MENTAL HEALTH SERVICES IN ZAMBIA; PAST, PRESENT AND FUTURE

MASTER OF SOCIAL WORK

BY

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2016

UNIVERSITY OF BOTSWANA

FACULTY OF SOCIAL SCIENCES

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200908094

A RESEARCH ESSAY SUBMITTED TO THE FACULTY OF SOCIAL SCIENCES: DEPARTMENT OF SOCIAL WORK IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF SOCIAL WORK

UNIVERSITY OF BOTSWANA

2016

DECLARATION

I declare that the work in this research essay titled: Mental health services in Zambia,

Past; Present and future is my own original work except where references where made.

NAME: MAUREEN SHIMANE CHILEMYA

SIGNATURE……..

DATE…….

ABSTRACT

The history of the development of mental health services in Zambia stretches back to the time before Zambia became independent. The history falls into four phases: the pre-colonial phase where care was under the traditional and spiritual healers, the rise of asylums mainly for custodial confinement, followed by establishment of mental hospitals during and soon after the colonial period and most recently the decentralisation of mental health into primary health care.

Fifty two years after independence, there have been notable developments in the mental health care provision. One of the notable development is that, the Zambian government recognises mental health as a serious public and development concern and the government has included mental health in the Basic Health care package. A number of reforms have been implemented aimed at strengthening the country's mental health system. A mental health policy is in its final stage of drafting and it will soon be implemented.

While the mental health services have improved in some ways, in many ways they have not lived up to the expectations. The difficulties are anchored in the deterioration in economic stagnation and the social conditions witnessed after many years of cooper price decline and overall economic stagnation. This has reduced funding to mental health services. The human resources is not adequate to meet the growing public health burden of mental illnesses. The Human Immuno-deficiency Virus (HIV) pandemic has impacted negatively on families resulting in many people developing mental illnesses.

In order to address the afore mentioned challenges, there is need to integrate mental health into routine clinical practice, provide treatment in primary care units, develop a health management system, provide training relevant to mental health care and provide adequate funding. In addition essential drugs must be made available, involve communities, families and consumers in the care of the patients.

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ACKNOWLEDGEMENT

This project would not have been what it is without the effort of other people. Special thanks go to my supervisors Dr T. Modie-Moroka and Professor R. Mupedziswa for their effort in supervising my work and helping me to accomplish my work.

To my friend Joanna and family, they were a great source of support and encouragement.

To my husband Josephat and children Lwimba, Grace, Greig and Eudora for their courage and love.

DEDICATION

This is dedicated to Operating Theatre staff of Bamalete Lutheran Hospital.

ABBREVIATIONS AND ACRONYMS

AIDS - Acquired Immune Deficiency Syndrome

BHCP - Basic Health Care Package - Central Board of Health

CSO- Central Statistics Office

HIV - Human Immunodeficiency Virus

HMIS - Health Management Information System

MDAC- Mental Disabilty Advocacy Centre

MDGs - Millennium Development Goals

MMaPP- Mental Health & poverty Project

MOH - Ministry of Health

NDP - National Development Plan

NDP- National Drug Policy

NGOs -Non-governmental organizations

NHP&SP- National Human Resource for health Strategic Plan

NHSP - National Health Strategic Plan

WHO - World Health Organization

ZDHS - Zambia Demographic and health Survey

CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

Introduction

A close examination of the history of mental illness and its treatment around the world shows that for the most part, the mentally ill were confined and, most often neglected. Over the years, especially after independence, in most of Africa, conditions have changed, though societal stigma and tends to influence discrimination and abhorrence of people with severe and persistent mental illness. Treatment trends have ranged, across centuries from banishment to "Ships of Fools' to asylums, to state-run institutions to advocacy organizations composed of patients and their families pressure for continued transformation, to public education and more research.

The African continent shows similar trends. The first officially documented management of patients with mental illnesses in Zambia existed in 1951 before independence- when the homeless mentally ill people were cared for in prison cells administered by the colonial masters (Banda, 1980). The first western style mental hospital was later established in 1962 in Lusaka Province. Before the establishment of the first psychiatric hospital, mental health services that existed were mainly traditional, meaning that the people who had mental illnesses were treated using outmoded medications, and not taken to mental institutions for inpatient treatment. The institutions were more or less like prisons. Admissions to these institutions started in 1951. With colonization by Britain in 1924, came the institutionalization of the people who had various mental illnesses. The aim of this study is to examine the development of mental health services in Zambia independence 1964.

Background to the Study

Zambia is a landlocked country, situated in the southern part of Sub-Saharan Africa. Zambia covers a land area of 752,612 square kilometers, which is about 2.5 percent of Africa. In 1924, the British Colonial Office assumed responsibility for administering the territory (Gewald, Hinfellaar & Macola, 2008).

The development of the mines also attracted large numbers of indigenous workers in search of employment, triggering the drift from rural areas and causing the gradual growth of the urban population (Kasonde & Martin, 1994). In 1953, Northern Rhodesia (Zambia) and Southern Rhodesia (Zimbabwe) joined Nyasaland (Malawi), to form the Central African Confederacy of Rhodesia and Nyasaland, despite the opposition of Northern Rhodesia's Africans. The arrangement lasted for ten years. Zambia attained its independence in 1964 (Richard, Hamilton & William, 2015). Administratively, the country is divided into ten provinces and 103 districts (Ministry of Local Government, 2013). Of the ten provinces, three are predominantly urban, namely Lusaka, Central and Copper Belt Provinces. The remaining provinces are Muchinga, Eastern, Northern, Luapula, North-Western, Western, and Southern and are predominantly rural provinces (Central Statistics Office, 2014)

The Economy

Zambia has a mixed economy consisting of a rural agricultural sector and a modern urban sector which geographically follows the rail line. Currently, the construction industry contributes to 14% of the gross domestic product (GDP), manufacturing industry and mining each contributes 8% of the GDP (Central Statistics Office, 2014). The economy of the then Northern Rhodesia was built on the exploitation of the wealth of mineral deposits, mainly copper. Copper accounted for 95% of annual export earnings and contributing 45% of government revenues during the decade following independence (Kasonde & Martin, 1984).

The copper mines attracted immigrants of European descent from Southern Rhodesia (now Zimbabwe) and South Africa. The Europeans were accompanied by a small number of farmers who established often large commercial farms along the principal railway line leading south (Kasonde & Martin, 1994). Copper has dominated the economy since large-scale mining operations started in 1924.

At independence in 1964, copper accounted for 91 % of total export earnings. Since then, the ratio has changed very little (Du Plessis, 2006). Zambia was once one of the wealthiest countries in sub-Saharan Africa (Mental Health & Poverty Report, MMaPP, 2008). At independence in 1964, Zambia had a per capita income of US$664.

This was almost double that of its neighbours. However, Zambia's subsequent economic performance did not live up to expectations created by the relatively fortunate starting point.

For the first 30 years after independence, the Zambian economy shrunk on average by 1% per year in per capita terms (Du Plessis, 2006). 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. Over the last forty years instead of progressing regarding human development, Zambia has gone backwards. In 2004, 63.7% of the Zambian population lived on a $1 a day (Fifth National Development Plan, FNDP, 2006).

An economic recovery programme was developed in the mid -1990's to try and improve the standards of living for Zambia, (Obilegwu, 1999). The economic recovery programme improved the economy. Other plans; the poverty reduction strategy plan and the transitional national plan development plan from 2002 to 2005 were developed. Both strategies were to serve as frameworks for economic and social development. Real GDP growth averaged 5% per year up from an average annual growth of 1% in the preceding years (Fifth National Development Plan, FNDP, 2014).

The subsequent development plan (2006-2010) the fifth development plan was developed from the need to institute a strategy that would focus on broad wealth and job creation – through citizenry participation and technological advancement (FNDP, 2014). The annual economic growth reached 6% during 2006-2010 as a result of prudent macroeconomic management, market liberalisation, and privatisation efforts.

