream health care system and it is given the least attention at macro and micro levels. In addition, mental health in our primary health care units is linked to stigma, marginalisation, Let us examine each one of these.

3.12 Financing of Mental Health Services

In the year under review, the proportion of the health budget to GDP was 3.9. Out of this, the proportion of the total amount of money spent for mental health services by the ministry of health was a paltry 0.38% (K 2 181 151 743.00). Out of this 48 percent was ascribed to the only mental hospital. The figure below illustrates proportionately the percentages of the expenditure towards general and mental health.

![Figure 8 Relative Expenditure of Mental health and Others in The Health Sector](image-url)
3.12.1 Out of Pocket Financing

Noting the absence of mental health related HMIS, we do not know the proportion of people living with mental illness. We do not even know the proportion of those living with mental illnesses that have free access to essential psychotropic medicines. For those that are able to finance mental health care through the operable out of pocket finance mechanisms, the cost of one antipsychotic tablet is ZMK 2, 400 ($1/2) and antidepressant medication stands at ZMK1 000 ($1/4). Noting the levels of human poverty that most people live on less than a dollar per day, and the chronic nature of mental illness, this cost is unaffordable. Given this scenario, one would hope to see relief from poverty through the implementation of health or social insurance schemes. Nonetheless, none of our mentally ill is covered by any health or social insurance schemes for they do not exist in Zambia. Below we show problems faced by people living with mental illness.

If someone has to spend K 200, 000 ($50) kwacha just for reviews or to be attended to here in Lusaka at Chainama, do you think everyone can manage that much? As a result of not affording such an amount, relapses and increase in mental health cases are results. We are creating poverty and if someone can spend K 100 000 ($25) ....

(Clinical officer Psychiatry)

The ministry of health has stated on paper that primary health care financing is integrated. However, there is a contradictory practice and some districts are funded directly. In addition, there seems to be variances in factors that are used to determine district financing. One Director says professional ratios, one alludes to disease burdens, another points at costs of medicines and one expresses lack of knowledge. But the question is which one is the determinant and how much is actually given?

Existence of Mental Health Budget

You can see this is the budget and mental health is everywhere, in fact you ask Dr. T we will come and show him, there is mental health everywhere all the districts, but the challenge is "make a difference"....for instance Nyimba district, mental health is 98 million, K798 thousand kwacha, then Mansa district mental health is 15 million, kwambwa district, mental health is 48 million, Chilengi is 3 million almost 4, Milengi not planned management its not a problem, Mwense, K2m, Nchelenge K57m, Samya K25m it goes on just like that.

(Director 2 Ministry of Health)

District Funding Of Mental Health Services

When one Director was asked as the basis for releasing the funds to the districts revealed that human poverty deprivation index was the determinant.

I think for the districts we have the resource centres based on ..... poverty deprivation levels, in the sense that poverty and ill health are inter related if you are poor you are likely to be ill at any time. So we actually respond to those deprivation conditions so that’s the criteria we use in allocating the districts.

(Director 2 Ministry of Health)
There is a canard that is surreptitiously told by the ministry of health to district officers and politicians that districts have an allocation of funding from Public Health Department at the ministry for mental health and that districts are not utilising these funds. The funds are said to be more than enough. Given this scenario, mental health workers are being blamed that they are not making an impact. The truth is that these funds are utilised by the program officer for the Public Health Department. In addition, there seems to be variance in factors that are used to determine district financing. One expert says professional ratios, one alludes to disease burdens, another points at costs of medicines and one expresses lack of knowledge. But the question is which one is the determinant and how much is actually given?

*Justification for the need of more money*

Yah so just tell Dr. T that we are not feeling your presence, so you have to justify as to why you need more money because you fail to use the little that you have been given. If they give you K10 and after one month you don’t use it what should they give you? Nothing. And you have a lot of money ie. Millions and millions in the districts, and it is being used for something else because there are no programmes. And note: that the allocation for mental health funds in hospitals is planned according to medicines and not programmes just like Obstetrics and gynaecology and paediatrics.

(Director 2 Ministry of Health)

*Lack of knowledge to determine monetary allocation*

To tell you the truth, I do not know how much money we allocate to mental health. That is a difficult question to answer, because we are just delivering this health package...If you are saying there is that money, I have never heard of that money that is news to me. I have never come across a budget allocated to the district for mental health. Anyway since you say it is there, I will verify with my accountant. The only money I know is the one which comes as a basket and I am sure mental health is included

(Director 3 Ministry of Health)

*Funds are enough*

You first said that mental health is neglected but is this neglecting when each district is being allocated with something; then I don’t know what neglecting means, because you people are even far much better than other programmes you know, but we are yet to see the impact.

(Director 2 Ministry of Health)

The contradictory sentiments from the directors on mental health financing seem to suggest lack of collaboration among directorates and this does not augur well for health service planning. In addition, the evidence that was availed to us affirms that financial resource allocation for mental health is there but it is not rationalised and it is deceptively said to be additional funding for districts and yet it is meant to be used by the public health office on mental health activities. These activities are said to be non-existent as claimed by district staff. Further than this, there is no evaluation report on
such activities from the public health office. It was difficult even to obtain a strategic plan at the time of the study though one was made available rather too late.

Hospital Funding of mental Health Services

For hospitals, we use ……..aa……. mainly we use the number of beds as factor, but those beds are based on bed professional ratios. And we allocate the no of beds for those facilities, so there is what we call, the cost per bed lay. So basically we use the bed professional ratios for the hospital, and those are the beds which are funded……. So what we do is that we protect the districts first, and then the hospitals and then the rest in support system are given because we know that prevention is better than cure. Because if we can prevent disease then we know that we are going to have health nation.

(Director 3 Ministry of Health)

A review of 2005 health budgets (integrated funding) shows that mental health is not funded as compared to activities like malaria, HIV/AIDS, Maternal and Child Health, tuberculosis and oral health inter alia which are succinctly reflected. A cursory look at the computation of the total costs meant for mental health in Zambia (inclusive of the public health office’s activities at the ministry) shows that it is lower than all other activities compared not withstanding the burden of disease. One would however note that the allocation of 0.38% of the total budget falls within the norm seen in low-income countries where mental health resources are completely absent or very limited. Such low-income countries like Zambia have no mental health programs or appropriate legislation; or, if they exist, they are outdated and not implemented effectively.

A point worth emphasising concerning the national and district budgets for mental health is that, it is very evident the budgets were not drawn basing on any published needs assessments23 and not even economic evaluations. Though these figures were presented grudgingly and painstakingly, it is evident that existing allocations of resources meant for the public health office in the ministry to address the un quantified and unqualified mental health burden are very low. It therefore follows that Zambia as a low-income country marginalizes mental health in the domain of financing as the picture seems to suggest based on World Health Organization (2001, 2005a) and Saxena et al, (2006) evaluations.

The assertion of integrated funding does not hold in Zambia’s case. It would be prudent that mental health is funded separately and planned for separately and allocations to mental health should be clearly articulated, rational and transparent. In addition, there is a need for accountability and planning of resources for mental health.

23 This includes establishing the prevalence, incidence and severity of priority conditions, estimating the service resources for the identified needs, and costing the resources for the estimated services.
3.13 Marginalisation and Stigma

Apart from funding problems, mental health in our primary care units is linked to stigma and marginalisation. Stigma contributes to loneliness, distress and discrimination against people with a mental illness and their families. Indeed, more than 40 negative consequences of stigma have been identified according to Byrne (1997) including discrimination in housing, education and employment and increased feelings of hopelessness. The end result is that many people are reluctant to seek help, less likely to cooperate with treatment, and slower to recover self-esteem and confidence. Tragically, this leads many to suicidal behaviour. It is important, therefore, for clinicians and other healthcare workers to appreciate that stigma and its associated prejudice form a very real barrier to recovery and may even be fatal. Discriminatory behaviour by mental health workers in general can also be implicated in the excessive premature death rate among people with mental illness (particularly from cardiovascular disease (Coglan, et al., 2001) — there is a tendency to ignore these patients' general health problems or discount them.

Marginalisation and stigma were evident at macro and micro levels and respondents provided varying vistas as shown below.

**Stigma and lack of mental health integration**

I felt unwell and I wanted some attention. I went to Kamwala clinic Oh dear me! A nurse came out so strong and told me “baba kansi kuno ni ku chainama” (man is this chainama) he said whoo sure ati ndani ana kuzuza ife kuno ti stokinga minkwala yo ofuntha? She said whoo sure aaa who told you that here we stock medicines for mad people…. They are not ready to offer mental health services in their clinic. … mental health has been excluded ….Imagine in my bad state I cant actually receive the treatment that I need at a nearest health centre within my locality until some one say imwe muzibika kudala ndimwe baku Chainama. Yendani Ku Chainama. (You are known that you are from Chainama. Can you just go to Chainama you mean not at any time have you ever stocked cabamazapine in this clinic? At sitiviziba nakuviziba ivo (We do not even know those things).

(User 1)

I think the government is not putting much on these special children and even the Ministry of Education itself you know…

(A teacher for pupils with special needs)

.... I answered you, even when we go to these planning workshops, mental health is not recognized as one of the top 10 priorities for health problems.

(District Supervisor)
First and foremost forgive me if I say this! There is no political will, about mental health in Zambia. If it was there, mental health was going to be given a lot of attention but the government itself stigmatizes mental health issues. It's like mental health is for “those” and not “us”...

(Registered Mental Health Nurse)

At the moment I wouldn't be comfortable to say the government is doing much. It's so little about what they are doing carrying mental health....So if it was lifted, mental health would also be up… So it is not recognized and that is why people are not training because of ignorance in mental health.

(Registered Nurse and Sister-In charge)

Relatives too discriminate I have experienced it especially from my relatives, most of the time even if I am not sick they want to bring me to the ward. Especially when they don't see me I don't know what they interpret they have to bring me to the ward even if I am ok.

(User 2)

Yah, there are cases where these pupils are referred to this school as “rejectees” coz of their being. And stigmatisation normally come from the community and not the within the school, as you can see, this is an integrated school and we are proud that the normal pupils have accepted their fellows. So really stigmatisation is only experienced in the community.

(Teacher specialized in dealing with teenage pupils with special needs)

But you people involved in the system do not involve us, where do we start from? You have a mental policy and act which involves the prisons, but have you ever invited one of us to represent our commission?

(Prisons Commissioner)

Psychiatry was side lined and that is the one of the case, we should have started if from the primary - secondary and then tertiary but you will find that even when you go for these meetings, even among the 10 top health problems have you ever had psychiatry, being one of them? Well, I remember that we had mental health corner in some of our upgraded clinics, where we had either psychiatry clinical officer/nurse managing those units in various health centres.

(Medical Practitioner)

3.14 Mental Health Care Providers

In Zambia, most of mental health care is rendered by non-physician practitioners called clinical officers and these are staff members who are at a level higher than nurses but lower than a doctor. They are trained for three years and have clinical skills that enable them to diagnose and treat mental illnesses though the law does not include them in administering psychotropic drugs. These clinical officers are based in primary care units (out patients units, long stay facilities and specialists services, psychiatric services in general hospitals and they link with other aspects of the health care system. They are in fact front line staff in the delivery of mental health care in
Zambia’s primary health care units in both long stay facilities and daily outpatient facilities. Where community outreach is needed, they are the closest one would find. Doctors rarely supervise their work since in most instances they work alone. There placement covers the top three portions of the WHO optimal mix of services (figure 9).

![Figure 9 WHO Primary health care Optimal Mix of Services](http://www.who.int/mental_health/policy/services/en/index.html)

One thing to be noted is that mental health services in Zambia are not shared equally by all people and this is on account of the fact that the ability to pay factor militates against the principle of Primary health care which states “Health services must be shared equally by all people irrespective of their ability to pay and all (rich or poor, urban or rural) must have access to health services. Primary health care aims to address the current imbalance in health care by shifting the centre of gravity from cities where a majority of the health budget is spent to rural areas where a majority of people live in most countries.” Noting that we do not have a fully established with our communities, the majority of mental health care is self managed or managed by informal community mental health services (for effective, example, community groups, religious organizations). From this, it therefore follows that this is one area that needs expertise and support so that there is a continuing effort to secure meaningful involvement of the community in the planning, implementation and maintenance of health services, beside maximum reliance on local resources such as manpower, money and materials.
3.15 Basic Training in Mental Health Care for Primary Care Staff

A cursory look at basic training in mental health care for primary care staff shows that for doctors, 8.3% of the training is devoted to mental health, in comparison to other disciplines: surgery 33.3%, paediatrics 16.7%, obstetrics and gynaecology 16.7%. As for nurses, 8.7% of the training is devoted to mental health in comparison to 26% to public health nursing, 23.7% medical nursing and 15.6% paediatrics nursing. 12% of the training for clinical officers is allocated to mental health as compared to 29% medicine, 23% obstetrics and gynaecology, 20% paediatrics, 16% surgery. This indicates a marginalisation of mental health.

3.16 Refresher Training In Psychiatry/Mental Health Care for Primary Care Staff

Training for non-doctor/non-nurse primary health care workers in vocational schools with at least two days of refresher training in psychiatry/mental health in the last year was inexistent. In addition, we did not make any assessments and treatment protocols in non-physician-based primary health care because we have no drugs and protocols of care. We however noted that mental health referrals from non-physician based primary health care units to the mental hospital per month was 81 - 100% and this is because the mental hospital has drugs and staff are perceived to be adequate. It is plausible that the low or non availability in non-physician-based primary health care clinics of one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) could be the single factor for referral. The need and constraints for retraining were presented by mental health workers in relation to a number of issues.

In Service Training - Long and Short Courses

In mental health, I think there isn't any in service training apart from those clinical officers who are doing post basic in the general medicine.

(Clinical Officer Psychiatry)

No I don't have sufficient training to formulate nursing care plans and carrying it out for mental disorders? We also don't have any in-service training that up-dates us on the current trends in psychiatry....No no no, to the best of my knowledge we have not included in that area mostly it is just in the general area.

(Registered Nurse and Sister-In charge)

Emphasising Retraining

In-service training do not take place in-service courses don't take place. As a person who has worked at the psychiatric hospital for a long time 20 years technology changes I feel from time to time people should be taken for in-service courses to update us because there so many conditions which come with new illnesses.

(Enrolled Psychiatry Nurse)
Retraining and Human Resource Shortages

Yes and No, there are few professional courses being carried out at Chainama College, if a nurse applies, or a member of staff applies, they will be told you can’t go because there is a shortage of man power. Right now there are some nurses who have applied to go for training, but they have been told they can’t go due to critical shortage of staffing. No in-service training.

(Registered Mental Health Nurse)

3.17 Prescriptions by Non-Doctor Primary Health Care Workers

In Zambia, prescriptions by non-doctor primary health care workers are interdicted by law (The pharmacy and poisons act). However, for practical reasons, Clinical Officers are allowed to prescribe and/or to continue prescribing psychotropic medicines.