The sixth national development plan 2011-2015 was developed with the aim of achieving sustained economic growth and poverty reduction through infrastructure and human development (Ministry of Finance and National Planning, MoFNP, 2011). In the pursuit of trying to improve the quality of life for all, the government of the Republic of Zambia is currently implementing the revised sixth National development plan for period 2013-2016 (MoFNP, 2014). Regrettably, commodity prices fell sharply in the face of a significant downturn in the world economy and this impacted not only on the profitability of the mining operations but social welfare like health (FNDP, 2006).

Indeed, Zambia's declining terms of trade, because of the falling copper price, often features in explanations of Zambia's economic decline (Obilegwe, 1999). The massive recession in the 1990s, coinciding with extensive World Bank and International Monetary Fund (IMF) Structural Adjustment Reform programs, resulted in severe declines (Marais, 2000).

Poverty in Zambia

According to Central Intelligence Agency CIA (2012), poverty levels stood at 64 % as at 2012. As much as 68 % of the population fell below the national poverty line living on $1 a day. The depth and severity of poverty also remain high despite the slight decline since 1998. There are many factors which contribute to the high level of poverty. The two important factors are; the high unemployment rate and lack of agricultural inputs. FNDP (2006), asserts that all the provinces along the line of rail (Copperbelt, Central, Lusaka, and Southern) have less than 60% of their working-age population in employment. The age-specific unemployment rates show that there is a high unemployment rate among the youthful population.

According to a United Nations Development Program (UNDP, 2011), the persistently high-income poverty observed at the moment is in sharp contrast to the rapid acceleration in economic growth experienced since 1999. The trend could imply that the country's improved economic performance over recent years has not translated into significant declines in human poverty.

The Zambian government spends about 4.5 % of its GDP on healthcare (CIA, 2014). However, the country's plagued with many health related problems which call for a more aggressive approach. There remain the ever increasing prevalent malnutrition and an increasing number of people living with HIV and AIDS (Phiri & Ataguba, 2014). More than one in every seven adults in the country is living with HIV and life expectancy at birth has fallen to just 49.9 years (Central Statistical Office, 2014). The most affected are the urban areas with a prevalence of 23% while the prevalence rate in the rural areas is 11%.

Furthermore, the Ministry of Health (MOH, 2010) indicates that the number of orphans has risen from the time the epidemic started, and the number is expected to continue rising. The implications for this are the increase in child and single headed households and poverty, with its resultant mental and emotional consequences.

Aim of the Study

To examine how mental health services have evolved since Zambia attained independence 1964.

Specific Objectives

1. To trace the progress of treatment for the mentally ill from the precolonial to post-colonial era.
2. To identify the milestones in the development of mental health services and to explore the history, strengths, weaknesses, challenges and solutions to mental health services in Zambia.
3. To provide information to stakeholders such as social workers, mental health nurses, psychiatrists, family members, traditional doctors and non-governmental organizations who are dealing with people with mental health conditions.
4. To offer insight on the future direction of mental health programmes and interventions that address mental health problems across the country.

Methodology

The purpose of this methodology is to discuss the methods, principles for regulating data collection and analysis used in this study. The study adopted a qualitative approach. The principal aim of the study was to appraise the evolution of mental health services in different parts of the Africa. Therefore, qualitative research enabled the writer to use secondary data which was analysed to gain a more in-depth understanding of the topic at hand.

Procedure

Documents were obtained from full-text online search engines like EBSCOhost, Oxford Journal, Google Scholar, PubMed Central and African journals. These sources were accessed from the stable uniform resource locater (URL) http://www.ub/library/online-resources. Other books and journals were accessed from the University of Botswana library.

Keywords, Authors name, title, call number, and international standard book number (ISBN) were used to search the material in the University of Botswana online public access catalogue (OPAC), which is accessed from URL http://www.ub.bw/library. Other article publications were accessed from stable URL, http://www.moh.gov.zm/files/shared/health-facilityreport2008.pdf.

Keywords like “history of mental health services,” “mental illnesses,” “mental health services in Africa” were used to search for documents. Different author’s names and book titles were also used to search for printed literature. The search identified 125 articles. Following the screening of abstracts and in some cases snip previews only 91 documents remained for inclusion in this study. Publications were included only if they had information on the history of mental illnesses and care, mental health and mental health services in Zambia and mental health services in Africa and mental health policy analysis. The data was reviewed against the following criteria;

- Relevance - Was the literature relevant to the study?
- Credibility - Had a sound approach been used?
- Objectivity - Had the biases been addressed?
- Balance- Was the literature balanced and based on evidence

Data analysis.

For this study, all the data collected from several documents was categorized into the following; mental health services, mental disorders, methods of intervention in mental health, and mental health policy analysis frameworks. The findings and recommendations emanating from the articles were synthesized according to the following main thematic areas covered by the articles mental illness, mental health and mental health services in Zambia.

Limitations of Document Analysis

According to Yin (1994) and Corbin and Strauss (2008) documents are produced for some purpose other than research. They are created independently of a research agenda. As a result, sometimes they do not provide sufficient details to answer a research question. Furthermore, Yin (1994) and Corbin and Strauss (2008) stated that documents might be deliberately blocked so that the researcher may not access them.

CHAPTER TWO

HISTORY OF MENTAL HEALTH SERVICES IN AFRICA

Introduction

This chapter will look at how the mental health services have evolved in some African countries. The aim is to gain background knowledge on the evolution of mental health services and the current trends in mental health care.

Colonialism, which refers to the establishment of political and economic control by one state over another, had an enormous impact on Africa. The colonial experience began in the late 1400s when Europeans arrived and set up trading posts in Africa. Colonialism reached a peak in the late 1800s and early 1900s when European powers dominated many parts of the continent. Colonialism in Africa created nations and shaped their political, economic, and cultural development. The legacy continues to influence the history of the continent.

Between the 1400s and 1800s, Europeans began to take an interest in Africa, mainly the coastal regions. Sailing along the shores of the continent, they established trading posts and engaged in commerce with local peoples. They made little attempt to explore the interior. During this period, Europeans had little influence in Africa. From the mid-1700s to 1880s, Europeans became more involved in the continent. One reason for this increased involvement was growing opposition to the slave trade. In 1787 the British founded a colony for freed slaves in Sierra Leone. About 30 years later, a group of Americans established Liberia for freed slaves and their descendants. Along with efforts to end slavery, Europeans also tried to bring Christianity to Africa. Their missionaries travelled throughout the continent, seeking to convert Africans and spread Western culture.

By the late 1800s, many Africans had begun to accept and adapt various elements of European civilization. At the same time, the nature of European interest in Africa changed dramatically.

Impressed by the continent's abundant supply of natural resources, Europeans sought to exploit the potential wealth. To achieve this goal, they attempted to overpower African peoples and force them to accept foreign rule.

In the 1870s rival European nations raced to colonize as much African territory as possible. By the late 1880s, they had divided up most of the continent among themselves, without permission from the African peoples.

Central and Southern Africa

Britain's colonial possessions in central and southern Africa included Southern Rhodesia (present-day Zimbabwe), Northern Rhodesia (Zambia), Nyasaland (Malawi), Bechuanaland (Botswana), Basutoland (Lesotho), and Swaziland. Before 1910, when South Africa became independent, Britain also had two colonies in that region, the Cape Colony and Natal. Involvement in South Africa dated from the early 1800s, when Britain acquired the Cape Colony from the Dutch. British immigrants flooded into southern Africa in the late 1800s. They never gained more than partial control there, however, because of the presence of large numbers of Dutch settlers, known as Afrikaners, or Boers. As British settlement increased, many Afrikaners tried to move north into Bechuanaland. The African rulers of Bechuanaland, fearing an invasion of the Dutch settlers, asked Britain for help in 1885. Britain agreed and Bechuanaland became a British protectorate. Britain maintained a system of indirect rule there until Bechuanaland gained independence in 1966.

A similar situation occurred in Basutoland, a mountainous land that the Afrikaners had originally considered unsuitable for settlement. In the 1850s, however, the Afrikaners began to expand into Basutoland. In response to an appeal from the local people for help, Britain established a protectorate in Basutoland. Originally governed as part of the Cape Colony, Basutoland came directly under British rule in 1884. However, most of the administration of the area was left in the hands of indigenous authorities.

Swaziland also became a British Protectorate. In this case, the British stepped in to end warfare between two African peoples, the Swazi and Zulu. Once again, Britain established a system of indirect rule. It granted Swaziland self-government in 1967 and full independence in 1968. In 1889 Britain gave the British South Africa Company, headed by Cecil RHODES, rights

to the area that became known as Southern Rhodesia. Attracted by the offer of large tracts of land, white settlers flooded the region.

Attempts by Africans to rebel against the settlers were brutally crushed, and Southern Rhodesia became a highly segregated society, dominated by whites. Forced to live on poor farmland in special areas known as reserves, many Africans had to work for the settlers to earn a living.

The British South Africa Company also gained the rights to Northern Rhodesia. At first, the British administered the region mostly through African local authorities, and there was little opposition to colonial rule. As in Southern Rhodesia, however, the settlers took over the best land and gained political and economic control of the colony and its rich copper mines. The area to the east of Northern Rhodesia became known as Nyasaland. Ruled after 1904 by British colonial officials, it never attracted as many white settlers as the Rhodesias.

Nevertheless, the spread of European-owned plantations in the region eventually aroused opposition among Africans, which led to armed rebellion in 1915. For many years, Nyasaland served as a source of labour for other colonies. Whites in Northern and Southern Rhodesia relied on Africans from Nyasaland to work on farms and in mines.

In 1953, to promote the economic and political development of the region, the two Rhodesias and Nyasaland joined as the Central African Federation. Meanwhile, African protests against colonial policies grew stronger. By the early 1960s, the colonial administrations of Nyasaland and Northern Rhodesia began allowing Africans greater participation in government. Both regions won independence in 1964; Nyasaland took the name Malawi and Northern Rhodesia became Zambia.

In Southern Rhodesia, settlers fiercely resisted any attempts to increase African power. In 1965 the white-dominated government declared independence for the colony. African opposition to the government erupted in guerrilla warfare, and in the 1970s the administration's power began to crumble. By 1980 a majority black African government ruled the nation, which was renamed Zimbabwe.

Effects of colonization on Mental health Services

The impact on mental health of populations was evident. Though there was, to some extent infrastructural development in the form of roads, railways, airports to name but a few, the policies and programme they initiated often altered the way of life for most African states. The systematic, indiscriminate partition (scramble) drawn without any clear, regional criteria in full cognizance of the ethnocultural, geographical and ecological realities of Africa brought different ethnic groups (tribes) having different historical traditions, cultures and speaking different languages under one or more colonial power. This situation disrupted the political development of these social groups; furthermore, ethnic groups were cleaved into fragments. These lines of partition are also run across pre- existing nations, ethnicities, states, kingdoms, and empires.

In disrupting pre-colonial political systems that worked for Africans and imposing alien models, colonialism laid the seeds of political crisis, say its critics. By redrawing of the map of Africa, throwing diverse people together without consideration for established borders, ethnic conflicts were created that are destabilizing the continent. The new nation-states were artificial, and many were too small to be viable. Less than a third of the countries in Africa have populations of more than 10million. The male counterparts were forced to work in urban areas during colonisation, and the result was long periods of absenteeism from their families. Alcohol abuse, violence against women and poor health status were among the obvious features when people returned to the rural areas of the work in urban areas. The information on the history of mental health in Africa is fragmented despite advances in research in other medical diseases like tuberculosis malaria and HIV and AIDS. The first books on mental health were written around 1950's. Interestingly most of these books were written by Europeans who were for the most part, the colonial masters and served as colonial medical officers (Ndetei, 1972)

Mental Health Services Pre- Colonization

Before colonization, mental illnesses in Africa were mostly believed to be caused by evil spirits or witchcraft (Harding, 1973). The treatment was mainly through the traditional healers. Each country had a different way of treating people with mental illnesses. In African traditional

medicine, mental ill-health is defined as a situation whereby the victim is prone to interpreting issues haphazardly as registered in his tortured consciousness (Ozekhome, 1990).

In Uganda Orley (1970) studied the causes of mental illnesses among the Baganda people. In his study, Orley found that the mental illnesses they were caused by spells castings and evil machinations. Orley further observed that the mental illnesses were brought by spirits acting on their initiative as well as those forces manipulated by people. The spirits were many, and they were related to the circumstances of the people (Asuni, 1973).

Prince (1964) studied the mental health of the Yoruba people of Nigeria, and he discovered that the causes of mental illnesses include natural, pre-natural or supernatural. Natural causes included a faulty diet, insects, worms, or hereditary factors. The pre-natural causes included magical practices of sorcerers, curse, and witchcraft. The supernatural causes came about because of offending the ancestors (Prince, 1964).

In Ghana, Field (1960) believed the theory that the people who had mental illnesses were demon possessed. Field described various beliefs such as witchcraft, magic, and mythology as possible causes of mental illnesses. In South Africa, the mental illness was said to be caused by witchcraft and possession by evil spirits (Sordarshi et al., 2010). Witches were believed to have the ability to mobilize their evil powers and the forces of nature to harm other people.
Some believed that mental illnesses were a consequence of causal factors (family problems, substance abuse, and poverty) that were left untreated and progressively became more severe.

Diagnosis of mental illnesses

African traditional healers used the method of divination to unearth the mental and psychological problems patients had. This was done by trying to investigate the inner being of their patients, even when patients had not manifested physical signs of mental illnesses (Dopamu,

1979). The medicine-man as a diagnostician would first of all look at the social, cultural and intellectual environment and background of the patient. He would then evaluate and interpret the cause of the disease, and give the necessary help (Asuni, 1973). Diagnosis in other parts of Africa was reached by divination, sacrifice and questioning the patients (Dawson, 1964). Oracles (a person with great wisdom) and divination (the practice of using signs to predict the future) played significant roles in the treatment of mental illnesses in African traditional medicine.

Treatment

Treatment of mental illnesses differed from region to region. In Uganda among the Buganda people, treatment included giving a patient herbs and blood cupping (Lambo, 1973). This is in contrast to Prince's report in 1964 of the Yoruba people of Nigeria. Prince (1964), wrote that treatment included magical and herbal therapy. Each healer had his standard way of treatment. He would only change treatment when there was no improvement. If the treatment failed after changing it, then the witches were consulted.

Dawson (1964) studied two societies the Temne and the Mende in Sierra Leone. He found that the treatment largely was reached by prestige, reassurance and suggestion. Some physical remedy was used and also common complications were analyzed. The physical treatment included herbal medication, and the psychological treatment included confessions and counter oaths (Dawson, 1964). The patients who were mentally disturbed were kept in shackles which were only removed when they got better. What Dawson discovered in his study was that actually, the treatment followed a certain sequence. There was a suggestion of one being ill, followed by the sacrifice of the environment, then ego strengthening and then group therapy was done.

Whisson (1964) wrote that practitioners found it easy to recognize the social causes of mental disorders and not the organic disorders. The people who claimed to be healers tied up their victims for several weeks after which the practitioner would introduce worms which he claimed to have extracted from the nose of the patient. Sometimes an assortment of herbs would be used as treatment. If the patients were not cooperative, they would be beaten up severely. Organic disorders were considered to have the supernatural power of mental origins.

In Ethiopia, the treatment of mental illnesses was carried out by traditional healers who interrogated the patient. The patient was made to go into a trance, and he would then be forced to give praises to the doctor treating him (Messing, 1959). Through this treatment, many patients ended up joining these traditional healers and never went back to their families because in a way they had been initiated.

The treatment of mental illnesses in Senegal was similar to that of Ethiopia (Pfeiffer, 1971). The disturbing spirit was transferred to the patient's shrine. Subsequently, the patient was able to talk about his problems. This made it possible for them to be their therapist. Treatment of the mentally ill in the then Northern Rhodesia was no different from how other countries were treating their mentally ill. According to Turner (1964), the treatment of mental illness was not individual but a group based. The treatment involved sealing up the breaches in social relationships simultaneously with ridding the patient of the pathological symptoms (Okpaku, 1991). The procedure was known as divination was also used in Northern Rhodesia. The practice of mental health care in Zambia was no different from that of other African countries. Traditional healers were the first people those with mental illnesses consulted. The forms of treatment may have been different among African countries but the aim was the same.