3.18 Alternative Care and Interaction with Conventional care

It was observed that the conventional system of physician-based primary health care clinics with its counterpart traditional do not interact in a complimentary/ alternative/ manner. There was no evidence of interaction in form of meetings, review of individual cases, co-ordination of activities and of referral issues, as well as training complimentary/alternative/traditional practitioners in relevant aspects of mental health of non-physician-based primary health care clinics with complimentary/ alternative/ traditional practitioners. The excerpts below attest to these observations.

Selective Conditions for Healers

Why, can’t there be somewhere else where they can be referred apart from Chainama? Right, why not UTH, you see, so discrimination is getting very, very deeply rooted, the clinics can play a part because there are certain psychosomatic cases which can be handled easily and quickly by us…..

(Traditional healer)

So let the clinics start to do something as 1st aid or first handling of a case. Before that case is referred to Chainama. So – work is important, but also the leaders must know as to when they can refer to Chainama and do you people really know the difference between – demons and the real madness? Because if somebody goes in a trance, they start speaking in tongues, that are not madness but spirituality, that is demon possession, if someone is being haunted by a ghost, it set by JUUU, it is not madness, if somebody starts speaking in Swahili the language he/she has never spoken before, then you know that the spirits is speaking through him. It is not madness.

(Traditional healer)
IV Human Resources

3.19 Staff Norms and Mixes

The existing staff strength and job allocations to address this burden remain very low in Zambia being one of low income countries and this is despite an increasing consensus among stakeholders on what mental disorders and interventions might constitute a basis for scaling up. The bulk of staff rendering mental health services are non physician based primary health care practitioners and these are nurses and clinical officers who were not initially trained in mental health.

Macro level interviews reviewed a pertinent challenge that there are inadequate numbers of mental health specialists, such as psychiatrists and psychiatric nurses, to serve the population and that there were displacements of human resources as well as misuse and that primary care providers are largely untrained in mental health care. The excerpts below attest to this.

Head count

It is now that the human resource department has started head counting. They have been going to the institutions and specifically counting every person and their title. What I know is that we to lump clinical officers lab, nurses together and we do not know who is suppose to be doing what?

(Director)

Staff misplacement

And this same head count that they have been doing has been telling us who are psychiatrist personnel and what they are doing are they in general work or they are doing psychiatry. But you find that when you go deeper out of town the people trained in psychiatry are actually doing general work, because some times the general personnel are not there. So they actually forced to do general work as well as psychiatry. But some of them even forget about psychiatry. They just do general work; we have just been going round the country to do a laboratory survey. But what we found is that people are not actually in their positions as they are trained and this is a common phenomenon for all of us. It is a little bit tricky, with the staff shortage, Nurses, clinical officers lab and environmental officers are working in outpatients.

(Director)

There are no workers, no workers, so if you stimulate districts that they should present mental health they should have people to work with, they are referring patients to Chainama because there are no professionals. I mean if you have nurse and general clinical officers, they are not trained in mental health so they shift patients to the main hospital where they think there are experts there

(Director)

The prevention system is not working that is why they are shifting patients to Chainama....We give you money you are doing nothing.... Ha, ha, patients are being referred because of no prevention programs; if you were doing that, no one would fall sick.
Even here in Lusaka, where did you hear people talking about prevention in mental health, never not even a single day? HIV/AIDS, malaria, are going round every time. T.B you been feeling their presence but mental health, nothing you stay across Chainama, nothing happens there. Not even sensitization, not even pamphlets, so what do you want us to do?

(Director)

3.20 Human resources working in or for mental health facilities

In Zambia, we are at the moment unable to provide accurate estimates of figures of human resources in mental health facilities per capital human resources working in or for mental health facilities or private practice per 100,000 population by profession. However, the data sources estimate that the total number of human resources working in mental health facilities or private practice per 100,000 populations is 1.06 with the breakdown as shown in table 5.

Table 5 Human resources working in or for mental health facilities or private practice per 100,000 population by profession.

<table>
<thead>
<tr>
<th>Type of mental Health worker</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>0.025</td>
</tr>
<tr>
<td>Other medical doctors, not specialized in psychiatry,</td>
<td>0.041</td>
</tr>
<tr>
<td>Nurses</td>
<td>UN</td>
</tr>
<tr>
<td>Clinical Psychologists</td>
<td>0.016</td>
</tr>
<tr>
<td>Social workers</td>
<td>0.008</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>0(^{25})</td>
</tr>
<tr>
<td>Other health or mental health workers (including auxiliary staff, non-doctor/non-physician</td>
<td>1.750</td>
</tr>
<tr>
<td>primary healthcare workers, health assistants, medical assistants, professional and</td>
<td></td>
</tr>
<tr>
<td>paraprofessional psychosocial counsellors)</td>
<td></td>
</tr>
</tbody>
</table>

There is only one psychiatrist who works only for government administered mental health facilities and two work for the University of Zambia as lecturers. There is also one psychiatrist working in the private sector. Twenty seven point three percent (27.3%) of nurses work in government facilities 14.8% of the clinical officers work in government facilities 100% of medical social workers work in private organizations and 100% of clinical psychologists work in government facilities.

Regarding the workplace, 2 psychiatrists work for the University of Zambia and one for the mental health hospital. No psychiatrist works in community-based psychiatric inpatient units. Four other medical doctors not specialized in mental health work in the only mental hospital and none of them work in other facilities, none in community-based psychiatric inpatient units. The proportion of psychiatrists, clinical psychologists and

\(^{24}\) The number for the nurses is unknown because we do not have national collated data and what is available excludes those in private practice.

\(^{25}\) We only have an assistant occupational therapist.
social workers, working exclusively for the government and not in various mental health sectors was 100%.

Table 6 Number of full-time or part-time mental health professionals per mental hospital bed per 100,000

<table>
<thead>
<tr>
<th>Type of mental Health worker</th>
<th>#</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>3</td>
<td>0.01</td>
</tr>
<tr>
<td>Other medical doctors, not specialized in psychiatry,</td>
<td>5</td>
<td>0.02</td>
</tr>
<tr>
<td>Nurses</td>
<td>35</td>
<td>0.19</td>
</tr>
<tr>
<td>Psychologists, social workers, and occupational therapists</td>
<td>3</td>
<td>0.01</td>
</tr>
<tr>
<td>Other health or mental health workers</td>
<td>41</td>
<td>0.20</td>
</tr>
</tbody>
</table>

As for nurses, 100 work in outpatient facilities, none in community-based psychiatric inpatient. 3 psychosocial staff (psychologists, social workers and occupational therapists) works in outpatient facilities, none in community-based psychiatric inpatient units. As regards other health or mental health workers, 24 work in outpatient facilities.

Table 7 Human resources working in or for mental health facilities or private practice per 100,000 population by profession.

<table>
<thead>
<tr>
<th>Type of mental Health worker</th>
<th>#</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>3</td>
<td>0.01</td>
</tr>
<tr>
<td>Other medical doctors, not specialized in psychiatry,</td>
<td>5</td>
<td>0.02</td>
</tr>
<tr>
<td>Nurses</td>
<td>100</td>
<td>0.17</td>
</tr>
<tr>
<td>Psychologists, social workers, and occupational therapists</td>
<td>3</td>
<td>0.01</td>
</tr>
<tr>
<td>Other health or mental health workers</td>
<td>24</td>
<td>0.20</td>
</tr>
</tbody>
</table>

The scenario shows that the staff norms are not adequate to provide quality care to people living with mental illnesses. The excerpts below add a plethora of constraints and effects.

**Time factor**

Similar to the findings of Jones et al., (2004) we found that time was a factor in providing effective and efficient health care. In the units, the time factor was widely acknowledged by both patients and doctors to constrain the most effective ways in which mental health care could be delivered. More than half of the respondents interpreted the main problem as being “how many people the doctors, nurses and clinical officers had to deal with, and the consequent lack of time” to manage each one of them and to discuss personal problems.
Improvisation

You are actually right, that's a sad part of it, so now, it's like we have to do some short cut, you know, you don't have to be so patient because this might led to ……….. you know you can have a patient who really needs time to be attended to but I only do it for 15 minutes and just to touch on the surface without going deep and this is not the way it is supposed to be done but because of manpower problem, things are being done wrongly.

(Clinical Officer General)

3.21 Training professionals in mental health

We do not have any figures for the number of professionals graduated last year in academic and educational institutions per 100,000 among psychiatrists and nurses. However 0.375 doctors were trained and graduated. For all staff, none had an opportunity to attend at least 1 year training in mental health care. There is no evidence that any of mental health care staff attended refresher training on the rational use of drugs, psychosocial interventions, or child/adolescent mental health issues.

<table>
<thead>
<tr>
<th>Type of mental Health worker</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>0.375</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>UN</td>
</tr>
<tr>
<td>Psychologists with at least 1 year training in mental health care</td>
<td>UN</td>
</tr>
<tr>
<td>Nurses with at least 1 year training in mental health care</td>
<td>UN</td>
</tr>
<tr>
<td>Social workers with at least 1 year training in mental health care</td>
<td>NA</td>
</tr>
<tr>
<td>Occupational therapists with at least 1 year training in mental health care</td>
<td>NA</td>
</tr>
</tbody>
</table>

A great many of our respondents were trained at Chainama College of Health Sciences and mainly as enrolled nurses, mental health nurses, clinical officers general and psychiatry. As for the medical practitioners, they were trained at the University of Zambia. A greater number of mental health care providers who are in very critical areas of care are not trained in psychiatry but only in other specialties or have the skill and knowledge in general care only. Below we present the scenarios on training.

Qualified Trained Staff

I first did clinical officer general then afterwards, I specialised in clinical officer psychiatry.

(An advanced diploma holder in clinical psychiatry)
I was a Registered Nurse and now I have done Registered Mental Nursing; I have been running the ward at the same time instructing students as a clinical expert.

(Registered Mental Nursing)

Untrained Staff in Psychiatry

I am a Clinical Officer General, by profession and I have been working here in the area of psychiatry. This is my seventh year.

(Clinical Officer General no post graduate training in psychiatry)

Basically I have been working in this institution for two years now I am turning into my third year this march 2007....This is a psychiatric hospital that offers basically treatment and management to mentally ill patients.

(General Nurse no post graduate training in psychiatry)

I have been working as a registrar in the psychiatric dept, here since 1997. So currently am in charge of female wards.

(Medical practitioner)

I am a Dr. and hold Bachelor of Sciences, Human Biology, Bachelor of Masters and Bachelor of Surgery. I went to the University of Zambia in 1994 and I graduated in 2001. Thereafter I worked as a Senior Housing Officer; initially it was Junior Housing Officer then Senior Housing Officer at UTH. Then I was sent to Maamba Hospital. I worked there briefly and then came back then I applied in 2003 to Chainama Hills Hospital, where I worked up to April, 2004 then I applied at the University of Zambia to be on Masters in Obstetrics and Gynaecology which I did for one year then I was sent to Kawama Hospital I was running the hospital there, and there were some political issues then I was sent back to Chainama here. So I have been in Chainama from last year August. I don't know if that is enough for the brief background.

(Genral Medical practitioner no post graduate training in psychiatry)

I am a medical Dr. by profession, and I am in-charge of clinical care services for the district. I have not had any specialist training in psychiatry.

(Director Clinical Care and General medical practitioner)

3.22 Membership and Support

In Zambia, we do not have users/consumers that are members of consumer association and not even family members that are members of family associations. But once in a while the government provides economic support to user/consumer associations for mental health. There is no evidence of government economic support for family initiatives say through the ministries of community development or health.
3.23 Public Education and Links with Other Sectors

When it comes to addressing mental health between the public education system and other sectors, linkages have not been developed. This has been compounded by the lack of coordinating bodies (e.g., committees, boards, offices) to oversee public education and awareness campaigns on mental health and mental disorders. However, only the Ministry of Health through the public health office attempts to do this but it is on a small scale. Children, adolescents and women who are more vulnerable to mental ill health are not targeted specifically. There is no marked evidence for public education and awareness campaigns on mental health targeted at professional groups, leaders and politicians in the last five years.

What the study has found is that although stakeholders have noted that mental illness is cross cutting, the problems arise when it comes to who is the principal social actor to initiate the determining if issues that are cross-cutting. Increasingly, issues of the present day mental health are multi-faceted and multi layered often involving more than one department, level of government or non-governmental agency and users. Policy and planning for mental health are therefore often cross cutting or have horizontal implications. Thus one of the critical strategies to successful policy development and mental health planning is to identify who needs to be involved in the process. Policy leaders and managers need to admit now on the basis of the data at hand that mental health policy and planning are crosscutting and if so, they need to ensure that the “right” people are included in the policy development and planning process. The following excerpts attest to the need for linkages in general.

**Links with Community Care**

All I remember is Matero After Care centre which takes care of the discharged patients who don't have relatives to take care of them. I have heard the existence of a home of the aged, but it doesn't specifically keep those with mental illness. I have heard of other schools, which take care of the mentally retarded. But we do not have links with them at all.

(Enrolled Psychiatry Nurse)

**Links and stigma**

As you know that I have had this illness from 1995, I wanted to settle down....So I visited the Ministry of Community Development and Zambian Agency for the people who have disabilities trying to see how I can be assisted, but again this is quite tricky because even these agencies as far as their operations are concerned no one knows how you can get in, wooo!!! Equally someone with a mental health is seen from a negative side, you couldn't because my experience there was that even these government agencies would actually consider or pay more attention to people who are blind, deaf, handicapped that category, but someone with a mental health problem oh I am sorry you seem to be just like other creature out there. You can't be accommodated you can't be given services.

(User 2)
**Net Working and Coping Skills**

So we formed network for young adults with people with mental health problems and then introduced the network to the hospital. At the time we had Mrs X as a group psychologist who actually supported the idea and eventually she came to propose that we should actually come up with an organization that will be all embracing it shouldn’t actually stigmatise us because actually to her, she was targeting the youths who were actually discriminated, the other people, the adults, the older and things like that, so I said ok we will come up with a name then come up with an organization that would be all embracing, thus how we formed mental health users network of Zambia. But the problem was whom do we link up with? The hospital seemed not to have any idea.

(User 1)

3.24 Participation in Educational Activities of Other Key Public Workers

Police officers, prison wardens and judges have not participated in any educational activities on mental health in the last 5 years and yet we have prisoners, remandees with mental retardation, psychosis in treatment contact with a mental health professional, either within the prison or outside in the community.

3.25 Legislative provisions to mitigate the welfare of people living with mental illness

We do have legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled and we also have legislation concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder. However, we are yet to have legislative or financial provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders and or financial provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders. We are far from formally collaborating programmes addressing the needs of people with mental health issues between (a) the Public Health Office in the Ministry of Health that is responsible for mental health and (b) the departments/agency responsible for:

1. Primary health care/ community health.
2. HIV/AIDS.
3. Reproductive health.
5. Substance abuse.
7. Education
8. Employment
9. Housing
10. Welfare
11. Criminal justice
12. The elderly and
13. Other departments/Agencies (specify in comments section)
We are yet to make provision of employment for people with severe mental disorders, through activities outside the mental health facility.