From this brief examination of some of the traditional concepts and treatments of mental illnesses in some cultures, it becomes obvious that there were some similarities and differences. Some recognized physical causes of mental illnesses and others did not. Consequently, the emphasis was placed on the treatment of the individuals who had mental illnesses and social order and integration than on an individual. In general, it can be seen that the aim of each system was to fulfill the social and cultural needs of its society at that time.

Asylums in Africa

When the colonizers came to Africa, they found the locals practicing their traditions in healing mental illnesses. When the colonizers started practicing their medicine in Africa they came up with the notion that the mental illnesses that the African people suffered from were different from the ones that the Europeans suffered from (Vaughan, 1991). European colonization of Africa was rationalized, to a large extent, on the belief that European civilization was qualitatively more

sophisticated, rational, humane and introspective than those of non-Europeans, particularly Africans (Vaughan, 1991).

One of the most popular explanations for the superiority of European civilizations was that Europeans were simply intellectually and cognitively superior to Africans, a stereotype dating back into the days of the Atlantic slave trade that justified the sub-human treatment of Africans on the basis that Africans were somehow sub-human and, as such, meant to serve whites (Heaton, 2008).

The colonizers attributed the increase in the number of mental illnesses among the black people to the growing contact with the whites and the pressures of civilization (Swartz, 2003). Swartz further wrote that the increased contact between the whites and the blacks had traumatic effects on the blacks. The effects included racism, economic oppression and inadequate housing due to an increase in migrant labor.

Many psychiatric institutions in Africa were opened in late 1800 and early 1900 (Mc Cullouch, 1995). This happened as a result of the impact that colonial psychiatrists had a bearing on the locals. The introduction of the institutions came through the extension of colonial rule, through the coercion of indigenous persons into European-styled psychiatric institutions. The role of mental asylums was to remove mentally "abnormal" people from the streets so that they would not be a threat to law and order (Sadowsky, 1999).

However, because colonial governments were concerned only with those people who posed a significant threat to law and order, asylums typically only housed severe cases of mental illness, those that were too violent or severely affected to be controlled in their home environments by family and friends (Heaton, 2008). The power of colonial psychiatry was very heavily linked to that of the state in African colonies, including Zambia.

Most of the African countries passed a law for people with mental illnesses called the lunacy Ordinance around this time (the 1900s). The Lunacy Ordinance emphasized the custody of the people who were wandering about and idling and had no permanent housing or employment

(Mc Cullouch, 1995). In Nigeria, the development of asylums began when the first mental asylum was built in Lagos in 1903 and Calabar in 1904 (Oyebode, 2006). This situation was mirrored in other parts of Colonial Africa.

Kissy Lunatic asylum in Freetown, Sierra Leone, was built in 1847; the first asylum facility in the Gold Coast was opened at Victoriaborg in 1888; the asylum in Accra in Ghana in 1907; Ingutsheni in the outskirts of Bulawayo in Rhodesia 1908; and, the Zomba Asylum in Nyasaland in 1910 (Sadowsky, 1999).

Many of these asylums were extensions of the local prisons and often complemented other designated areas in prisons and annexes that functioned as prisons. In South Africa, the Robben Island Lunatic Asylum was established in 1846 by the colonial government as part of a larger general infirmary that housed lepers, lunatics, and the chronically sick. Zambia did not have asylums per say, but those who had mental illnesses and needed to be admitted were sent to Southern Rhodesia at the Ingutsheni Asylum (Mayeya et al, 2004).

Unfortunately, the asylums that were built were not so big that they could accommodate all the people admitted there. They were also under resourced (Vaughan, 1991). This made it impossible for the asylums to serve their purpose. Many people who were sent to these asylums were never discharged. Requests for expansion and improvement of facilities were regularly denied.

The result was that colonial asylums quickly became chronically overcrowded, dilapidated, and offered little to no therapeutic value to those detained within them (Vaughan, 1995). With time, the numbers kept increasing and the purpose they were made for was not fulfilled.

Around 1930's asylums reformed (McCullouch, 1995). During this period mental illnesses were classified and identified as such. Mental illnesses such as mania, dementia and psychosis were identified (Carver, 2005). New treatments for the mental illnesses were also discovered. They included malaria treatment for general paralysis of the mentally ill and therapies for schizophrenia and mania (Vaughan, 1991). The possibility that the mental illnesses could be alleviated by physical treatments transformed the asylum life (Sadowsky, 1999).

Despite rapid recent advances in knowledge and the evidence based approach in the developed countries especially in the western world, services in many African countries remain under developed with a large imbalance between urban and rural communities. It is equally sad to note that the first phase of the historical process described above still prevails in almost all African countries where traditional care based on local healers remains the point of first contact for most patients.

Current mental health situation in Africa

To describe the current state of mental health services in the majority of African countries as deficient is an understatement. Some countries have managed to decentralize mental health services and a large number of countries have embraced the policy of integration of mental health services into general health as the most effective way to realise equality and access to mental health intervention. Most developing countries dedicate less than 2 % of government health budgets to mental health care (WHO, 2012).

According to a study by the Grand Challenges in Global Mental Health Initiative, the biggest barrier to global mental health care is the lack of an evidence-based set of primary prevention intervention methods (WHO, 2012). This indicates that mental health is one of the most under resourced areas of public health in the African Region, even though mental health problems are on the rise. Thus, in many countries of the Region this area of public health requires more attention than it is currently receiving. This is the same problem Zambia is facing where the budget allocation to mental health care is less than 3% of the total health care budget.

Families and Mental Health

In most parts of Africa, the family remains a valuable resource for the support of patients with mental health problems (Fournier, 2011). Although most families are willing to care for their sick relatives, severe mental disorders may deplete resources of even the most willing and able families.

As urbanisation becomes more widespread and the extended family system is gradually breaking down, the availability of critical care for the mentally ill is becoming scarce (WHO, 2008).

The breakdown of the traditional family structures and values could also be contributing to poor mental health because this results in children, youth, and adults being poorly prepared to cope with life and may force them to turn to alcohol and illicit drugs as coping mechanisms.

Drug abuse

Indeed, reducing consumption of alcohol and illegal drugs has become a major challenge for Africa given that harmful use of alcohol is considered one of the four top risk factors for Non-Communicable diseases. Abuse of psychoactive substances is a mental health problem with strong social origins. In particular, the sources of problems due to the use of alcohol and the means of curtailing them are often found in the social fabric (WHO, 2012). Unless the issue of drug abuse is attended to, the number of people using drugs and developing mental health problems will continue rising.

Early diagnosis

Routine metal health screening in primary health care can detect possible symptoms of different mental illnesses (John, 2009). If routine mental health check-ups are made an early identification of mental of illnesses can be made and treatment be given early. Unfortunately, here has been an increase in the number of cases of mental illnesses in most African countries, yet there has been a lack of early diagnosis which turns the mental illnesses into chronic conditions.

Human resources

Despite the growing number of people suffering from mental illnesses in Africa, there is still wide- spread neglect of human resources for mental health care. Available evidence suggests

an alarming and inequitable distribution of professionals (Horton, 2007). Not only is there a scarcity of staff numbers but there is also a shortage of appropriate training (Saxena et al., 2007). Nearly 90% of African countries have less than one psychiatrist per 100,000 people, and the median density in many African countries is 0.06 per 100, 000, compared to 10.5 for European countries (Alem, 2007).

The shortages have been attributed to a lack of financial incentives for professionals to receive mental health training; poor working conditions, migration of professionals to high-income countries and inadequate training facilities (Sikwese, 2010). Like any other African country Zambia is facing a critical shortage of human resource even though the extent of the problem is still not well known (Katotonka, 2007).