The proportion of primary and secondary schools with either a part-time or full-time mental health professional (e.g., psychologist, social worker, nurse specialized in mental health) is unknown. Following the introduction of training teachers in special education at the University of Zambia, the number of primary and secondary schools with either a part-time or full-time mental health professional (e.g., psychologist, social worker, nurse specialized in mental health) now amounts to 7 and all of them are in private schools.

3.26 Monitoring Evaluation

At the time of review of Zambia’s mental health system, there was no mental health strategic plan. Routine data on mental health service delivery is not available to inform a mental health strategic plan. We do not have a formally defined list of individual data items that ought to be collected by all mental health facilities that include critical data like: the number of psychiatric beds, number of admissions, and number of days spent in hospital and diagnoses. The proportion of mental health units and other primary care units that routinely collect and compile data by type of information is not known. However, Chainama Hills Hospital has its own data collection methods and tools and it is the only reliable mental health unit. Given this scenario, the planning unit and the information management unit in the ministry of health received no data in the last year and no report covering mental health data has been published by the government health department in the last year.

From the time the ministry of health embarked on the health reform agenda, several projects have been implemented. The ministry of health has had a number of strategic plans. We were unable to be availed any monitoring calendar or outcomes for any mental health activities and this may suggest that monitoring is not done or if it is done, then report are not made or if made, then they are just not distributed to potential consumers. The ministry however, claims that it has some monitoring and evaluation and yet it does not have a mental heath monitoring and evaluation system. Given this scenario, it is difficult to monitor and evaluate the appropriateness of policies. Noting too that there are no indicators, we are not in a position to understand whether the current policy and the draft plans have achieved their intended objectives. So far from the time the mental health policy was conceived hitherto, we are not able to (i) evaluate and monitor the policy development process and the planning of the implementation and (iv) assess whether the objectives of the policy will be met, or to what extent they relate with the indicators. We do not seem to have any tools for monitoring and evaluating previous, present and future mental health projects. We also do not have measures of performance and as such it is even difficult to gauge performance. Performance measures typically evaluate the structure, process, or outcomes of care (Donabedian 1980, 1982, 1985) and are expected to be important, scientifically acceptable, usable and feasible (McGlynn 1998, 2003b; Kerr et al. 2001).
Noting the absence of monitoring tools and outcomes, we have observed that:

1. Monitoring and evaluation of all planned mental health activities is seems to be unimportant to the ministry of health. The ministry seems emphasise planning and implementation (box 1 and 2) but fails to check for outcomes (box 3). This makes the ministry failing to realise that monitoring and evaluation ensures that the organization is following the direction established during the strategic planning.

![Figure 10 Relationship between Planning, Implementation, and Program Outcomes](image)

2. Effectiveness of mental health projects cannot be ascertained – the extent to which the project or program process has achieved its purpose(s). Depending on how effectiveness is defined, an effectiveness review can be conducted against the terms of reference, the information provided to decision-makers or principles and criteria of good practice and;

3. Performance of mental health projects cannot be ascertained and this is about the success story or failure story of the project or program process as measured by its outcomes and results.

The ministry however, claims that it has some monitoring and evaluation and yet it does not have a mental health monitoring and evaluation system. Given this scenario, it is difficult to monitor and evaluate the appropriateness of policies. Noting too that there are no indicators, we are not in a position to understand whether the current policy and the draft plans have achieved their intended objectives. So far from the time the mental health policy was conceived hitherto, we are not able to (i) evaluate both, as documented; (ii) monitor the implementation of the plan; (iii) evaluate the implementation of the plan; and (iv) assess whether the objectives of the policy have been met, or to what extent they have been met. We do not seem to have any tools for monitoring and evaluation except for the general or aggregated assessments and we do not have any mental care plans. Many respondents including experts have argued that nationwide mental health quality improvement will not take place without the establishment of national information standards that are all embracing, having common measures of performance and guaranteeing transparency of information around quality
and costs. It may be inferred from this state of affairs that the elements of quality improvement efforts in mental health care — safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity are unlikely to be addressed under the present arrangements. Withstanding these observations, the excerpts below testify.

Absence of Monitoring and Evaluation

The health reforms did not do us well. We are still occupied with inspections as evaluations. I think that is why we lost direction, if you talk of inspection, they were there the health inspects from the public health directorate but they were busy scrambling for positions. So you look at the inspection just did a national date and we are still struggling to see whether we can revamp the thing lower enforcement for the laws that fall within the sector was just going down. We have just lost direction, and I hope as this structure, we won't fall into the same trap.

(Director 3 Ministry Of Health)

Ambivalence out the Monitoring System

The monitoring system is there but because of the poor monitoring arrangements and accurate indicators, we cannot come up with accurate accounts.

(Director 3 Ministry Of Health)

3.27 Research

On the research front, there is little research being done in mental health in Zambia. The extent and content of mental health research in the last five years accounts for a paltry 3.3% and this involves epidemiological, service and clinical domains only. There is need for future policy on mental health to consider research in mental health epidemiology since it represents a common starting point for many economic analyses of mental health care and policy formulation, whether on the basis of identified socio-economic risk factors for psychiatric morbidity (such as income level / poverty, or employment status), underlying incidence, prevalence and other data for modelling economic burden or intervention cost-effectiveness, or the study design for clinical and economic evaluations.

While the ultimate objectives of the two disciplines (health economics and epidemiology) may differ – efficiency concerns on the one hand, aetiology and risk factors on the other – both are essentially pitched at understanding the consequences of disease and its treatment at the level of the population. Policy developers, analysts and planners need to consider research as a cardinal activity. This is because the two disciplines when they embrace research can be viewed as offering complementary perspectives on mental health policy review, formulation, planning, monitoring and evaluation. A good example of the link between health economics and epidemiology relates to the estimation of national and global disease burden. In particular, the Global Burden of Disease (GBD) studies set out to provide a set of internally consistent estimates of incidence, prevalence, duration and case-fatality for conditions and their
disabling consequences, which could be used to generate summary measures of population health capable of being linked to resource allocation decisions (See Murray and Lopez (1996) for an elaboration.

3.28 Respondents’ Perspectives on the Way Forward

Our respondents observed a number of problem areas and they were eager to suggest possible solutions. Below we present excerpts of possible solutions.

**Inter ministerial integration**

...Yes, mental health can only be integrated in our system if you people invite us in your activities that you do. You should be forming workshops where you invite us and discuss as to how we can work together in dealing with these people, and am not just saying you invite the prisons alone, but all the stakeholders who seem to be playing a role in managing these people. In that case, mental health can even be specialised in our Act, unlike falling under the general health which is stated in our Act. ....Coming to training of our officers in psychiatry, I think that is a good idea, as long as you discuss this with the police us and the police service commissions since the train some of our officers and develop curricula. So if you, the owners strongly involve us to work hand in hand, then all is well for mental health, and that's what I can say.

**(Prisons Commissioner)**

**Solutions and Opportunities to Staffing**

We need a directorate to represent us and I am not saying that the person who is there is incapable, he has done a lot for mental health, but when it comes to argue with the other people, we need also to be there at a directorate level, so that is why there was even a proposal that a directorate should be there and we hope that will be done soon. Just like in other countries like Zimbabwe, Malawi, Botswana and South Africa etc. they have mental health directorates in their ministries.

**(Director Clinical Care)**

Coming to training of our officers in psychiatry, I think that is a good idea, as long as you discuss this with the police and the police service commissions since the train some of our officers and develop curricula. So if you, the owners strongly involve us to work hand in hand, then all is well for mental health, and that's what I can say.

**(Director of Policy, Prisons)**

...for social workers we must have three - about that number then we shall be sufficient. In the EEG department, I think we need somebody understanding me or they should just like we have co-operation with Leeds University, they can just be training EEG cadres so that we can have continuity in delivering the service to the public......

**(Focus group of Clinical officer Psychiatry)**

Just to add on for the social worker I think we need more of a psychiatry social worker even for the psychologist, we need a clinical psychologist. Because certain cases need somebody who is specialised in that field. And for the nurses most of the nurses practicing in the hospital are general nurses they are not trained in psychiatry and those who are
trained are those who just trained in enrolled psychiatry nurse not necessarily in registered nursing. So we need more of registered mental nurses and we need more psychiatric social workers, clinical psychologists and other carders in relation with psychiatry.

(Focus group of Clinical officer Psychiatry)

**Need for a Statutory Desk Office**

..... I believe myself that the level of mental health representation in the ministry is too low to be forceful in the decisions that are being made in the by the ministry. In other countries, mental health is a full directorate or full department in the ministry, for example in Zimbabwe and Kenya is actually regulated by the mental health services act, so even when there is a recognition in the ministry, the last person to temper with is the director of mental health because his position and work is neglected by the Act or supported by the act so to say. But here in Zambia you know very well, this is a responsibility vested in one person who is able but falls short of the power to reach where the decision is supposed to be. Look at the office he is accommodated in and am sure this office is even better coz it has a window, if you are looking for this person, you really have to work hard to find him, not because he is not at work but because he is alone, no supportive staff, the structure is not known. If he has to see the PS, he has 10, 20 people ahead of him, before he can do that. So we think the ministry of health needs to attend to that very quickly, after all, the cause of death in this country among the 1st ten, mental health is being ranked 6th so, if that is the status quo, why don’t they translate that in the structure of the ministry as well?

(Director of NGO)

**Need for insurance**

And we are also trying to look at the health insurance issues, like how we can put health insurance services into our ministry and even on employment issues like employment insurance. But we have not specifically looked at the mental ill aspect but we are trying to come up with some kind of social health insurance like at the moment you know the poor people, the vulnerable, they don’t really have the dependable kind of the health system coz if you go to hospitals apart from the introduction to rural areas you have to pay something you see,... Sometimes even when it is free, but you have to buy drugs on tryouts own, like for the old, its supposed to be free but you will still find that they are given prescription to get drugs on their own. But if you have something like health insurance then it should be accessible to all. We will have quality health services for everybody including the mentally ill and this means that everyone will be catered for. And this will only mean if we put it in place. So from this angle that’s how we can deal with the mentally ill.

(Officer in the Ministry of labour and Social Services)

The respondents in this study have expressed ways to address what they considered were critical problems. For instance, the need to have ideal staff norms and mixes if delivery of mental health care will be effective and efficient was emphasised. Expansion of psychiatric training is needed in Zambia. It would be prudent to have psychiatric training carried out within the country so that the training can be most appropriate for the needs of the mental health system befitting our desired staff norms and mixes based on the available resources. To effectively assign resources, policy developers, leaders and managers need to: (i) be clear on the “inventory” of expertise and knowledge of their staff; (ii) identify the particular mix of skills required for a given policy project; and (iii) assemble the resources that most closely fit the skill set identified as required under the given circumstances.
Noting that we have a critical shortage of psychiatrists, occupational therapists, social workers and psychologists, it would be prudent to assign suitable resources to address the human resource problem at hand. This is a critical aspect of leading policy development/managing the policy and planning care processes. Notwithstanding Zambia's context of stretched resources, it may be prudent to rely on building the present staff and this may require retraining the untrained primary health care workers in mental health, upgrading some mental health programs through refresher training and particularly primary health care nurses and clinical officers. It may also need reprioritizing out-patient work.

Based on these observations, regional collaboration on training and particularly for psychiatrists could be an alternative. This could be beneficial to Zambia especially that she has inadequate resources and training facilities. The World Psychiatric Association may be approached in this domain because it has produced and implemented many educational programs for the benefit of those seeking continuing medical education. The World Psychiatric Association has worked together with the World Federation for Medical Education and the World Health Organization to close the gap between psychiatry and the rest of medicine, promote a better understanding of mental illness and care for the mentally ill and strive to introduce improvements to medical education. In this regard, WHO and the World Federation for Medical Education may be considered as cooperating partners.
CHAPTER FOUR — DISCUSSION

4.0 Introduction

The purpose of the discussion chapter is:

1. To summarise the main findings from the Results chapter;
2. To comment on these results, and relate the findings to previous research and
3. To discuss these findings and make recommendations for future action

This study set out to answer seven research questions and the answers for each of the questions are as follows:

**What is the context of mental health in Zambia?**

Regarding the context within which mental health care takes place in Zambia, we have observed that the political climate is conducive to policy reform in the sense that government has been dynamic in bringing about rapid development. The ministers of health have been instrumental in policy changes suggesting availability of political will. It should be noted that national poverty and individual poverty are critical in mental health care and need to be considered in the design of mental health care plans and programs. There is need to consider capacity building of our mental heath system and particularly increase resource allocation. The social, political and economic environment in Zambia does not accord priority to mental illness from the macro level to the micro level a factor that needs to be addressed urgently. Socially, people with mental illness exhibit felt as well as enacted stigma.

**What is the current situation regarding mental health care within the country?**

This research question yielded the most data. It had five components: Mental Health Services, Mental Health in Primary Health Care, Human Resources, Public Education and Links with Other Sectors and Monitoring and Research. The answers worth exhibiting are as follows.

As far as Mental Health Services are concerned, there is no mental health authority in the country. However, at the ministry of health, there is a directorate of Public Health that is said to coordinate mental health care. There is evidence of minimal integration of services in mental health but we do not have formal arrangements in spite of the existence of the mental health authority in the Public Health Directorate. Mental health services are not fully fledged in the sense that care is not wholly provided in all our outpatient facilities, day treatment facilities, community-based psychiatric inpatient units, community residential facilities, mental hospitals, forensic inpatient units and other residential facilities. This is because some of the service areas do not exist. Care is further compounded by the absolute lack of : drugs, psychosocial treatment, availability of essential psychotropic medicines and inequity of access to mental health services, as
well as severe lack of critical mental health practitioners. Service delivery is critically affected by lack of monitoring and research.

What are the Policy and Planning Processes in the Public Sector?

Policy planning process in the public sector is presently guided by cabinet guidelines and a three stage process is followed before a policy can be implemented. In terms of mental health policy processes and content, it fails to meet the World health Organization standards and public theory and practice. It is over three years now that the policy was adopted by cabinet office, but it has not been officially launched, and we have not sat as a nation to: (i) determine the strategies and time frames, (ii) set indicators and targets, (iii) determine the major activities (iv) determine the costs, the available resources and the budgets. We have not yet (i) developed a mental health program, (ii) considered any implementation issues for policy, plans and programs, (iii) disseminated the policy, and (iv) generated political support and funding. We are yet to: (i) develop support from key organizations, (ii) empower mental health providers (iii) reinforce intersectoral coordination, and (iv) promote interactions among stakeholders.

How have the mental health policies been developed?

Policy development process in the public sector is presently guided by cabinet guidelines and a three stage process is followed. In terms of mental health policy process, the same defects observed in the planning are evident. At the moment, the adopted mental health policy would not be handy in guiding the design of Zambia's mental health system because it was planned based on a hypothetical situation and not driven by any evidence. This is contrary to what Kingdon (1995), Davies et al., (2000), Soroka (2002) and WHO (2005a) assert as an ideal policy processes and contents. Other than these tenets, the policy panning process does not seem to have begun with a clear agenda or problem; there is no clear identification of who was to be involved in the policy formulation, how the elements of the policy were to be agreed upon and communicated. There is no evidence of the mechanisms for implementation including plans and budgets and not even the manner of policy evaluation and monitoring.

In addition, the current mental health policy fails to provide a framework for enactment or review of mental legislation. In the absence of a policy, monitoring and training on human rights has been futile or inexistent. Further than this, we are not in a position to make a definite stand on mental health financing because we are yet to determine the disease burden.

Who are the Critical Stakeholders and in what ways do they influence Mental Health Policy Formulation?

The ministry of health considers critical stakeholders who are likely to influence mental health formulation to belong to staff within the ministry and these are identified according to interests groups. There is no regard for Stakeholders with (i) responsibility for funding, (ii) responsibility for provision (iii) responsibility for regulation (iv)
international organizations (v), non governmental organizations and other line ministries as critical partners in mental health care. As stated earlier, these additional stakeholders are critical in the formulation of mental health policy, and should be included in future mental health policy initiatives.

*In what ways are the Mental Health Policies appropriate?*

The current mental health policy fails to meet the benchmarks of the essentials of a mental health policy, as shown in the results, above.

*What alternatives exist to improve and strengthen current mental health policy development in Zambia?*

There are several weaknesses and negligible strengths in the Zambian mental health system as shown above. Compared to many other African countries, Zambia does not have a policy in action and not even a well resourced mental health service. Its human resource and financial bases, including facilities and psychotropic medications are in dire straits. Noting the shortfalls in the policy making processes, there are indeed alternatives to improving and strengthening the current mental health policy development in Zambia. Since we have an indigenous policy formulation mechanism (The cabinet booklet) which is too general and it is supposedly a document which ought to be used by an expert with prowess in public policy theory and practice.

Having presented the answers to the research questions, this study about Zambia’s mental health system has shown the importance of having a society being a system of social structures (economic, legal, health structures) that ought to be purposively and well integrated to confer its citizenry quality health care as close to the family as possible. One criticism of the current mental health system is that is fluid in the sense that there is a mental health policy but not in action - without plans and programs and that the existing 1951 law is redundant (not used).

Globally, health is now universally regarded as an important index of human development and that it is maintained on scientific premises of evidence driven research and ideal laws.

Policies of human development not only raise the income of the people but also improve other components of their standard of living, such as life expectancy, health, literacy, knowledge and control over their destiny. Health is both a major pathway to human development as well as an end product of it. Health and development converge and contribute to each other. While it is true that health is not everything, it is also true that without health, everything else is nothing. This is not the reality and philosophical thinking of mental health policy practice in Zambia noting the increasing marginalization of mental health.
It may be mentioned here that Zambia needs a better and comprehensive health care system since it is one of the prime objectives of development. It is important to realize this when we look at development at large in our context. The interrelationship between mental health and general economic development is complex and very well understood. Better mental health care is both an objective of and an instrument for development. Poverty denies access to mental health in terms of status and services and health is a crucial link between poverty and reproductive choice.

The mental health needs of the greater majority in our Zambian society are not being met. The needs are not being met because the health system is dysfunctional from a structural level as well as from a regulatory level. There are no interconnections existing within the Ministry of Health and between the ministry and other sectors because there is no mental health policy in action. In addition, the 1951 mental health law that was inherited from the colonial legacy has failed to confer rights and obligations to people living with mental illness and carers. Instead it strives to protect the general public only from perceived dangerous mental patients, while failing to uphold the human rights of people living with mental illness. The mental health law seems to be redundant as it is not used. Noting that the structure within which mental health care ought to be provided is in place, we see that other health disciplines or priority conditions are prominent and well catered for. On the contrary, as for mental health, it is marginalised.

We have established that apart from the systemic problem, the other critical problem is integration and this is financial, structural and/or clinical practice integration. The problems of integration are rooted in the faulty design and the following are evident:

1. There is no inter-directorate integration in the ministry of health.
2. There is no integration between the community and the health centre.
3. There is no intersectoral (ministerial) integration.
4. There is no clinician integration whereby we do not have a significant number of trained health workers who could provide mental health care at all levels and the service units are not composed of interdisciplinary teams. Clinical integration may or may not be present, dependent on the local arrangements among mental health and physical health care providers. Across the country, most clinical practice integration is “person dependent”, not systematically designed into the process of delivering care in either the primary care or tertiary setting.
5. There is no clinical practice integration in the sense that there are no formal collaboration and consultation mechanisms, required screening practices, collaboration practices that have been built into integrated service protocols.
6. There is no programmatic integration in that we do not incorporate mental health into health education activities, HIV/AIDS, TB, reproductive health and Child Health and malaria for instance.
7. There is failure to promote structural integration in that all primary care services being under a common administrative authority have no standards for monitoring and evaluation, collaboration and clinical integration.
8. There is a kind of artificial fiscal integration whereby mental health care and other primary care services fall under a common funding stream, and it is therefore
impossible to assess expenditure on mental health care or evaluate the implementation of mental health policy at service delivery level. With regard to the mechanisms of integration, we see that keeping the focus on clinical integration as the goal is important for Zambia. There is no one ideal methodology for promoting clinical integration; structural and fiscal integration may present disincentives and difficulties in promoting clinical integration, compared to the flexibility of independently collaborating front line providers which factor we would like to see. While clinical integration is desirable, it must be balanced against competing priorities within the system— and reference is made to HIV/AIDS, TB, reproductive health and Child Health and malaria inter alia. Fiscal integration does not naturally promote clinical integration, without attention to the issues of HIMS and clinical practice and program design. Furthermore, much integration needs to be designed as a routine practice within each funding stream so that it can be easily accomplished within any singly funded setting. There are many advantages of integrating mental health survives into primary health care and the following stand out:

- Reduced stigma for people with living with a mental illness and their family.
- Improved access to care and treatment of co-morbid physical conditions.
- Improved prevention and detection of mental illness.
- Enhanced treatment follow-up of mental illness.
- Better physical contact.
- Better acceptability.
- Reduced chronicity and social integration.
- Guaranteeing human rights protection
- Guaranteeing the pooling of resources together.

4.1.2 Study Recommendations

This study is advancing eleven overall recommendations, in the following domains:

1. Integrate mental health into routine clinical practice. This could be achieved by working pragmatically to establish clinical practice integration through designing preventive and care activities in the community and formalising collaboration in the areas of consultation and programs.

2. Provide treatment in primary care units. The management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services – it needs to be recognized that many are already seeking help at this level.

Noting that Zambia’s HMIS is not fully developed and rigid and that present HMIS does not accommodate mental health needs, there is need to develop HMIS in mental health.

4. Training. In order to provide treatment in primary care units, general health personnel need to be trained in the essential skills of mental health care. Such training ensures the best use of available knowledge for the largest number of people and makes possible the immediate application of interventions. Mental health should therefore be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services. We need to increase and improve training of mental health professionals, who will provide specialized care as well as support the primary health care programs. Though primary care provides the most useful setting for initial care, specialists are needed to provide a wider range of services. Specialist mental health care teams ideally should include medical and non-medical professionals, such as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers and occupational therapists, who can work together towards the total care and integration of patients in the community.

5. Making psychotropic drugs available. Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in our essential drugs list, and the best drugs to treat conditions should be made available whenever possible. Since Clinical officers are not required by law to prescribe psychotropic drugs, it may be prudent to initiate legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable.

6. Give care in the community. Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from the mental hospital and psychiatric unit to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources.

7. Educating the public. Public education and awareness campaigns on mental health should be launched. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders.
8. Involving communities, families and consumers. Communities, families and consumers should be included in the development and decision-making of policies, programs and services. This should lead to services being better tailored to people’s needs and better used. In addition, interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families.

9. Reviewing national policies, developing plans and quickening Mental Service legislation. We would like to see our mental health policy revisited and this is because, policies of human development not only raise the income of the people but also improve other components of their standard of living, such as life expectancy, health, literacy, knowledge and control over their destiny. Mental health is both a major pathway to human development as well as an end product of it. Mental health and development converge and contribute to each other. While it is true that mental health is not everything, it is also true that without it, everything else is nothing. This is not the reality and philosophical thinking of mental health policy practice in Zambia noting the increasing marginalization of mental health.

Policy reviews are necessary steps for significant and sustained action. There is evidence that some countries that have recently developed or revised their policy and legislation have made progress in implementing their mental health care program. This should be an all inclusive and evidence based one embracing the following essential components as enunciated in the WHO-AIMS assessment instrument for mental health systems:

- Organization of services: developing community mental health services
- Organization of services: downsizing the large mental hospital.
- Organization of services: developing a mental health component in primary health care.
- Human resources.
- Involvement of users and families.
- Advocacy and promotion.
- Human rights protection of carers.
- Equity of access to mental health services across different groups.
- Financing.
- Quality improvement (accreditation and not licensure)
- Monitoring system.

In addition as the policy undergoes review, we are recommending that the process and outcome ought to embody at all times (i) an establishment of links with other earlier and more recent policy initiatives (ii) policy themes that it intends to address, (ii) a timeframe and specific goals and (iii) establish its status (e.g. consultation document, white paper, parliamentary bill). Within this realm, we need to fortify prospective Mental Health Policy Development by establishing
a National Mental Commission. It is recommended further that the policy should be complemented by a long-standing national mental health commission (or a similarly constituted body), which shall be able to report independently from and to the government, with direct access to the President or Minister of Health as the case may be. Its aims would be to monitor service effectiveness and identify gaps in service provision, training and performance of the work force, management and government. It would be informed by consumer, care and provider experience, and by reviews of evidence-based research regarding health needs and cost-effective services. It should accurately cost such service gaps, and advise government on a strategy for implementing them. It could also promote and advise formally on enhancing community awareness, decreasing stigma and discrimination and improving workforce recruitment and retention.

We may have to learn from some variants of mental health commission models in other countries. The following may be noted:

*The President’s New Freedom Commission on Mental Health in USA*

This was a component strategy of the New Freedom Initiative announced by the George W Bush White House in February 2001, which included 10 proposals designed to ‘tear down the barriers that face Americans with disabilities today (USDS, 2002).

*National Institute for Mental Health in England*

This Institute is pivotal to the implementation of the UK National Health Service (NHS) Framework for mental health service reforms in England, which on paper appear quite similar to our reforms, although initiated much later. Established in 2002, the NIMHE is an explicitly ‘federal organization’, both ‘devolved and united’. It is governed by a Council drawing on representation from all regional parts of NIMHE. Each Regional Development Centre is governed via local stakeholder arrangements to ensure that they all have ‘a real and influential voice within NIMHE. The NIMHE aims to ‘improve the quality of life for people of all ages who experience mental distresses, by supporting staff to put policy into practice, and directly involving service-users, families and communities (NIMHE, 2003).

*The Mental Health Commission of New Zealand.*

The New Zealand Mental Health Commission is presently nearly 8 years old and a likely lifespan of 11 years or more is anticipated at this point in time. It was established as a Ministerial Committee under Section 46 of the NZ Health and Disability Act 1993 and began work in 1996. The Commission became a separate Crown entity with the enactment of the Mental Health Commission Act 1998, which was amended to extend the limit of its statutory life from 2001 to 2004 and recently it, has been further extended to August 2007 (MHC, 1998).
10. Links with other sectors. Sectors other than health, such as education, labor, welfare, law, and nongovernmental organizations should be involved in improving the mental health of communities. Nongovernmental organizations should be much more proactive, with better defined roles, and should be encouraged to give greater support to local initiatives.

11. Monitor community mental health. The mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The indices should include both the numbers of individuals with mental disorders and the quality of their care, as well as some more general measures of the mental health of communities. Such monitoring helps to determine trends and to detect mental health changes resulting from external events, such as disasters.

12. Support more research. There is need to have a research unit in the ministry of health and if not possible, there may be need to have a research commissioning and contracting unit. We are suggesting more research into health systems, teaching, and public health policy, biological and psychosocial aspects of mental health in order to increase the understanding of key problems and to develop more effective interventions. Such research should be carried out on a wide international basis to understand variations across communities and to learn more about factors that influence the cause, course and outcome of mental disorders. Building research capacity in the Ministry Of health hospitals and training institutions is an urgent need.

From these recommendations, it is clear that Zambia needs a better and comprehensive mental health care system since it is one of the prime objectives of development. We are submitting that it is very important to realize this when we look at development at large in our context. The interrelationship between mental health and general economic development is complex and very well understood. Better mental health care is both an objective of and an instrument for development. Human poverty denies access to mental health in terms of status and services and health is a crucial link between human poverty and reproductive choice.

4.1. 3 Implications of the Study

The results from this study have important implications for people living with mental illnesses, mental health practitioners, health services researchers, policy makers, planners and policy analysts. For there to be a policy, there must be a real or perceived problem. The identification of this problem occurs within a larger social, cultural, political and historical context. We need evidence based data (empirical and experiential - interpretive) to improve the quality of mental health care.

This study points to the fact that health policies and mental legislation are significant predictors of effective mental health plans which in turn are predictors of the desired quality health care. Governments need to look at other jurisdictions or countries to do in
response to similar problems. Alternatively they may consider the problem in a generic way. Whether a policy option is being imported from another jurisdiction or from another industry retrospectively or is developed generically, it is necessary to arrive at a consensus on the option that is to be chosen. Achieving this consensus requires the relevant stakeholders to consider the possible options to choose from among those available. Choosing stakeholders to consult is of great importance because any group that is excluded from the process will create ill will and potential opposition. It is preferable to have all stakeholders involved in the process even if it will be considered that it will culminate into a time and resource consuming activity or even acrimony (Whiteford, 2005).

When developing possible interventions in mental health, it will be research prudent to also consider the environment of political decision making which is admittedly complex. When advancing possible options, we are suggesting that the relative power of each political player in the political landscape, the position taken by them and the intensity of commitment for or against the policy come into play. A stakeholder and SWOT analysis ought to be part of the implementation planning.

4.2 Conclusion

Our conclusions are that Zambia's mental health system is in dire straights. It has no standards and all attempts to develop the adopted mental health policy and mental plans have been met with paucities in both evidence and methodologies. It therefore follows that we need to start afresh. It is possible to start afresh because there is a high level mandate to develop public policies from the Minister of Health. While this project tends to look at regularities and country specifics, it would be research prudent to look at the findings from other three study countries South Africa, Uganda and Ghana *inter alia* to add validity to the research output. This is suggested because of sharp similarities and contrasts which seem apparent.

4.2.1 Limitations and Significance of this Study

This study is significant from several points of view.

1. This is the first known broad based study in mental health in Zambia addressing nearly all facets of mental health. It is an initial step toward addressing the various problem areas in mental policy and systems development.
2. The study is significant in the methodology it has adopted, which combines qualitative and quantitative research methods to provide answers to the questions under exploration. As such, the research design will lucidly inform other researchers who may be interested in doing a similar study.
3. This study is adding perspectives towards resolving the paucity of public health research in Zambia in spite of the availability of policy guidelines on the process of developing legislation and policy. The paucity was in part due to the relative absence of a framework to inform public health policy research that provides a
comparative schema to inform policy developers and analysts. The use of WHO-AIMS provided essential information for mental health policy and service delivery. Policy developers in Zambia will be able to develop information-based mental health policy and plans with clear baseline information and targets. Moreover, they will be able to monitor progress in implementing reform policies, providing community services, and involving consumers, families, and other stakeholders in mental health promotion, prevention, care and rehabilitation. Through this report, policy analysts and developers will have a fairly comprehensive picture of the main weaknesses in the current mental health system, and this knowledge should facilitate improvements over time.