Conflicts and wars

Populations in Some Africa countries such as Somalia, Ethiopia, Sudan, Rwanda and Democratic Republic of Congo (DRC) have encountered armed conflicts and natural disasters to varying degrees (Bujura, 2002). This has resulted in the displacement of many people from these regions and the consequences of these hardships maybe mental illnesses (Bujura, 2002). It is believed that the refugees have mental problems ranging from post-traumatic stress disorders to chronic mental illnesses (WHO, 2012). The rise in the number of people suffering from mental illnesses places an even greater burden on already under-resourced health care service in Africa.

Stigma

Most People who suffer from mental illnesses can recover fully or can live with and manage them particularly where they seek help early (Mayeya, 2002). Even though a significant number of people in Africa are affected, they encounter social stigma attached to their mental ill health. Their problems are made worse by the stigma and discrimination they experience from society.

Patients with severe and persistent mental illnesses are amongst the least likely of the group with long-term health conditions to find work, live in decent houses, to be socially included in mainstream society and to be in long steady relationships (Mayeya, 2002). This is because society, in general, worsens someone's mental health problems and delay or impedes their getting help and treatment in their recovery.

Conclusion

This chapter was looking at how mental health services have evolved in Africa pre, during and post-colonization. Currently, the number of people with mental health challenges in Africa is increasing though not at the same rate as HIV/AIDS, tuberculosis, and malaria. Considering that still has the lowest rate of mental out and inpatient facilities inherited from the colonial masters, there is a need for all African countries to optimize the delivery of mental health care services and take steps towards making this crisis n longer silent. The next chapter will discuss the findings in respect of the development of mental health services in Zambia

CHAPTER THREE

HISTORY OF MENTAL HEALTH SERVICES IN ZAMBIA

Introduction

This chapter will look at how the mental health services have evolved in Zambia before and after independence**.**

Mental health during colonization

Zambia was colonised in 1924 by the British government and as part of British institution-building, a different type of medicine was introduced. Doctor David Livingstone first introduced western medicine to Zambia (Lewis, 2011). However, he did not introduce any health institutions. Health facilities came with the official colonization process (Bob, 2013). Health facilities were tabled in Zambia by the parish society towards the end of the 19th century in the western province. After that, other missionaries from Scotland and other parts of Europe joined in (Kasonde & Martin, 1994).

The early spread of western medicine in Zambia was in the service of colonial interests and was at the center of the colonial imperative. Early European doctors functioned to offer medical treatment to European explorers, missionaries, colonial administrators and their families. To every colonial post, there was established a church, a school, and a hospital. The medical care in Zambia grew against the backdrop of the copper industry boom. The copper industry necessitated the establishment of medical facilities by the companies for their staff.

In 1925, the British South African Company (BSAC) brought in medical doctors and nurses specifically to treat their own people (Kasonde & Martin, 1994). At this time, both government and the missionaries provided a certain kind of medical care to its people. By 1939, a few hospital facilities were established in different towns on a segregated basis (kasonde &Martin, 1994). The introduction of western medicine was accompanied by official disapproval and discouragement of traditional medicine which was accorded low status (Bob, 2013).

Mental Health Care during Colonial Period (1924-1964)

After the colonisation of Zambia in 1924, most severely ill mental patients were sent to Ingutsheni Hospital in Zimbabwe (then Southern Rhodesia) and Village Chiefs and Headmen cared for the mildly ill (Harworth, 1993). The Lunacy Ordinance was enacted in 1927 to help formalize psychiatric care and make the high court responsible for the mentally ill (Haworth, 1993). Two prison-like buildings were established in 1947 and 1949 in the copper-belt and southern provinces, respectively and a Mental Disorders Act was put in place (MoH, 2000). The Mental Disorders Act of 1951 replaced the Lunacy Ordinance of 1951. Further developments (also prison-like) included the establishment of mental health observation centres, run by four registered nurses, in all general and district hospitals (Banda, 1980).

Opening of the main psychiatric hospital - Chainama Hills Hospital (1962)

The turning point in Zambia's mental health service provision was the opening of the main mental hospital (Chainama Hills Hospital) in June 1962 (MOH, 2000). Its first administrators were the Brothers of St John and the Franciscan Sisters of the Catholic Church. It had a capacity of 250 beds, later increased to 500 (Banda, 1980).

Services were subsequently decentralized leading to the establishment of seven mental units in all provincial hospitals except the north-western province. Policy issues were handled by the main mental hospital until about 1974 when the Ministry of Health took over responsibility (MOH, 2000).

Under the colonial government, the focus of mental health services was on institutional care and psychopharmacological treatment of patients with mental illnesses (WHO, 2000). The protection of society prevailed over the human rights of the individual (Burns, 2008). In this regard patients who with mental illnesses were largely removed from society and treated in mental institutions which were urban based. Training of enrolled female and male psychiatric nurses started at about the same time the main mental hospital was opened. By 1968, training of medical assistants in psychiatry had also begun (Mayeya et al., 2004).

Health Care in Zambia after independence (1964-1990)

After independence, Zambia inherited a health care system from the colonial masters. Health care became the mandate of the government through the Ministry of Health (Bob, 2013). Some missionaries were given the opportunity to continue running their hospitals. Other mission hospitals were taken over by the government because the missionaries either pulled out or were unable to continue running them (MoH, 1980). After independence, the traditional ways of treating the patients was not done away with. They were encouraged to continue. The Zambian Government increased the number of institutions as the need arose (MoH, 1999).

Primary Health Care was introduced in Zambia in 1980, and it was at the level of the district that the concept of Primary Health Care became tangible because the district was defined as the basic unit of its implementation. Each health unit sub-centre, health care, and district hospital had a complementary role to play including interaction with local communities and their traditional healers and community health workers (MoH, 1980).

Decentralization of Health Care Services

In 1991, as a result of the first democratic elections held since independence, the new government began a new era in health care management, one intended to transform health care into a more affordable care that serves basic needs (MoH, 2008). Zambian health reforms were delayed compared to those of many nations of comparable financial and demographic status, but this enabled Zambians to learn from others' experiences while avoiding much of the waste of time and effort that had been expended in learning these lessons (MoH, 2011).

The new government recognized the need for a new system based on effective, efficient, and affordable standards that used an essential packag**e** of cost-effective services, decentralized to the district level. The new system created was comprehensive with an improvement in human resources, civil service, Pharmaceuticals, information systems, financing/budgeting, and management structures, (Foltz, 1997; Kalumba, 1997; MoH, 1998 & Bob, 2013).

The decentralisation approach called for broader participation of all the key stakeholders, particularly the communities, in the governance of the health sector. Decentralisation was also meant to provide the health care at the district level. Grants were introduced to cover a significant proportion of local expenditure. This was intended to allow the health boards to make decisions for allocation of resources, user fee levels and expenditures (Kalumba, 1997).

Significant changes were made by the National Health Service Act (1995) to the role and structure of the Ministry of Health and in the establishment of an essentially autonomous health service delivery system to achieve this. Of the many reforms made- was the creation of the Central Board of Health to serve as the national coordinator of health service delivery, the technical unit responsible for the delivery of health services and implementation of health reform policies and strategies on behalf of the Ministry of Health and be part of Government's strategy to ensure that an ordinary Zambian citizen had a legitimate "voice" in the running of health service delivery (Kalumba, 1997).

Other policies

Apart from the National Human Resource for Health Strategic Plan (NHRP&SP)-1992, some other health policies and strategies such as Child Health Policy, Reproductive Health Policy, HIV and a Defined Basic Health Care Package (BHCP) were also developed over the last 15 years. Ministry of Health implemented 2006 to 2010 (NHRP-SP 2006-10), and significant achievements were made, though shortages have continued (MOH, 2008).

When most of these policies and improvement were being made in the Ministry of Health, mental health policies and improvements lagged behind. It is an indication that much has not changed in the delivery of mental health services since Zambia attained independence in 1964.

Current mental health services available

In Zambia, hospital-based figures show a prevalence rate of 3.61 and 8.1 per 10,000 for acute psychotic disorders and schizophrenia respectively (Mental Disability Advocacy Centre - MDAC, 2014). 10% of the admissions for acute disorders are alcohol and drug abuse cases.