Just like all other research, this study has its own limitations too. The limitations arise from the methodologies that were used. These limitations play an important role in making suggestions for future research. The following are the limitations.

1. Although the WHO-AIMS instrument provides a useful planning tool for low- and middle income countries, limitations exist. One of the most notable limitations involves the difficulty of obtaining a sample large enough to generalize from. The three districts selected in this study do not provide ideal sample study units to generalize the sought phenomena from them nomothetically. However, generalisation could be made ideographically not on account of an ideal sample size but on the basis of how typologies of human settlements within the Zambian context deductively fit into the data. These districts represent the three typologies of human settlements embracing typifications of numerous categories that construct the type of social action, social life, health behaviours, health care financing, that one is likely to see in an urban, suburban and rural settlement in Zambia.

2. The limited funds militated against doing a much wider study and as such the study does not embrace a large sample size of districts or cities and social actors. However, this limitation was to some extent by reaching out to respondents who were selected based on the principle of maximum variation, in order to provide as wide a range of perspectives as possible on mental health policy development, implementation and service delivery. The thrust of the study was not representation but to marry the single reality from the WHO-AIMS instrument and the multiple realities of social actor’s accounts and observations with a view to provide a holistic picture or reality of Zambia’s mental system.

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26 This is concerned with finding general laws about human behaviour and generalise this to other humans in order to make predictions about their behaviour in given circumstances. Scientists involved in this kind of research use statistical methods in order to find the average in variations within human behaviour, and they are also very concerned about using random and large samples.

27 Idiographic research is concerned with exploring uniqueness, i.e. what makes a unit of analysis distinctively individual. Idiographic research uses fewer cases, and looks at them more in depth using flexible, long term and detailed procedures such as the case study method. This approach does not rule out general principles, but the idea is that gaining a thorough and more subtle understanding of a few units will lead to more general understanding of others.
3. In addition, there are limitations related to validity of findings on some variables arising from relying on certain models of care implicit in the WHO-AIMS instrument — for example, the use of ICD-10 (WHO, 1992) mental and behavioural disorders to structure psychiatric and psychosocial services. Some of these models like ICD-10 do not embody psychosocial nomenclature. This is one of the models of care that is used by almost all Ministries of Health in the world. However, alternative models of care exist outside the formal health sector and within the formal sector. This instrument does not assess alternative models of mental health care like DSM IV. However, this limitation was controlled by the use of methodical triangulation where researchers used interviews as well as observations to include the variants or deviations from ICD-1.

4. The WHO-AIMS 2.2 instrument rendered some difficulty in operationalising some key constructs. For example, the issue of equity of access to mental health services for the majority groups (poor people and rural dwellers) is a significant one in Zambia, because most mental health resources are used by the urban, affluent members. Measuring the extent of this inequity is important in promoting more equitable access to mental health care. However, it is very difficult to operationalise in quantitative items that assess this issue. Consequently, many of the items in the WHO-AIMS instrument that address issues of equity employ differing ordinal rating scales. It is difficult to appreciate inequity when facets have differing measures. In addition scales discriminate the element of personal experience or a lived life in an environment of inequity. In this study, we provided an enrichment of this limitation by paradigmatic methodical triangulation so as to provide evidence of convergence with the data from the WHO-AIMS instrument. This was achieved by combining data collection methods and creating room for emergence of equity categories (called variables in nomothetic research) in the mass of qualitative data. We did this because little could be gained from a single paradigm research study and that greater evidence could be obtained through triangulation (Campbell and Fiske, 1959; Denzin, 1970; 1994; Flick, 1992; Gilbert, 1993; Neuman, 2000; Bryman, 1998, 2004). Therefore, the inclusion of qualitative methods as we did in this study may help improve assessment of complex issues, such as measuring equity access to care.

5. The other and final limitation was the refusal to participate in the study, desire to be anonymous and selective information giving. However, an attempt was made to use different data collection methods and other respondents.
CHAPTER FIVE — INTERVENTION PROPOSALS

We have a strong moral standpoint that the government has a responsibility to give priority to mental health. Noting that low and middle-income countries have resource constraints, international support is essential to initiate mental health programs and as such. The actions to be taken in Zambia will depend on the resources available and the current status of mental health care which is in dire straights. This raises a profound need to identify priority problems for interventions and to select from among them those problems that are likely to have the greatest impact if not mitigated or planned for. We have twelve recommendations each representing a set of problems or challenges. It is not research prudent to just advance one solution for each problem area. What is ideal is to design possible scenarios or alternatives. The development of scenarios will help us compare one scenario with another with a view to select one best option.

The use of scenarios, or ‘forecasting’, can be a useful method where empirical data are relatively scarce to proceed with an intervention and particularly when the phenomenon to be resolved will be in the distant future. The social future of mental health in Zambia cannot be forecast without ambiguity; because the present knowledge and methods are not sufficiently powerful to permit accurate predictions of mental health burdens, political, social and health behaviours over long periods of time. Nevertheless, as Vlachos (1977) argues, it is prudent to use scenarios in such circumstances as starting points. Scenarios are a class of methods that rely on informed disciplined imagination by projecting into the future histories describing how the world might look like under different circumstances. In order to design and select choices of scenarios for the implementation of proposals, the rational comprehensive approach based on Banfield's (1955; 1959) model of abstracting from the messy "real world," is chosen. We have chosen this approach because before designing scenarios and making choices, we have:

1. Well-defined problems at hand;
2. A full array of alternatives (three for each recommendation) to consider in attempting to solve the elicited problems;
3. Full baseline information;
4. Full information about the values and preferences of citizens; and
5. Full adequate time, skill, and resources (Relative).

In addition, noting that we are riddled with many problems, we need to select only critical health, social and economic problem areas. To do this, we have opted to use Kingdon’s model (1995:106) which is driven by the analytic hierarchy process. The justification for using Kingdon’s model is that potentially relevant issues are numerous, yet the state cannot address all of them at once. If many issues die away because attention fades, some problems are of a cyclical nature and tend to correct themselves over time. Because policy-makers can only focus on a few core issues simultaneously, the political construction and selection of the problems on the implementation agenda constitute a key phase strategic planning. As a result, beliefs about what are the most pressing problems of the day must be taken into account. The possible scenarios appear in Table 9 below.
### Table 9 Minimum actions required for mental health care, based on overall recommendations

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Scenario A</th>
<th>Scenario B</th>
<th>Scenario C</th>
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</table>
| Establish national policies, and strengthening the key result areas in the implementation draft plan by incorporating data from the MHAPP situation analysis | • Conduct evidence based situational analysis.  
• Formulate mental health programs and policies there from the existing policy.  
• Establishing a National Mental Commission.  
• Increase the budget for mental health care and ensure fairness in component financing.  
• Create structures through which the mental system will operate at macro, meso and micro levels integratively.  
• Create drug and alcohol policies at national level  
• Increase the budget for mental health care. | • Conduct a mid term review  
• Formulate mental health programs and policies there from the review  
• Increase the budget for mental health care and ensure fairness in component financing.  
• Create structures through which the mental system will operate at micro levels integratively.  
• Create drug and alcohol policies at national level | • Proceed with the current policy until the next review.  
• Formulate mental health programs and policies there from.  
• Maintain the status quo on alcohol and drug policies  
• Maintain the current structure.  
• Maintain the current budgeting system. |
| Ensuring enactment of draft mental services bill | • The new legislation based on current knowledge and human rights considerations should be enacted and embrace the observed human right omissions. | • Review current legislation and include fundamental human rights. | Maintain the status quo |
| Ensuring Mental Health Care integration at the district | • The present scenario prevails | Recognizing mental health as a component of primary health care. Activities may include:  
• Developing nomenclature that could be used in determining common mental illness.  
• Treatment of common mental disorders in all primary care units by clinical officers.  
• Designing a referral system of unmanageable mental illnesses.  
• Training curricula of all health personnel to have adequate time and content mental health care.  
• Provide refresher training to primary care workers. | Recognizing mental health as a component of primary health care. Activities may include:  
• Designing a referral system of unmanageable mental illnesses.  
• Treatment of all mental disorders at Primary units by both clinical officers and nurses.  
• Provide refresher training to primary care workers |
| Make psychotropic drugs available | • Ensure availability of all essential drugs in all health care settings.  
• Provide easier access to newer psychotropic drugs under public or private treatment plans.  
• Legitimate the prescriptions by non-doctor primary health care workers (Clinical Officers) who are interdicted by law (The pharmacy and poisons act) | • Ensure availability of all essential drugs in all health care settings.  
• Provide easier access to newer psychotropic drugs under public or private treatment plans.  
• Legitimate the prescriptions by non-doctor primary health care workers (Clinical Officers) who are interdicted by law (The pharmacy and poisons act) | • Ensure availability of 5 essential psychotropic drugs in all health care settings.  
• Legitimate the prescriptions by clinical officers and nurses who are interdicted by law (The pharmacy and poisons act). |
| Give care in the community | • Move people with mental disorders out of prisons  
• Decongest the mental hospital and improve care within them.  
• Develop general hospital in patient psychiatric units  
• Give individualized care in the community to people with serious mental disorders.  
• Initiate pilot projects on integration of mental health care with general health care.  
• Provide community care through out reach activities. | | Develop alternative residential facilities.  
• Provide community care facilities (100% coverage)  
• Give individualized care in the community to people with serious mental disorders through community supporters. |
Table 9 Minimum actions required for mental health care, based on overall recommendations (continued)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Scenario A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate the public</td>
<td>Promote public campaigns against stigma and discrimination.</td>
</tr>
<tr>
<td></td>
<td>Support nongovernmental organizations in public education.</td>
</tr>
<tr>
<td></td>
<td>This could be done through NGO GRZ and donor funding.</td>
</tr>
<tr>
<td></td>
<td>The Ministry of Health to use the mass media to promote mental health, foster positive attitudes, and help prevent disorders including promoting public campaigns against stigma and discrimination.</td>
</tr>
<tr>
<td></td>
<td>Cooperating partners in augment the campaigns for the recognition and treatment of common mental disorders through joint development and execution of strategies.</td>
</tr>
<tr>
<td></td>
<td>Develop and sign memorandum of understanding in this venture.</td>
</tr>
<tr>
<td>Develop human resources</td>
<td>Conduct an “inventory” of expertise and knowledge of their staff.</td>
</tr>
<tr>
<td></td>
<td>Identify the particular mix of skills required for a given level of care.</td>
</tr>
<tr>
<td></td>
<td>Assemble the resources that most closely fit the skill set identified as required under the given circumstances.</td>
</tr>
<tr>
<td></td>
<td>Train psychiatrists locally, clinical Officers, psychiatric nurses.</td>
</tr>
<tr>
<td></td>
<td>The World Psychiatric Association may be approached in this domain because it has produced and implemented many educational programs for the benefit of those seeking continuing medical education. WHO and World Federation for Medical Education may be considered as cooperating partners.</td>
</tr>
<tr>
<td></td>
<td>Create regional training centres for psychiatric nurses, psychologists and psychiatric social workers.</td>
</tr>
<tr>
<td></td>
<td>Train specialists in advanced treatment skills within the region.</td>
</tr>
<tr>
<td>Link with other sectors</td>
<td>Initiate school and workplace mental health programs</td>
</tr>
<tr>
<td></td>
<td>Encourage the activities of NGOs</td>
</tr>
<tr>
<td></td>
<td>We need to integrate the conventional system of physician-based primary health care clinics with its counterpart the traditional or alternative system.</td>
</tr>
<tr>
<td></td>
<td>Strengthen school and workplace mental health programs.</td>
</tr>
<tr>
<td>Monitor community mental health</td>
<td>Include mental disorders in basic health information systems.</td>
</tr>
<tr>
<td></td>
<td>Survey high-risk population groups</td>
</tr>
<tr>
<td></td>
<td>Institute surveillance for specific disorders in the community (e.g., depression)</td>
</tr>
<tr>
<td></td>
<td>Develop advanced mental health monitoring systems</td>
</tr>
<tr>
<td></td>
<td>Monitor effectiveness of preventive programs.</td>
</tr>
<tr>
<td>Support more research</td>
<td>Conduct studies in primary health care settings on the prevalence, course, outcome and impact of mental disorders in the community.</td>
</tr>
<tr>
<td></td>
<td>Establish libraries in our hospitals and the ministry of health.</td>
</tr>
<tr>
<td></td>
<td>Institute effectiveness and cost effectiveness studies for management of common mental disorders in primary health care.</td>
</tr>
<tr>
<td></td>
<td>Extend research on the causes of mental disorders</td>
</tr>
<tr>
<td></td>
<td>Carry out research service delivery</td>
</tr>
<tr>
<td></td>
<td>Investigate evidence on the prevention of mental disorders</td>
</tr>
</tbody>
</table>
CHAPTER SIX – DISSEMINATION OF FINDINGS

The following institutions/people should receive a copy of this report.

1. The Permanent Secretary Ministry Of Health
2. The Dean School Of Medicine
3. The Country Representative (WHO)
4. All directors Ministry Of Health
5. Professional associations
6. Heads of Health worker Training institutions.
8. Registrars General nursing council of Zambia and Medical Council of Zambia
9. NGOs involved in several psychiatric reform initiatives and care.
11. User NGOs.
12. DFID Zambia

In addition to sending copies of the report, it might be convenient to make a presentation inviting the above mentioned individuals/groups/organizations and directors at the ministry of health. The presentation could be the first part (the first day or half day) of the planning workshop. Key mental health workers should also be included in the workshop.
BIBLIOGRAPHY


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WHO (1978). Alma Ata 1978: Primary Health Care, HFA Sr. No. 1


APPENDICES
Appendix I Checklist for evaluating a mental health policy and plan

Introduction

Once a policy and/or plan have been drawn up in a country it is important to conduct an assessment of whether certain processes which are likely to lead to the success of the policy and plan have been followed, and whether various content issues have been included in the policy and plan. It may also be important at various other junctures during the implementation period to assess the policy and plan itself and, if necessary, make adjustments to the policy and plan or even review it completely. These checklists assist in evaluating the process of developing a policy and plan and the content thereof.

Sometimes there will be two separate documents, one for the policy and one for the plan. At other times the policy and the plan may be integrated into one document, for example, in the case of a mental health program. In this latter scenario, it would be advisable to use both the checklists for the assessment rather than just focusing on one.

While these checklists are limited in that they do not assess the quality of the processes or contents of the policy and plan, when completing the checklists evaluators are encouraged to consider the adequacy of both the process and content closely. For each item of the checklist, space is provided in the last column to provide comments about the current status and where relevant actions that could be taken to improve the situation. In some instances the comment may, for example, merely be that it is covered in a different policy or that it is not possible within current resources to cover every aspect). The different modules in the WHO Mental Health Policy and Service Guidance Package should be consulted for more detail on what may be included in relevant sections and for a better understanding of the policy issues mentioned in the checklists.

These checklists may usefully be completed by those who drafted the policy and plan and/or by employees in the government itself. A multidisciplinary team of drafters, or even an individual within the government, may employ the checklists to help improve the policy. Nonetheless also having independent reviewers of the policy and plan is important. The drafters themselves may not always have all the relevant information that an independent reviewer/review panel may have. Moreover those involved in drawing up the policy and plan may have personal or political interests or may be “too close” to the policy and plan to see anomalies or provide critical input.

Ideally then an independent multidisciplinary team should be convened to conduct an evaluation of the policy and plan. A team is advantageous as no single person is likely to have all the relevant information required and critical debate is crucial for reaching the optimal policy and plan for the country. Moreover, when relevant interest groups have been involved in the process of the development of the policy and plan and/or in an evaluation which leads to changes being made to the policy and plan, they are more likely to ensure it is effectively implemented. Groups that would be useful to include would be consumer organizations, family organizations, service providers, professional organizations and NGOs. Representatives of other government departments effected by the policy would also be important.
<table>
<thead>
<tr>
<th>CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to rate each item please use the following rating scale:</td>
</tr>
<tr>
<td>1 = yes</td>
</tr>
<tr>
<td>2 = to some extent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCESS ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Is there a high level mandate to develop the policy e.g. from Minister of Health?</td>
</tr>
<tr>
<td>2) Is the policy based on relevant data:</td>
</tr>
<tr>
<td>■ from a situational assessment?</td>
</tr>
<tr>
<td>■ from needs assessment?</td>
</tr>
<tr>
<td>3) Have policies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?</td>
</tr>
<tr>
<td>They are utilised though not being acknowledged in the report. Therefore, it is difficult to know the relevance of these references as in relationship to the situation analysis.</td>
</tr>
<tr>
<td>4) Has a thorough consultation process taken place with the following groups:</td>
</tr>
<tr>
<td>■ Representatives from the Health?</td>
</tr>
<tr>
<td>■ Representatives from Finance?</td>
</tr>
<tr>
<td>■ Representatives from Social Welfare and Housing?</td>
</tr>
<tr>
<td>■ Representatives from criminal justice system?</td>
</tr>
<tr>
<td>■ Consumers or representatives of such groups?</td>
</tr>
<tr>
<td>As you can see from the ratings below, there was inadequate representation from both inter and intra sectoral collaboration e.g. key ministries like Human rights, Labour, community development, youth and sport, social welfare and from intra such as directorate of clinical care and diagnostic services, Human resource and technical support services e.t.c.</td>
</tr>
<tr>
<td>Family members or representatives of such groups?</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Other NGOs?</td>
</tr>
<tr>
<td>Private sector?</td>
</tr>
<tr>
<td>Any other key stakeholder groups? Please name them</td>
</tr>
<tr>
<td>5) Has an exchange taken place with other countries?</td>
</tr>
<tr>
<td>6) Has relevant research been undertaken to inform policy development, e.g. pilot studies</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTENT ISSUES</th>
<th>Rating</th>
<th>Comments/ Action required (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Is there a realistic vision statement?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2) Are values and associated principles which inform the policy included?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3) Do these values and associated principles emphasize and/or promote:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Human rights?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Social inclusion?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Community care?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Integration?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Evidence based practice?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Intersectoral collaboration?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Equity with physical health care?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4) Have clear objectives been defined?</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5) Are objectives consistent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- With vision?</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
### With values and principles?

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6) Are there clear descriptions of areas for action to indicate the main policy directions and what will be achieved?</td>
<td>1</td>
</tr>
<tr>
<td>7) Are there areas for action written in a way that commits governments, e.g. do they say 'will' instead of 'should'</td>
<td>1</td>
</tr>
</tbody>
</table>

Commitment of ownership comes as the government adopts the policy document of which it has done.

### COORDINATION & MANAGEMENT?

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8) To what degree areas for action comprehensively address COORDINATION &amp; MANAGEMENT?</td>
<td>1</td>
</tr>
</tbody>
</table>

a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate Mental Health functions and services?

b) Does the policy clearly set up or refer to a multisectoral coordinating body to oversee major decisions in mental health?

There is only one recognised person who is the programme officer to oversee the Mental health services from the public health perspective.

### FINANCING?

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>9) To what degree areas for action comprehensively address FINANCING?</td>
<td>1</td>
</tr>
</tbody>
</table>

a) Does the policy indicate how funding will be utilized to promote equitable mental health services?

b) Does the policy state that equitable funding will be provided between mental health and physical health?

c) If mental health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?

There are no insurance schemes in the country.

### LEGISLATION AND/OR HUMAN RIGHTS?

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>10) To what degree areas for action comprehensively address LEGISLATION AND/OR HUMAN RIGHTS?</td>
<td>1</td>
</tr>
</tbody>
</table>

a) Does the policy promote human rights?

Mental health patients are not recognised as part of the vulnerable groups, they are regarded as just like any other citizens who should launch a complaint when they feel they are abused.

b) Does the policy promote the development and implementation of human rights oriented legislation?

c) Is it envisaged to set up a review body that monitors different aspects of human rights?

There is one person who is the programme officer to oversee the Mental health services from the public health perspective.
<table>
<thead>
<tr>
<th>11) To what degree areas for action comprehensively address <strong>ORGANISATION OF SERVICES?</strong></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Does the policy promote the integration of mental health services into general health services?</td>
<td>1</td>
</tr>
<tr>
<td>b) Is a community oriented mental health approach promoted in the policy?</td>
<td>1</td>
</tr>
<tr>
<td>c) Does the policy promote deinstitutionalization?</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12) To what degree areas for action comprehensively address <strong>PROMOTION, PREVENTION AND REHABILITATION?</strong></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Is provision made in the policy for the prevention of mental disorders?</td>
<td>1</td>
</tr>
<tr>
<td>b) Is provision made in the policy for interventions that promote mental health?</td>
<td>1</td>
</tr>
<tr>
<td>c) Is provision made in the policy for interventions for the rehabilitation of people with mental disorders?</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13) To what degree areas for action comprehensively address <strong>ADVOCACY?</strong></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Is the policy supportive of consumers and family organizations?</td>
<td>1</td>
</tr>
<tr>
<td>b) Is there emphasis on raising awareness of mental disorders and their effective treatment?</td>
<td>1</td>
</tr>
<tr>
<td>c) Does the policy promote advocacy for people with mental disorders?</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14) To what degree areas for action comprehensively address <strong>QUALITY IMPROVEMENT?</strong></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Does the policy make a commitment to providing high quality evidence based interventions?</td>
<td>1</td>
</tr>
<tr>
<td>b) Does the policy imply a process to measure and improve quality of services?</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15) To what degree areas for action comprehensively address <strong>INFORMATION SYSTEMS?</strong></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Will mental health information systems be set up to guide decision making for future policy, planning and service development?</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16) To what degree areas for action comprehensively address <strong>HUMAN RESOURCES AND TRAINING?</strong></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The policy does not address working</td>
<td>1</td>
</tr>
<tr>
<td>Qn</td>
<td>Description</td>
</tr>
<tr>
<td>----</td>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
<td>a) Does the policy commit to putting in place appropriate working conditions for mental health providers?</td>
</tr>
<tr>
<td>2</td>
<td>b) Are appropriate management strategies discussed to improve recruitment and retention of mental health providers?</td>
</tr>
<tr>
<td>3</td>
<td>c) Are training in core competencies and skills seen as central to human resource development?</td>
</tr>
<tr>
<td>17</td>
<td>17) To what degree areas for action comprehensively address <strong>RESEARCH AND EVALUATION</strong>?</td>
</tr>
<tr>
<td></td>
<td>a) Does the policy emphasize the need for research and evaluation of services, as well as the policy and strategic plan?</td>
</tr>
<tr>
<td>18</td>
<td>18) To what degree areas for action comprehensively address <strong>INTERSECTORAL COLLABORATION</strong>?</td>
</tr>
<tr>
<td></td>
<td>a) Does the policy emphasize collaboration with all other relevant government departments?</td>
</tr>
<tr>
<td></td>
<td>b) Does the policy emphasize collaboration with all relevant non-governmental organizations including consumer and family groups?</td>
</tr>
<tr>
<td>19</td>
<td>19) Are there clear statements of what role each sector will play in each area for action?</td>
</tr>
<tr>
<td>20</td>
<td>20) Have the following groups been considered:</td>
</tr>
<tr>
<td></td>
<td>- People with severe mental disorders?</td>
</tr>
<tr>
<td></td>
<td>- Children and adolescents?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Older persons?</td>
<td>1</td>
</tr>
<tr>
<td>People with intellectual disability?</td>
<td>1</td>
</tr>
<tr>
<td>People with substance dependence?</td>
<td>1</td>
</tr>
<tr>
<td>People with common mental disorders?</td>
<td>1</td>
</tr>
<tr>
<td>People affected by trauma?</td>
<td>1</td>
</tr>
</tbody>
</table>

21) Given resources available in the country has a “reasonable balance” been achieved between the above groups?

Taking into account the financial and human resources available in the country, comment of the general feasibility for implementation of the policy.

Comments

It has been difficulty for the planners to plan because the magnitude of the problem is not clearly defined. This is due to lack of a well worked out needs of assessments.

This evaluation of the policy checklist has contributions from the following the following stakeholders:

1. Dr Patrick Msoni Psychiatrist (Hospital Manager)
2. Dr Muyangana Medical doctor
3. Mrs Naomi Banda Chief policy analyst (clinical care)
4. Mr John Mayeya Mental health Programme Officer
5. Mrs Didduh Mubanga Principal clinical officer
6. Mr Nseluke Clinical Officer Psychiatry
7. Mrs Banda Sister in-Charge
8. Mrs Mzumala Registered General Nurse
9. Ms Mwamba Nayame Registered Mental Nurse
Appendix II WHO Checklist on Mental Health Legislation

World Health Organization

This checklist has been developed by WHO staff, Dr Michelle Funk, Ms Nattalie Drew, Dr Margaret Grigg and Dr Benedetto Saraceno, in collaboration with Professor Melvyn Freeman, also WHO faculty member for legislation, with contributions from Dr Soumitra Pathare and Dr Helen Watchirs, also WHO faculty for legislation. It has been derived from the WHO manual on Mental Health Legislation, Mental Health Policy and Service Development Team, Department of Mental Health and Substance Dependence, World Health Organization.

Introduction and how to use this Checklist

This Checklist is a companion to the WHO Manual on Mental Health Legislation. Its objectives are to a) assist countries in reviewing the comprehensiveness and adequacy of existing mental health legislation and b) help them in the process of drafting new law. By using this instrument countries can assess whether key components are included in legislation and ensure that the broad recommendations contained in the manual are carefully examined and considered.

A committee to work through the checklist is recommended. While an individual such as the focal point in the Ministry of Health may be able to complete the tool this has limitations. Firstly, a single person is unlikely to have all the relevant information that a well selected team would. Secondly, different individuals or representatives of different groups are likely to have differing views on various issues. An evaluation committee which allows critical debate to take place and for consensus to be developed is invaluable. While countries must decide the composition of the committee it is advisable to include a legal practitioner familiar with various country laws, the governmental mental health focal point, representatives of consumer and family groups, representatives of mental health professionals, non-governmental organisations and other government departments. It is recommended that the process be led and mediated by an independent human rights and/or legal expert.

This tool should generally not be utilised without thoroughly working through the manual itself. A number of important items included in this tool are explained in the manual and the rationale and different options for legislation are discussed. The manual emphasises that countries should make their own decisions around various alternatives and ways of drafting legislation as well as around a number of content issues. The format of this Checklist allows for such flexibility and aims to encourage internal debate, thus permitting countries to make decisions based on their own unique situations.

The tool covers issues from a broad perspective and many of the provisions will need to be fleshed out/elaborated upon with respect to details and country specifications. Moreover, not all provisions will be equally relevant to all countries due to different social, economic, cultural and political factors. For example not all countries will choose to have community treatment orders; not all countries have provision for "non-protesting patients"; many countries do not have the death penalty and, in most countries, the use of sterilisation on people with mental disorders will not be relevant. However, while
each country in their evaluative process may determine that a particular provision is not relevant; this determination should be made as a part of the Checklist exercise. All provisions in the checklist should be considered and discussed carefully before it is decided that one or more provision is not relevant to a country's particular context.

The manual points out that countries may have laws which affect mental health in a single or in numerous different legislations, for example general health, employment, housing, discrimination and criminal justice laws, among others. Moreover some countries utilise regulations, orders and other mechanisms to complement an Act. When conducting this audit it is therefore essential to collect and collate all legal provisions relating to mental health and to make decisions based on comprehensive information.

For each component included there are three options to be decided upon, a) has the issue been adequately covered in the legislation b) has it been covered, but not fully and comprehensively and c) has it not been covered at all. If the response is either (b) or (c) the committee conducting the assessment must decide the feasibility and local relevance of inclusion of the issue – leading to the drafting of locally appropriate legislation.

This Checklist does not cover each and every issue that could or should be included in legislation. This does not mean that other items are unimportant and that countries should not pursue them, however for the sake of simplicity and easy use the scope of this Checklist has been limited.

The manual is very clear that drawing up or changing mental health legislation is a “process”. Establishing what needs to be included in the legislation is an important element of this process and this Checklist tool a useful aid to achieving this goal. Nonetheless, the objective of drafting a law which is implementable in a country must never be separated from the “content” and must always be a central consideration.
**WHO Checklist on Mental Health Legislation**

For each component included in the checklist, three questions need to be addressed: a) Has the issue been adequately covered in the legislation? b) Has it been covered, but not fully and comprehensively? c) Has it not been covered at all? If the response is either (b) or (c), the committee conducting the assessment must decide on the feasibility and local relevance of including the issue, leading to the drafting of locally appropriate legislation.

This checklist does not cover each and every issue that could or should be included in legislation. This does not mean that other items are unimportant and that countries should not pursue them; however, for the sake of simplicity and ease of use, the scope of this checklist has been limited.

<table>
<thead>
<tr>
<th>Legislative issue</th>
<th>Extent to which covered in legislation (tick one)</th>
<th>If (b), explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a) Adequately covered</td>
<td>• Why it is not adequately covered</td>
</tr>
<tr>
<td></td>
<td>b) Covered to some extent</td>
<td>• What is missing or problematic about the existing provision</td>
</tr>
<tr>
<td></td>
<td>c) Not covered at all</td>
<td>If (c), explain why it is not covered in current legislation (Additional information may be added to new pages if required)</td>
</tr>
</tbody>
</table>

**A. Preamble and objectives**

1) Does the legislation have a preamble which emphasizes:
   a) the human rights of people with mental disorders?
   a) b) c)

   b) the importance of accessible mental health services for all?
   a) b) c)
2) Does the legislation specify that the purpose and objectives to be achieved include:
   a) non-discrimination against people with mental disorders?
   b) promotion and protection of the rights of people with mental disorders?
   c) improved access to mental health services?
   d) a community-based approach?