The other common mental disorders found are Affective Organic Brain Syndromes (Mayeya, et al, 2010).

Service Provision

The health care vision of Zambia is to provide all Zambians with equity of access to quality cost-effective health care as close to the family as possible. The government through extensive consultations has made mental health a part of the National Health Strategic Plan and Basic Health Care Package (MoH, 2010). The Zambian government funds the mental health services. However, the percentage of the health care budget allocated to mental health is minimal.

Links between public and private practice

Most of the patients with mental illnesses are usually treated in state institutions (MOH, 2011). There are no private facilities in Zambia for patients with mental illnesses.

Traditional health practice

The people who practice traditional and herbal medicine include herbalists, diviners, and spiritual healers. People with mental health problems still consult them before they seek help from conventional health practitioners (MOH, 2011). The challenge is, there is a little collaboration between traditional and conventional health professionals.

Links between police and prison

The Mental Disorders Act 305 of Zambia states that if an individual who is "mentally disturbed" and is deemed dangerous to her/himself and others or is wandering at large and unable to take care of her/ himself; such a person can be apprehended and put in police custody for the safety of others and her/himself (Mental Disorders Act, 1951). In Zambia, many who are acutely disturbed usually end up in police custody before they are admitted to the mental health facilities. This happens because a system allowing for mental health in the police and prisons is not available (Bleeker, Hollander & Bob, 2013).

Human resources

From the time Zambia attained independence to date, the expectation is that the number of trained personnel should be on the increase as the population has increased and training facilities improved. This however is not the case. Instead it has been observed that the number of trained personnel is declining (MDAC, 2014). This is as a result of the brain drain, retirement, death and lack of interest of people to train in mental health. According to a country survey, there are only 260 mental health workers in mental institutions in Zambia (MDAC, 2014).

It has been further observed that most of the trained personnel prefer to work in bigger institutions denying smaller institutions the much needed services. Currently, there are three psychiatrists for the whole country of 13 million population. Other key mental health workers such as psychologists, social workers and occupational therapists are in short supply (Mayeya et al, 2008).

Mental health information system

According to MMAHP (2010) a mental health information system is not in existence. This makes it very difficult for the mental illnesses to be fully integrated into the health management information system. As a result there are no mental health indicators in the mental health information system.

Drug supply

The treatment for mental illnesses in Zambia is mainly psychotropic meaning that almost all the mental illnesses are treated using conventional drugs. The drugs are not readily available at all levels. The psychotropic drugs are primarily prescribed by psychiatrists and clinical officers. Therefore no other person can prescribe them in other institutions where these two cadres are not found.

Mental health promotion

Mental health promotion is essential to prevent and reduce the severity of certain mental health conditions such as stress, depression and post-traumatic stress disorder. Promotion can further delay the onset and support outcomes for these mental conditions. However, in Zambia, mental health promotion is lagging behind. As a result, there are grave consequences of untreated mental illnesses. The cost manifests itself through absence from school or work and poor performance. Similarly, a mental health program to address mental health matters of vulnerable groups such as children and women is lacking.

The era of traditional healers

The Zambian health care system before independence owes its beginnings to traditional medicine which was used by Africans (Bob, 2013). Traditional medicine as elsewhere south of the Sahara was the only medical service available to the sick. The traditional healer commonly referred to as Ng'anga played a recognizable function within the community to deal with health and illness. The traditional doctors used vegetable, animal, mineral substances and methods based on sociocultural traditions to deal with disease and to improve health.

The healer treated both relatives and non-relatives according to traditional practice. Traditional healers healed physical sickness, psychological problems, and discord within the family or community.

Role of non-governmental organizations (NGOs)

There is a strong collaboration with NGOs and these work directly in the area of mental health. A large number of NGOs provide mental health services as part of other programmes. NGOs provide an extensive network of mental health services, including half of all community-based residential facilities (MOH, 2011). There are various NGOs which deal with mental health matters, and these include; (MMAPP), Mental Health Users Network of Zambia (MHUNZA), Christian Organizations for Mental Patients (COMP) and a few others.

HIV and AIDS

The HIV/AIDS pandemic has not spared the country at all, and many families have lost their loved ones and in worst cases economically active people. The current prevalence rate among the reproductive age group 15-49 years is estimated to be at 16% (Simenda, 2013). The most affected are the urban areas with a prevalence rate of 23% while the prevalence rate for rural areas is 11%. Zambia is one of the most highly urbanised countries in Africa.

Furthermore, the social impact of HIV/AIDS is the high number of orphans (children who had lost parents). The implications of this are a marked increase in a child, and single-parent-headed households and poverty**,** with the resultant psychological and emotional consequences.

Conclusion

There has been considerable achievement in the provision of health care in post-independence Zambia, an increase in health care centres, strides in quality health workforce issues, the incorporation of traditional medicine in the National Health Care policy, significant improvements in selected health indicators such as health service delivery, health support systems; significant improvements in the pharmaceutical sector & medical supplies sector. Other notable improvements made in health care service delivery include arresting communicable diseases to manageable proportions, though several challenges still exist. Despite all the developments in the provision of health care in Zambia since independence, mental health care has been neglected.

CHAPTER FOUR

DISCUSSION AND RECOMMENDATIONS

Introduction

The purpose of this chapter is to discuss the findings in respect of the development of mental health services in Africa and Zambia in particular. The 4 phases of mental health care – the use of traditional healers, the institutionalization of patients, the opening of a mental health facilities and the involvement of the community– characterize the evolution of psychiatry globally and locally. These phases moved mental health care closer to the center of medical practice. The discussion will look at the infrastructure, the human resource, the policy, funding and the mental health in the community.

Mental health services

Mental health spending figures in Africa are dismal. Consistent with mental health care spending figures in low and middle-income countries (LMICs), health care infrastructure is still developing, and spending is often wanting in most African countries. The mental health services in Zambia are not so different from other services in many African countries. In Zambia, the mental health services are coordinated by the Directorate of Public Health at the Ministry of Health (Sikwese et al., 2010). At the general hospitals, the mental health issues are coordinated by the persons responsible for mental health.

Mental health services are not entirely fledged in the sense that care is not wholly provided in all 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 (Mwape, 2010).

The levels of care in many African countries are structured as follows: (a) health posts that serve small village areas; (b) health centers for larger towns; and (c) district or regional hospitals that provide a specialist level of care upon referral (Alem, 2007). Most of the time, specialists are primarily available at the regional or district level, so expert specialized care is only available to patients who can find their way to the district hospital.

Part of the problem of poor infrastructure and inaccessible care is that there are very few

facilities equipped to treat the severely mentally ill who may need acute or higher level of care, for example, the average number of psychiatric hospital beds per 1000 people in Africa is .034% (Saxena et al., 2007). Those that do exist often are located in urban centers and are poorly staffed and equipped. For example, in Ethiopia, there is only one psychiatric hospital in the capital, Addis Ababa (Alem, 2007). Other countries such as Botswana, South Africa, and Egypt may have more hospital capacity that is slightly better equipped and staffed (WHO, 2011), but these are still not sufficient to cover the entire population. Care is further compounded by the absolute lack of psychosocial treatment, unavailability of essential psychotropic medicines and access to mental health services. Service delivery is critically affected by the lack of monitoring and research.

Traditional healers

Traditional medicine plays a role in the provision of mental health services. Frequently people go to traditional healers before accessing mental health services. Most people with mental health issues in Zambia have seen a traditional healer for support. People may also see a traditional healer at the same time as a mental health professional or – particularly in cases of relapse afterwards. The scarcity conventional medicine in rural areas tends to make people to rely on traditional healers, and sometimes they take advantage of the vulnerability of the patient. However, data on the numbers of traditional healers and their practices in Zambia are lacking.

Many policy-makers in Africa talk about the need to integrate traditional health care into Orthodox service delivery, but on the whole, little success has been achieved where such integration has been attempted. One possible reason for this is that the policy of integration has not been well articulated.

Such policies have commonly failed to specify the service needs which can be met by the traditional approach, or to show how specific traditional interventions are to be assessed for efficacy or to give some idea of how good standards in service delivery can be achieved and maintained. Only very few traditional methods have empirical databases to support their effectiveness and safety.