B. Definitions
1) Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity?
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<th>Question</th>
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<tbody>
<tr>
<td>2) Is it evident from the legislation why the particular term (above) has been chosen?</td>
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<td>3) Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation?</td>
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<td>4) Are all key terms in the legislation clearly defined?</td>
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<td>5) Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)?</td>
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<td>6) Are all “interpretable” terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?</td>
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<td>C. Access to mental health care</td>
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<tr>
<td>1) Does the legislation make provision for the financing of mental health services?</td>
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<tr>
<td>2) Does the legislation state that mental health services should be provided on an equal basis with physical health care?</td>
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<td>3) Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?</td>
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<td>4) Does the legislation promote mental health within primary health care?</td>
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<td>5) Does the legislation promote access to psychotropic drugs?</td>
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<td>6) Does the legislation promote a psychosocial, rehabilitative approach?</td>
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<td>7) Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?</td>
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8. Does the legislation promote community care and deinstitutionalization?

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**D. Rights of users of mental health services**

1) Does the legislation include the rights to respect, dignity and to be treated in a humane way?

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2) Is the right to patients’ confidentiality regarding information about themselves, their illness and treatment included?

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- a) Are there sanctions and penalties for people who contravene patients’ confidentiality?

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- b) Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?

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- c) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?

|   | a) | b) | c) |
3) Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?
   a) Are circumstances in which such access can be denied outlined?
   b) Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?

4) Does the law specify the right to be protected from cruel, inhuman and degrading treatment?

5) Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?

6) Does the law insist on the privacy of people with mental disorders?
   a) Is the law clear on minimal levels of privacy to be respected?
<table>
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<th>Question</th>
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</table>
| 7) Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions? | a)  
|                                                                         | b)      |
|                                                                         | c)      |
| 8) Does the law make provision for:                                      | a)      |
|                                                                         | b)      |
|                                                                         | c)      |
| • educational activities,                                               |         |
| • vocational training,                                                   |         |
| • leisure and recreational activities,                                   |         |
| • religious or cultural needs of people with mental disorders?          |         |
| 9) Are the health authorities compelled by the law to inform patients of their rights? | a)      |
|                                                                         | b)      |
|                                                                         | c)      |
| 10) Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning? | a)     |
|                                                                         | b)      |
|                                                                         | c)      |
### E. Rights of families or other carers

1. Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?
   - a)  
   - b)  
   - c)  

2. Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient’s individualized treatment plan?
   - a)  
   - b)  
   - c)  

3. Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?
   - a)  
   - b)  
   - c)  

4. Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?
   - a)  
   - b)  
   - c)  

5. Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning?
   - a)  
   - b)  
   - c)  

### F. Competence, capacity and guardianship

1. Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?
   - a)  
   - b)  
   - c)  
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<th>Question</th>
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<tbody>
<tr>
<td>2) Does the law define “competence” and “capacity”?</td>
<td>a)</td>
<td>b)</td>
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<tr>
<td>3) Does the law lay down a procedure and criteria for determining a person’s incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?</td>
<td>c)</td>
<td></td>
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<tr>
<td>4) Are procedures laid down for appeals against decisions of incapacity/incompetence, and for periodic reviews of decisions?</td>
<td>a)</td>
<td>b)</td>
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<tr>
<td>5) Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?</td>
<td>b)</td>
<td>c)</td>
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<tr>
<td>6) Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?</td>
<td>a)</td>
<td>b)</td>
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<tr>
<td>7) Does the law make provision for a systematic review of the need for a guardian?</td>
<td>a)</td>
<td>b)</td>
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<tr>
<td>8) Does the law make provision for a patient to appeal against the appointment of a guardian?</td>
<td>a)</td>
<td>b)</td>
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<tr>
<td><strong>G. Voluntary admission and treatment</strong></td>
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<td>1) Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?</td>
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<tr>
<td>2) Does the law state that all voluntary patients can only be treated after obtaining informed consent?</td>
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<tr>
<td>3) Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?</td>
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<tr>
<td>4) Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?</td>
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<tr>
<td>5) Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?</td>
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### H. Non-protesting patients

1) Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment?

   a) ____________________________

   b) ____________________________

   c) ____________________________

2) Are the conditions under which a non-protesting patient may be admitted and treated specified?

   a) ____________________________

   b) ____________________________

   c) ____________________________

3) Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met?

   a) ____________________________

   b) ____________________________

   c) ____________________________

### I. Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined)

1) Does the law state that involuntary admission may only be allowed if:

   a) there is evidence of mental disorder of specified severity and;

   a) ____________________________

   b) ____________________________

   c) ____________________________
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<td>b) there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient’s condition if treatment is not given? and; c) admission is for a therapeutic purpose?</td>
<td>a) b) c)</td>
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<tr>
<td>2) Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?</td>
<td>a) b) c)</td>
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<tr>
<td>3) Does the law insist on accreditation of a facility before it can admit involuntary patients?</td>
<td>a) b) c)</td>
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<td>4) Is the principle of the least restrictive environment applied to involuntary admissions?</td>
<td>a) b) c)</td>
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<tr>
<td>5) Does the law make provision for an independent authority (e.g. review body or tribunal) to authorize all involuntary admissions?</td>
<td>a) b) c)</td>
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<tr>
<td>6) Are speedy time frames laid down within which the independent authority must make a decision?</td>
<td>a) b) c)</td>
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<tr>
<td>7) Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?</td>
<td>a)</td>
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<td>8) Does the law provide for a right to appeal an involuntary admission?</td>
<td>a)</td>
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<tr>
<td>9) Does the law include a provision for time-bound periodic reviews of involuntary (and long-term “voluntary”) admission by an independent authority?</td>
<td>a)</td>
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<tr>
<td>10) Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfill the criteria for involuntary admission?</td>
<td>a)</td>
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**J. Involuntary treatment (when separate from involuntary admission)**

1) Does the law set out the criteria that must be met for involuntary treatment, including:
   - Patient suffers from a mental disorder?
     
     a) | b) | c)
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<tr>
<td>• Patient lacks the capacity to make informed treatment decisions?</td>
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<tr>
<td>• Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?</td>
<td>b)</td>
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<tr>
<td>2) Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment?</td>
<td>c)</td>
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<tr>
<td>3) Does the law make provision for a second practitioner to agree on the treatment plan?</td>
<td>a)</td>
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<tr>
<td>4) Has an independent body been set up to authorize involuntary treatment?</td>
<td>b)</td>
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<td>5) Does the law ensure that treatment is for a limited time period only?</td>
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<tr>
<td>6) Does the law provide for a right to appeal involuntary treatment?</td>
<td>a)</td>
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<tr>
<td>7) Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?</td>
<td>a)</td>
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K. Proxy consent for treatment

1) Does the law provide for a person to consent to treatment on a patient’s behalf if that patient has been found incapable of consenting? | a) | b) | c) |
2) Is the patient given the right to appeal a treatment decision to which a proxy consent has been given? | a) | b) | c) |
3) Does the law provide for use of “advance directives” and, if so, is the term clearly defined? | a) | b) | c) |

L. Involuntary treatment in community settings

1) Does the law provide for involuntary treatment in the community as a “less restrictive” alternative to an inpatient mental health facility? | a) | b) | c) |
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<th>M. Emergency situations</th>
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| 2) Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment? | a)  
|   | b)  
|   | c)  |
| 1) Are the criteria for emergency admission/treatment limited to situations where there is a high probability of immediate and imminent danger or harm to self and/or others? | a)  
|   | b)  
|   | c)  |
| 2) Is there a clear procedure in the law for admission and treatment in emergency situations? | a)  
|   | b)  
|   | c)  |
| 3) Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases? | a)  
|   | b)  
|   | c)  |
| 4) Does the law specify a time limit for emergency admission (usually no longer than 72 hours)? | a)  
|   | b)  
|   | c)  |
| 5) Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended? | a)  
|   | b)  
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<tr>
<td>6) Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?</td>
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<tr>
<td>7) Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?</td>
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<td>b)</td>
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**N. Determinations of mental disorder**

1) Does the legislation:

   a) Define the level of skills required to determine mental disorder? | a) | b) | c) |

   b) Specify the categories of professionals who may assess a person to determine the existence of a mental disorder? | a) | b) | c) |

2) Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body? | a) | b) | c) |
O. Special treatments

1) Does the law prohibit sterilization as a treatment for mental disorder?
   a) Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?
   a)  
   b)  
   c)  

2) Does the law require informed consent for major medical and surgical procedures on persons with a mental disorder?
   a) Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?
   a)  
   b)  
   c)  

   b) In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?
   a)  
   b)  
   c)  
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<tr>
<td>3) Are psychosurgery and other irreversible treatments outlawed on involuntary patients?</td>
<td>a) b)</td>
<td>c)</td>
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<tr>
<td>a) Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?</td>
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<td>4) Does the law specify the need for informed consent when using ECT?</td>
<td>a) b)</td>
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<td>5) Does the law prohibit the use of unmodified ECT?</td>
<td>a) b)</td>
<td>c)</td>
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<tr>
<td>6) Does the law prohibit the use of ECT in minors?</td>
<td>a) b)</td>
<td>c)</td>
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**P. Seclusion and restraint**

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<tr>
<td>1) Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?</td>
<td>a) b)</td>
<td>c)</td>
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<tr>
<td>2) Does the law state that seclusion and restraint should never be used as a means of punishment or for the convenience of staff?</td>
<td>a) b)</td>
<td>c)</td>
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</table>
3) Does the law specify a restricted maximum time period for which seclusion and restraints can be used?

4) Does the law ensure that one period of seclusion and restraint is not followed immediately by another?

5) Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?

6) Does the law lay down adequate procedures for the use of seclusion and restraints, including:
   - who should authorize it,
   - that the facility should be accredited,
   - that the reasons and duration of each incident be recorded in a database and made available to a review board, and
   - that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?
Q. Clinical and experimental research

1) Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?

   a)  
   b)  
   c)  

2) Where a person is unable to give informed consent (and where a decision has been made that research can be conducted):

   a) Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?

      a)  
      b)  
      c)  

   b) Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?

      a)  
      b)  
      c)  

### R. Oversight and review mechanisms

1) Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?

   a) Does the above body:

      (i) Assess each involuntary admission/ treatment?

         a) ________

         b) ________

         c) ________

      (ii) Entertain appeals against involuntary admission and/or involuntary treatment?

         a) ________

         b) ________

         c) ________

      (iii) Review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?

         a) ________

         b) ________

         c) ________

      (iv) Regularly monitor patients receiving treatment against their will?

         a) ________

         b) ________

         c) ________

      (v) Authorize or prohibit intrusive and irreversible treatments (such as psychosurgery and ECT)?

         a) ________

         b) ________

         c) ________
b) Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a “wise person” reflecting the “community” perspective?

c) Does the law allow for appeal of this body’s decisions to a higher court?

2) Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?

   a) Does the above body:

      (i) Conduct regular inspections of mental health facilities?

      (ii) Provide guidance on minimizing intrusive treatments?

      (iii) Maintain statistics; on, for example, the use of intrusive and irreversible treatments, seclusion and restraints?
| (iv) Maintain registers of accredited facilities and professionals? | a) | b) | c) |
| (v) Report and make recommendations directly to the appropriate government minister? | a) | b) | c) |
| (vi) Publish findings on a regular basis? | a) | b) | c) |
| b) Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons? | a) | b) | c) |
| c) Is this body’s authority clearly stated in the legislation? | a) | b) | c) |
| 3) a) Does the legislation outline procedures for submissions, investigations and resolutions of complaints? | a) | b) | c) |
b) Does the law stipulate:

- the time period from the occurrence of the incident within which the complaint should be made?
- a maximum time period within which the complaint should be responded to, by whom and how?
- the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?
- the right of patients to an interpreter during the proceedings, if necessary?
- The right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?

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### S. Police responsibilities

1) Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate health care services?

   a)  
   b)  
   c)  

2) Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?

   a)  
   b)  
   c)  

3) Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder?

   a)  
   b)  
   c)  

4) Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?

   a)  
   b)  
   c)  

5) Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?

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T. Mentally ill offenders

1) Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person’s psychiatric history, mental health status at the time of the offence, the likelihood of detriment to the person’s health and the community’s interest in prosecution?

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2) Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment?

a) Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body?

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<tr>
<td>Question</td>
<td>Options</td>
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<tr>
<td>3) Does the law allow for people who are found by the courts to be “not responsible due to mental disability” to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?</td>
<td>a) b) c)</td>
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<tr>
<td>4) Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?</td>
<td>a) b) c)</td>
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<tr>
<td>5) Does the law allow for the transfer of a convicted prisoner to a mental health facility if he/she becomes mentally ill while serving a sentence?</td>
<td>a) b) c)</td>
</tr>
<tr>
<td>a) Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?</td>
<td>a) b) c)</td>
</tr>
<tr>
<td>6) Does the legislation provide for secure mental health facilities for mentally ill offenders?</td>
<td>a) b) c)</td>
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<tr>
<td>U. Discrimination</td>
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<tr>
<td>1) Does the law include provisions aimed at stopping discrimination against people with mental disorders?</td>
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<thead>
<tr>
<th>V. Housing</th>
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<tbody>
<tr>
<td>1) Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?</td>
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<td>b)</td>
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<td>c)</td>
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<tr>
<td>2) Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?</td>
</tr>
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<td>a)</td>
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<tr>
<td>3) Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders?</td>
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<thead>
<tr>
<th>W. Employment</th>
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<tbody>
<tr>
<td>1) Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?</td>
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<tr>
<td>2) Does the law provide for “reasonable accommodation” for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?</td>
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<tr>
<td>3) Does the law provide for equal employment opportunities for people with mental disorders?</td>
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<tr>
<td>4) Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental disorders?</td>
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<tr>
<td>X. Social security</td>
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<tr>
<td>1) Does legislation provide for disability grants and pensions for people with mental disabilities?</td>
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<tr>
<td>2) Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?</td>
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<tr>
<td>Y. Civil issues</td>
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<tr>
<td>----------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>1) Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?</td>
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<tr>
<th>Z. Protection of vulnerable groups</th>
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<tbody>
<tr>
<td><strong>Protection of minors</strong></td>
<td></td>
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<tr>
<td>1) Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?</td>
<td>a)</td>
<td>b)</td>
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<td></td>
<td>c)</td>
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<tr>
<td>2) If minors are placed in mental health facilities, does the legislation stipulate that</td>
<td>a)</td>
<td>b)</td>
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<tr>
<td>a) they should have a separate living area from adults?</td>
<td>c)</td>
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<td>b) that the environment is age-appropriate and takes into consideration the developmental needs of minors?</td>
<td>a)</td>
<td>b)</td>
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<tr>
<td>3) Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?</td>
<td>a) b) c)</td>
<td></td>
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<tr>
<td>4) Does the law stipulate the need to take the opinions of minors into consideration on all issues affecting them (including consent to treatment), depending on their age and maturity?</td>
<td>a) b) c)</td>
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<tr>
<td>5) Does legislation ban all irreversible treatments for children?</td>
<td>a) b) c)</td>
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**Protection of women**

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<tr>
<td>1) Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?</td>
<td>a) b) c)</td>
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<tr>
<td>2) Does the law ensure that women in mental health facilities:</td>
<td>a) b) c)</td>
</tr>
<tr>
<td>a) have adequate privacy?</td>
<td>a) b) c)</td>
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<tr>
<td>b) are provided with separate sleeping facilities from men?</td>
<td>a) b) c)</td>
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</table>
| 3) Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment? | a)  
|   | b)  
|   | c) |

**Protection of minorities**

1) Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?