While some traditional healers may offer helpful support, others financially exploit people desperate for help, only offering questionable 'care' and frequently without the consent of the individual concerned.

Infrastructure

The infrastructure for the mental health services that was available in Zambia before it attained independence is still the same to date. Little has changed despite the fact that the population has increased. The main mental facility remains Chainama hospital. The other small mental health facilities in other provinces are still in existence but very little has been done to improve them. There are still only 560 psychiatric beds in the country which has a population of 13 million (MDAC, 2014). Many of the wards are overcrowded, in particular, the wards at the main mental health facility (Chainama Hills Hospital). As a result of overcrowding, in- patients find themselves sharing mattresses. There are inadeaquate washing facilities and toilets. Some patients have no access to outdoor space. Some are allowed out of the ward only once a week. The wards generally have nothing for people to do. There are no newspapers, books, pens, paper or telephones.

All the mental hospitals still have seclusion rooms for the patients who are said to be a danger to other admitted patients. These seclusion rooms do not have adequate bathroom facilities. People in seclusion are often dependent on other patients to assist them whenever they need help Mental Disability Advocacy Centre (MDAC, 2014). In order to restrain the patients who are deemed violent, sedating them and handcuffing them is common.

The physical health of patients is compromised by poor hygiene facilities, an inadequate diet, and violence by some patients. Many patients feel unsafe in the hospital. Health care is routinely denied to mental patients, and clinical negligence has reportedly resulted in deaths. No independent investigations take place after a death in a mental health facility unless the relatives request this (MDAC, 2014).

None of the facilities has a complaints system. Patients are unaware of how they can complain, so abuses are hushed up and no-one is ever held to account. Zambia's mental hospitals are breeding grounds for abuse.

Human rights

Zambia ratified the UN Convention on the Rights of Persons with Disabilities in 2010, thereby committing to upholding the rights of all people with disabilities, including people with mental health issues (MMAPP, 2010). However, abuse and ill-treatment against people with mental health issues are still widespread and based on stigma and discrimination. The Mental Disorders Act 1951 entrenches state discrimination against people with mental health issues and is in urgent need of repeal.

A mental health bill is in its final stages of development, to replace a colonial-era law focused on the protection of society and incarceration of people deemed of "unsound mind" (MDAC, 2014) Case law relating to people with mental health issues is absent: people's rights and interests have not been legally defended, upheld or developed.

Mental health priorities in Zambia include mental health policy development, review of legislation, integration of mental health into the essential health care package/primary health care, human resource development, infrastructure repair, improvement of drug supply and improved communication across professional and institutional lines (International Mental Health Policy Programmes and Services Project, 2001). Since the advent of the health reforms, mental health services are slightly improving but not at the rate they should be.

Human resources

Mental health is an intersectoral issue, with interventions required in education, social welfare, criminal justice systems and the NGO sector. Nonetheless significant inputs are needed from the health sector to address mental health problems. However, in low-and middle-income countries, the health infrastructure to address these needs is highly limited. For example, Tanzania has 13 psychiatrists in the public sector for a population of 32 million while Kenya has 16 psychiatrists in the public sector for a population of around 30 million (WHO, 2005a).

Both Kenya and Tanzania each have around 200 psychiatric nurses, but these numbers are falling rapidly with movement out of mental health care to more lucrative programmes, as well as because of retirement and mortality.

There is a serious deficit of trained personnel in the medical field in Zambia just like many other African countries. This is even more pronounced in mental health. Ngungu and Beezhold (2009) state that, the strategy for mental health is less than coherent and the limited availability of mental health professionals to spearhead this agenda has contributed to the lack of progress. Zambia has only three psychiatrists for a population of 13 million (MDAC, 2014). Two of these are not in clinical practice but are attached to the local university.

In addition to being scarce, mental health workers are often misplaced and end up being assigned duties in the provision of general health care. For example, none of the mental health workers in the urban clinics within the capital city were providing mental health care because they had been placed outside the mental health care system (MMaPP, 2008).

Zambia needs more psychiatrists just to help build capacity in the mental health services, let alone to run such services. There are few psychologists, occupational therapists and mental health social workers (Sikwese et al, 2010). The bulk of patients is treated by mental health workers (clinical officers and nurses) who possess diploma qualifications post their secondary school education. There are few Clinical Psychologists to provide psychotherapy to Zambians.

The bulk of individuals reportedly providing psychotherapies are lay counselors that had short training (2 weeks, eight months) in psychosocial counselling courses that were designed for HIV counseling services.

Mental health policy processes

Zambia has an approved national mental health policy. The country's mental health system depends on the mental health law that is outdated. Since the early 2000s, there has been some effort to reform the Act, and this reached the stage of a draft parliamentary bill in 2006 (Ngungu and Beezhold, 2009). Between 2001 and 2005, the government began to integrate mental health policies into in the national series strategic plans. This meant that mental health was going to be listed as part of the health priorities.

The Zambian policy was finalised in 2005, and the process was led by the Health Ministry (Mayeya et al., 2008). Some steps were taken to improve the mental health legal framework. In 2006, new legislation, the "Mental Health Service Bill" was drafted by the Ministry of Health (Mayeya et al., 2008).

Some stakeholders and mainly practitioners within the ministry helped to draft the Bill. Ideally, the task of drafting legislation should be delegated to a specially constituted committee. Mayeya et al (2004) report that, when one looked at the draft Bill, it showed that it did not contain among others, the following essentials according to WHO Checklist on Mental Health Legislation and as enunciated by WHO (2005b): Fundamental freedoms and rights of mental health service consumers, family members, and other caregivers. Mechanisms to implement the provisions of mental health legislation also lacked as well as review mechanisms. However, the draft Bill had very notable improvements over the 1951 Act in the sense that it intended to ensure and comply with international human rights law (Sikwese, et al., 2010). The current mental health policy fails to provide a framework for enactment or review of mental legislation. In the absence of policy, it is hard to determine the disease burden, and financing of mental health care becomes difficult.

Mental health services in the community

The rehabilitation and long-term care of severely ill mental patients can be expensive. It is now generally accepted that while community care may be more humane, it is not necessarily cheaper than custodial care. Most African societies are fortunate in still being able to draw on the support of families for the care of the mentally ill. However, as urbanization becomes more widespread and the system of extended families breaks down, such readily available resources for the mentally ill may become scarce.

Due notice must also be taken of the fact that, even in traditional communities, not every family is willing or able to care for their mentally ill members. The large numbers of vagrant persons with psychotic disorders or mental retardation in many African towns and villages attest to this. Mental health services are nearly non-existent at the primary healthcare level.
Instead, mental health services are highly centralised, available only in eight hospitals across Zambia (MDAC, 2014).

Costs and journey times mean that mental health services are completely inaccessible to the vast majority of the population. Outpatient mental health care amounts to symptom management with drugs only (MMaPP, 2010). No other forms of support are offered.

According to Mwape, et. al, (2010) & Mweemba, et al., (2009), evidence shows that mental health services at the Primary Health Care level are less expensive than psychiatric hospitals for both patients and government. If patients with mental illnesses are referred to the main psychiatric hospital in the country without being screened, it imposes a financial burden on patients and even the government (Flisher, 2007). Integrating mental health services that are affordable and cost-effective into primary care can lead to improvements in health seeking behaviour that ultimately result in better clinical outcomes (Chisholm et al., 2007).

Clinical staff is so few that they often do not have time (and in some cases willingness) to inform patients of the potential benefits and risks of different treatments, nor to discuss patient views on medication options. There is little opportunity for early identification of mental illnesses and intervention if Primary Health Care is underutilised (Chisholm et al., 2007). This seriously undermines the ability of people with mental health issues to get the support they may need to participate fully in their communities.

Funding

The Government of Zambia covers approximately 60% of each person's healthcare costs, with the remaining 40% met by development partners and patients' fees (Mwanza et al, 2010) The Department of Mental Health at the Ministry of Health receives an estimated 300,000 Kwacha (approximately 36,000 EUR) per year to run mental health programmes across the country. Therefore, of the 11.3% national health budget mental health gets 0.008% (Mwanza et al, 2010). It is therefore heavily reliant on external funding from donors such as the World Health Organization and the UK Department for International Development. With 1% being spent on mental health it becomes difficult for mental institutions to meet their daily needs. Even planning is difficult for them.

Challenges that hinder progress to mental health services

Lack of funds

Many barriers impede progress mental health services in Africa. Much effort is put in to try and improve the availability of services. Lack of funds allocated to mental health by most African governments poses a problem in expanding services so as to adequately meet the demand. Lack of adequate transport and medication continue to pose as obstacles in the provision of proper care.

Lack of research

According to research carried out by the United States National Institute of Mental Health and the Global Collaboration Alliance of Chronic Disease, one of the biggest barriers to mental health is the lack of collaboration in conducting research (Collins, 2011). Research is essential for determining general needs when treating mental illness as well as for creating and monitoring cost effective interventions (WHO, 2007). Shortage of trained personnel in mental health is another barrier to improving mental health services.

Despite the challenges that are faced in the care of the mentally ill in most countries, there are some positive achievements. For example, the Ministry of Health in Liberia is working towards increasing mental health access to mental health services throughout the country. In that country training of more mental health clinicians has also been intensified (Lupick, 2012).

War stricken countries like Sierra Leone have established a rehabilitation project providing counselling and other support for people living with war trauma (Gordon, 2011). In the DRC, women have been victims of war, and a Centre was opened where they could go and receive counselling (Gordon, 2011). Also, a project on mental health and policy, whose main goal was to expand mental health research in Africa, was completed at the University of Cape Town in South Africa. The research had targeted the evaluation of mental health policies in Uganda, Zambia, Ghana and South Africa.

Poverty

People living in poverty are at increased risk of developing mental health problems due to factors such as increased levels of stress, exclusion, and reduced access to social capital, as well as physical factors such as malnutrition, obstetric risks, and exposure to violence (Patel, 2007). Simultaneously, those with mental illnesses are more likely to slide into poverty due to stigma and exclusion from social and economic opportunities due to the high cost of accessing treatment, or the loss of employment due to diminished productivity (Saraceno, Levav, & Kohn, 2005).

Poverty levels and their relationship to mental health in many African including countries Zambia prompted the United Nations to come up with policies that could deal with the issue by the formulation of the Millennium Development Goals (MDGs). The aim was for the MDGs to serve as a catalyst to end poverty and accelerate development in low- and middle-income countries. The MDGs included diversifying economies with opportunities for all and achieving basic standard of well-being for every person. Mental health is relevant to achieving these goals.

However, Africa's progress in achieving the health-related MDGs had been especially slow (United Nations, UN, 2009). Across the continent, the limited recognition at the policy level of the link between poverty reductions and mental health exacerbated the impact of this relationship. Some countries, such as South Africa even displayed retrogressive trends despite relatively high levels of health expenditure (Chopra et al., 2009).

There has been lots of debate about the omission of mental health and other non-communicable diseases from the MDGs, with some advocating for a more holistic approach to attaining the targets, through strengthening health systems to improve the provision of integrated care for physical and mental disorders (WHO, 2012), and others suggesting that strategies based on MDG initiatives can be used to achieve other development objectives, such as improving population mental health (WHO, 2012).

The MDGs were replaced by sustainable development goals (SDGs) in September 2015 (WHO, 2015). The SDGs now include a mental health permeable as well as a target within Goal 3 of the agenda which seeks to ensure healthy lives and promote well-being for all at all ages. As part for

this new programme African countries have the opportunity to embrace the SDGs so that a difference can be made in the care of people with mental illnesses.

Stigma

Stigma surrounding mental health conditions is due mainly to widespread misconceptions about their causes and nature. Around the world, mental health conditions often are viewed as manifestations of personal weakness, or as being caused by supernatural forces. People with mental health conditions commonly are People with mental health conditions experience stigma and discrimination on a daily basis. People with mental health conditions comprise a vulnerable group assumed to be lazy, weak, unintelligent, difficult and incapable of making decisions. They also are thought to be violent, despite the fact that they are far more likely to be victims rather than perpetrators of violence.

The consequences are substantial. Attributions of mental health conditions to possession by evil spirits or punishment for immoral behaviour frequently lead to harmful treatment practices. Discrimination and exclusion from community life are common and can occur in housing, education, employment, as well as in social and family relationships. Over time, significant social and economic deprivation occurs as a consequence.

Mental health policy

Zambia has an approved national mental health policy but the mental health plans have not been fully developed and implemented. Presently the planning process is being guided by cabinet guidelines which makes it difficult for the users to have an input.

The way forward

The future of mental health services in Zambia is optimistic as long as the challenges are addressed. Several constraints have plagued the sector such as the unavailability of a mental health policy, out-dated legislation, inadequate human resource and dilapidated infrastructure. There is need to do the following things:

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.

Provide treatment in primary care units

There is growing evidence in favour of integration of mental health into primary health care, and there is a tendency to accept that it is more cost-effective compared with hospital-based services. Like all other branches of medicine, it is difficult for non-professionals to diagnose and treat all conditions. But is has been shown that well trained general practitioners are capable of diagnosing and treating most common mental disorders (Patel et al, 2007). There is some evidence from developing countries that mental health can be scaled up at the national level through involvement of multipurpose health workers with limited education as the first point of contact with the primary health care system.

However, still more evidence needs to be generated and systematically reviewed on how integration can be implemented in the most cost-effective way. In the absence of strong health systems, integration is out of the question. Revitalizing the primary health care initiative provides a positive prospect for the future.

Development of Health Management Information Systems (HMIS)

A mental health information system aims to improve the effectiveness and the efficiency of mental health services and ensure a more equitable delivery by enabling service providers to make more informed decisions for improving the quality of mental health care. Noting that Zambia's HMIS is not fully developed and rigid and that existing HMIS does not accommodate mental health needs, there is a need to develop a good HMIS in mental health.

Provide Training

Human resource capacity can be improved through effective education, training, and recruitment. A review of the knowledge and competencies of staff in relevant areas can provide a starting point for developing appropriate measures to improve them. Relevant training on mental illnesses, which incorporates human rights principles, should be integrated into current curricula and accreditation programmes. In-service training should be provided to current practitioners providing and managing services. For example, strengthening the capacity of Primary Health Care workers, and ensuring availability of specialist staff where required, contribute to efficient and affordable healthcare for people with mental illnesses.

Provide adequate funding and improve affordability

Existing public services for people with mental illnesses are often inadequately funded, affecting the availability and quality of such services. Appropriate and sustainable financing of publicly provided services are needed to ensure that they reach all targeted beneficiaries and that high quality services are provided. During the development of the national mental health strategy and related action plans, the affordability and sustainability of the proposed measures should be considered and adequately funded through relevant budgets.

Make essential drugs available.

Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in the essential drugs list, and the best drugs to treat conditions should be provided whenever possible. Since clinical officers in Zambia are the first contact to patients but 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.

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.

Involve communities, families and consumers

Communities, families and consumers should be included in the development and decision-making of policies, programs, and services. Also, 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.

Educate 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. Therefore it is vital to improving public understanding of mental illnesses, confront negative perceptions and represent the illnesses fairly.

For example, education authorities should ensure that schools and employers should be encouraged to accept their responsibilities towards staff with disabilities.

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 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.

Support more research.

There is a need for a research unit in the Ministry of Health or if not possible, there may need to have a research commissioning and contracting unit. There is need for more research into health systems.

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

Conclusion

Zambia mental health care services have somewhat not changed much from the colonial era. Despite the growing burden of mental illness and the resultant high level of suffering of individuals and society, efforts to address this anomaly have been unsatisfactory due to low budgetary resources presence of competing and conflicting health system needs, scarcity of mental health personnel, and the stigma involved in seeking mental health care. Mental health policies signal a government's intent to address the mental health needs of its citizens, but Zambia still needs a relevant, modern and appropriate policy as well as the inclusion of mental health care into the country’s primary health care.

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