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2) Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?

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3) Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country?

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### A2. Offences and penalties

1. Does the law have a section dealing with offences and appropriate penalties?  
   a)  
   b)  
   c)  

2. Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law?  
   a)  
   b)  
   c)
Appendix III - Checklist for Evaluating a Mental Health Plan

* Not used because at the time of data collection, the plan was not yet developed

In order to rate each item please use the following rating scale:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Comments/Action required (if any)</th>
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<tbody>
<tr>
<td>1 = yes</td>
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<tr>
<td>3 = no</td>
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<tr>
<td>2 = to some extent</td>
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<tr>
<td>5 = unknown</td>
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**PROCESS ISSUES**

1) Is there a high level mandate to develop the plan, e.g. from Minister of Health?

2) Does the plan include strategies and activities which are consistent with an existing and up-to-date policy?

3) If no policy is available, does the plan include strategies and activities which are consistent with another official document(s) stating the direction(s) for mental health? Please provide relevant document(s).

4) Are strategies and activities written in a way that commits governments, e.g. do they say 'will' instead of 'should'?

5) Has the plan been informed by:
   - a situational analysis; and/or
   - needs assessment?

6) Have effective strategies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary?

7) Has a thorough consultation process taken place with the following groups?
   - Representatives from the Health?
   - Representatives from Finance?
   - Representatives from Social Welfare and Housing?
   - Representatives form criminal justice system?
   - Consumers or representatives of such groups?
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<th></th>
<th>Family members or representatives of such groups?</th>
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<td></td>
<td>Other NGOs?</td>
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<td>Private sector?</td>
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<td></td>
<td>Any other key stakeholder groups? Please name them.</td>
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**OPERATIONAL ISSUES**

8) Have comprehensive strategies been identified for each priority area for action?

Looking at **STRATEGIES**:

9) **Timeframes**:
- Are time frames provided for each strategy?
- Are these time frames reasonable and feasible?

10) **Indicators**:
- Are there indicators for each strategy?
- Are the indicators used appropriate for measuring the particular strategy?

11) **Targets**:
- Are there targets for each strategy?
- Are the targets realistic?

Looking at **ACTIVITIES**:

12) Are clear activities defined for each strategy?

13) Is the person/group/organization responsible for each activity delineated?

14) Is it clear when each activity will start and finish?

15) Are the outputs for each activity outlined?

16) Have potential obstacles been identified?

17) **Cost and Funding**:
- Have the costs for achieving each activity been
<table>
<thead>
<tr>
<th>CONTENT ISSUES</th>
<th>Rating</th>
<th>Comments/Action required (if any)</th>
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<tbody>
<tr>
<td>18) Does the plan include relevant strategies and activities for \textbf{COORDINATION \ &amp; MANAGEMENT}?</td>
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<tr>
<td>a) Are the composition and functions clearly defined for:</td>
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<tr>
<td>■ The MH coordinating body?</td>
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<tr>
<td>■ The MH focal point?</td>
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<td>b) Is adequate infrastructure organized (including computers, internet access, and administrative support)?</td>
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<tr>
<td>c) Are regular meetings of the coordinating body scheduled?</td>
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<tr>
<td>d) Is a system of reporting to a high level MoH official set up for the MH coordinating body?</td>
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<tr>
<td>e) Overall are strategies and defined activities:</td>
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<tr>
<td>■ Relevant</td>
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<td>■ Evidence based</td>
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<td>■ Realistic and implementable</td>
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<td>■ Adequately funded</td>
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<tr>
<td>19) Does the plan include relevant strategies and activities for \textbf{FINANCING}?</td>
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<tr>
<td>a) Is it clear how services will be funded?</td>
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<td>b) Is the plan clear on whether/how user charges will be made?</td>
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<tr>
<td>c) Overall are strategies and defined activities:</td>
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<tr>
<td>■ Relevant</td>
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<tr>
<td>■ Evidence based</td>
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</table>
20) Does the plan include relevant strategies and activities for **LEGISLATION AND/OR HUMAN RIGHTS**?

- Where legislation and/or regulations are to be developed, have clear strategies/activities been specified for:
  - the process of drafting the law/regulations?
  - defining the content of the law/regulations?
  - implementing the law/regulations?

b) Overall are strategies and defined activities:
- Relevant
- Evidence based
- Realistic and implementable
- Adequately funded

21) Does the plan include relevant strategies and activities for **ORGANIZATION OF SERVICES**?

- Are there strategies and linked activities for services to be provided at primary, secondary and tertiary levels with continuity between them?
- Are there strategies and linked activities for deinstitutionalization?
- Are there strategies and linked activities for developing community mental health services?
- Is provision made for psycho-social rehabilitation services at all levels of the health system?

- Overall are strategies and defined activities:
- Relevant
- Evidence based
- Realistic and implementable
- Adequately funded
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>22) Does the plan include relevant strategies and activities for <strong>PROMOTION, PREVENTION AND REHABILITATION</strong>?</td>
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<tr>
<td>a) Are there clear strategies and linked activities for the promotion of mental health?</td>
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<tr>
<td>b) Are there clear strategies and linked activities for the prevention of mental disorder?</td>
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<tr>
<td>c) Overall are strategies and defined activities:</td>
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<tr>
<td>- Relevant</td>
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<td>- Evidence based</td>
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<td>- Realistic and implementable</td>
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<tr>
<td>- Adequately funded</td>
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<tr>
<td>23) Does the plan include relevant strategies and activities for <strong>ESSENTIAL MEDICINES PROCUREMENT AND DISTRIBUTION</strong>?</td>
<td></td>
</tr>
<tr>
<td>a) If psychotropic medicines are currently not included on the Essential Drug List is there a strategy and linked activities to change this?</td>
<td></td>
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<tr>
<td>b) Does the plan incorporate strategies and linked activities to improve the reliability of the supply and distribution system at relevant levels of health service where treatment is to provided?</td>
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<tr>
<td>c) Are there strategies and relevant activities for monitoring the continuous maintenance and assessment of psychotropic medicines</td>
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<tr>
<td>d) Overall are strategies and defined activities:</td>
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<tr>
<td>- Relevant</td>
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<td>- Evidence based</td>
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<tr>
<td>- Realistic and implementable</td>
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<tr>
<td>- Adequately funded</td>
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<tr>
<td>24) Does the plan include relevant strategies and activities for <strong>ADVOCACY</strong>?</td>
<td></td>
</tr>
<tr>
<td>a) Is there a strategy and linked activities to support (technically and/or practically) consumer groups, family groups and non-governmental organizations?</td>
<td></td>
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</tbody>
</table>
b) Is there a strategy and linked activities to involve consumers and family representatives in policy and service planning?

c) Overall are strategies and defined activities:
- Relevant
- Evidence based
- Realistic and implementable
- Adequately funded

25) Does the plan include relevant strategies and activities for QUALITY IMPROVEMENT?

a) Is there a strategy and linked activities for assessing quality assessment?

b) Is there a strategy and linked activities for ongoing quality of mental health facilities, e.g. standards?

c) Is there a strategy and linked activities for accrediting facilities based on quality?

d) Are both hospital and community mental health facilities included in quality assessment?

e) Overall are strategies and defined activities:
- Relevant
- Evidence based
- Realistic and implementable
- Adequately funded

26) Does the plan include relevant strategies and activities for INFORMATION SYSTEMS?

a) Has a strategy and linked activities been defined for:
- Reviewing the current mental health information system? and/or
- Improving the current mental health information system?

b) Does the strategy or linked activities include the systematic collection of mental health data from a
range of sources at different levels of the health system, for example, general hospitals, primary health care and community levels)?

c) Is it clear how the information will feed back into:

- Policy development, mental health planning and service delivery?
- Clinical practice?

e) Overall are strategies and defined activities:

- Relevant
- Evidence based
- Realistic and implementable
- Adequately funded

27) Does the plan include relevant strategies and activities for **HUMAN RESOURCES AND TRAINING**?

a) Is there a well defined strategy and linked activities to assess available personnel and competencies at different service levels?

b) Is there a strategy to improve the number of providers for mental health?

c) Are there relevant management strategies and activities to address:

- Recruitment?
- Retention?
- Deployment of staff?

d) Is provision made for ongoing education, training and skills development?

e) Is there a strategy /or relevant defined activities to introduce changes to undergraduate and graduate curricula of health and allied health workers?

f) Is there a strategy for training health providers to develop the appropriate competencies e.g. at the levels of primary health care, community care, general hospital and specialist care.
<table>
<thead>
<tr>
<th>Informal community services?</th>
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<tr>
<td>Primary health care services?</td>
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<tr>
<td>General Hospital care</td>
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<td>Specialist care</td>
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<tr>
<th>g) Overall are strategies and defined activities:</th>
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<tr>
<td>Relevant</td>
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<tr>
<td>Evidence based</td>
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<tr>
<td>Realistic and implementable</td>
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<tr>
<td>Adequately funded</td>
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<table>
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<tr>
<th>28) Does the plan include relevant strategies and activities for <strong>RESEARCH AND EVALUATION</strong>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Are there strategies for improving capacity to conduct research and evaluation?</td>
</tr>
<tr>
<td>b) Is research addressing practical issues for the country?</td>
</tr>
<tr>
<td>c) Has provision been made to evaluate the policy and plan?</td>
</tr>
<tr>
<td>d) Overall are strategies and defined activities:</td>
</tr>
<tr>
<td>Relevant</td>
</tr>
<tr>
<td>Evidence based</td>
</tr>
<tr>
<td>Realistic and implementable</td>
</tr>
<tr>
<td>Adequately funded</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>29) Does the plan include relevant strategies and activities for <strong>INTERSECTORAL COLLABORATION</strong>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Is there a structure advocated through which intersectoral collaboration should take place?</td>
</tr>
<tr>
<td>b) Have the following groups been considered?</td>
</tr>
<tr>
<td>People with severe mental disorders?</td>
</tr>
<tr>
<td>Children and adolescents?</td>
</tr>
<tr>
<td>Older persons?</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>People with intellectual disability?</td>
</tr>
<tr>
<td>People with substance dependence?</td>
</tr>
<tr>
<td>People with common mental disorders?</td>
</tr>
<tr>
<td>People affected by trauma?</td>
</tr>
</tbody>
</table>

c) Given resources available in the country has a "reasonable balance" been achieved between the above groups?

d) Overall are strategies and defined activities:
   - Relevant
   - Evidence based
   - Realistic and implementable
   - Adequately funded

Taking into account the financial and human resources available in the country, comment of the general feasibility for implementation of the policy.
RE: PERMISSION TO CONDUCT RESEARCH

We are conducting a study in the context of a wider international study of mental health policy development and implementation in four African countries: Ghana, South Africa, Uganda and Zambia.

We are writing to you seeking permission to conduct this research as part of a policy development research. Our research is actually a situation analysis of mental health policy development and implementation in Zambia and we shall very much appreciate if we were to do this study in your institution or with you. Below are some details about the study.

SUBJECT: Mental Health Policy Development and Implementation.
SAMPLING: See model
DATA COLLECTING TOOLS:
Observations focus group discussions, interviews and documentary reviews WHO-AIMS instrument.

SAMPLING METHODS

Purposive, snowball and availability sampling

Should there be a need for me to do other things, in case this request found merit and favour, we shall be most grateful to oblige. Thanking you in advance for your cooperation.

Yours sincerely

Mwanza Banda Dr.
Appendix V — Researcher’s Introductory Letter

Dear Sir/ Madam,

My name is Alice Sikwese. I am a research officer for Mental Health Policy Development and Implementation project here in Zambia. May I ask for your help concerning the study I am doing? I am finding out a few important facts about the mental health system. I shall explain the project to you in detail should this information contained in this letter be insufficient.

I have sent this letter to you and a few other people. To make sure that I hear all your points of view, I am eager to get a reply from you. I do hope that you will agree to assist me in this study and spare some time later at your convenience for a discussion concerning my study prior to the interview. The aim of our study is to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries.

I will not interfere in your work or position or way of life at all. What you will share with me will be highly appreciated. I present here a copy of the consent form for you to sign should you be willing to help me in this study. I should be most grateful for your help. I am optimistic that you will be of great help to this cause.

Yours sincerely

Alice Sikwese
Appendix VI — Respondent’s Consent Form

The request:

I have been asked by Alice Sikwese to take part in the project. She will explain to me in detail about the project. I should feel free to ask him questions pertaining to the project. If I have additional questions later, Mwanza Banda Dr., the person who is responsible for the project, will come here to discuss them with me.

Description of the project:

I have been asked to take part in the project that is dealing with how patients and I talk about their health problems. The aim of our study is to investigate the policy level interventions that are required to break the vicious cycle of poverty and mental ill-health, in order to generate lessons for a range of low- and middle-income countries.

What will be done?

If I decide to take part in the project, I will be involved in a series of interviews or be asked to provide documentation, or answer some questions on public policy and mental health system.

My part in the project will involve helping Alice Sikwese. Answering questions from the checklists may take not more than twenty minutes and the interview will last between twenty to thirty minutes and the interview may be recorded if I am willing. My name will not be on the tape and the checklist. If I agree to have the interview recorded, the tape will be destroyed soon after it has been transcribed.

Risks:

The possible risks in the project are not there at all. I may however feel some discomfort with some questions, which is usual. In case I am anxious, and if I feel to stop the interview or answering the checklist, I shall do so voluntarily because the decision to be part of the study is entirely up to me and I may terminate the interview any time. Whatever I decide, it will not be held against me. I understand Alice Sikwese, is not a member of any health management or regulatory board and that my participation will not have an impact on my job or on any other matter.

Benefits:

There are no guaranteed direct benefits to me immediately on account of this research. My taking part will help improve the mental health system in Zambia.

Confidentiality:

My participation in the project is confidential to the extent permitted by law. None of the information will identify me by name once in the write up. They will use pseudonyms instead of real names in the study. All information provided by me will be confidential. This guarantees me that no any other person will have information related to me.

Decision to quit:

The decision whether to take part or not is up to me. I do not have to be in the study. If I decide to take part in the study, I can quit any time. What ever I decide is Okay for me. I shall tell Alice Sikwese. the person who is responsible for the project that I am quitting or I cannot go further in the interview.
Rights and complaints:

If I have concerns about the project; I may contact Mwanza Banda Dr. or the University Of Zambia Administration at the following address and phone numbers:

Telephone: 252641      Dean’s Office
Telegrams: UNZA, LUSAKA . Box 50110
Telex: UNZALU ZA 44370                                Lusaka, Zambia
E-mail drmbanda@yahoo.com. I have read the consent form and have understood what is stated. All questions I have about the research have been answered. By signing the form, I am indicating my willingness to participate in this good cause. The consent form will be kept in the locker in safety and will not be attached to any transcript or other materials.

Researcher’s signature                                            Respondent’s signature