



Human rights and mental health in Zambia



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MENTAL HEALTH USERS
NETWORK OF ZAMBIA

Human rights and mental health in Zambia



2014



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Key

- : Inpatient psychiatric facilities
- : Traditional healers
- : Interview locations

1. Chainama Hills Hospital, Lusaka (the only tertiary care referral hospital in the country).
2. Traditional healer Mizyu, located at Kayama Township in Lusaka Province.
3. Traditional healer Jeremiah Arunk, Chizanga Township, Lusaka Province.
4. Traditional healer Maut, in N'yombe, Garden Township in Lusaka Province

Traditional healers psychiatric facilities and interview locations visited in Zambia by MDAC/MHUNZA monitors, 2011-2014. © MDAC.



1. Foreword

I commend the government of Zambia for facilitating access to MDAC and MHUNZA to conduct the first ever human rights investigation into mental health services in the country. Independent human rights monitoring and documentation are a vital source of information for governments and civil society as they seek to advance the rights of people with mental health issues. The willingness of the government of Zambia should serve as an example to other countries in the region and globally.

The report itself documents a number of serious human rights violations including unlawful detention in psychiatric hospitals, unregulated use of seclusion and restraints in both conventional and traditional healing settings, and physical abuse and exploitation within communities. These reflect what I have observed in other developing contexts, often occurring as a result of low awareness of human rights standards, limited financial and human resources and insufficient human rights advocacy. The report serves as a clear call for more awareness and greater action by governments which have ratified the UN Convention on the Rights of Persons with Disabilities (CRPD), which Zambia did in 2010.

A key finding in this report is that people with mental health issues experience abuse and exploitation in settings where they seek services (psychiatric facilities and traditional healing settings), and also in their communities. Abuse in the home is widespread, reflecting the wider social discrimination faced by people with mental health issues. The persistent disregard for rights of people with mental health issues often stems from deeply-ingrained stigma, a global phenomenon. Stigma breeds exclusion, discrimination and criminal neglect.

Action to stop ill-treatment and other forms of abuse should be swift. I am hopeful that the government of Zambia will take such action. The current process of legislative reform, including the passage of the Mental Health Bill and the drafting of a new Constitution, provide opportunities to outlaw violations in all settings and mandate the provision of human rights-compliant services in the community. The government should regulate traditional healers so that the unqualified “healers” can never be allowed to exploit or abuse people.

In common with the situation in many other countries, people with mental health issues in Zambia are still frequently deprived of their liberty and placed in psychiatric institutions. To change this situation, I urge the government of Zambia to implement Article 19 of the CRPD. This requires governments to take steps to ensure that people with mental health issues live safely in their communities with choices equal to others. The Zambian government must close facilities that result in long-term incarceration, recognising that the rightful place of everyone in Zambia is to access support so that they can live with whom they



want. Facilities such as the Nsadzu Mental Health Rehabilitation Centre which segregate and isolate people should ensure that residents are supported to be fully included in their communities just like everyone else.

The Zambian government has been willing to allow independent human rights monitoring of mental health services. A next step is for it to ratify the Optional Protocol to the UN Convention against Torture. The government should then establish an independent monitoring body mandated to conduct similar monitoring on a regular basis – and not just to psychiatric hospitals but to every facility where a person can be deprived of their liberty.

I thank MDAC and MHUNZA for producing this report. Collaboration between user-led organisations such as MHUNZA and professional human rights organisations such as MDAC enhances awareness of the human rights of people with disabilities both domestically and internationally.

I hope that the evidence of ill-treatment established by this report will provide momentum to decision-makers to undertake reforms, and will inspire others and people with disabilities themselves to come forward and advocate for change. We need leadership both within government and outside it to create more inclusive societies. The Zambian government should increase the mental healthcare budget. International donors should invest in services which respect human rights.

People with mental health issues have been waiting for too long to be included in societies. The evidence of human rights violations in this report spurs us to quickly reverse the situation. Change is possible and it must start now.

Shuaib Chalklen
United Nations Special Rapporteur on Disability



Photo: Sylvester Katontoka (MHUNZA), Mr. Ngoma (Chainama's longest resident) and a male resident (left to right), Chainama Hospital male rehabilitation ward (Ward E). 30 October 2012. © MDAC

The tattoos were all over my body [...] It was painful. The first drugs were very painful, the drugs for the eyes. I would sleep the whole day not feeling well.

Testimony from a young woman with mental health issues about visiting a traditional healer

2. Executive Summary

In 2011, the Lusaka-based NGO Mental Health Users Network of Zambia (MHUNZA) asked the international human rights NGO Mental Disability Advocacy Center (MDAC) to accompany it in monitoring ill-treatment of people with mental health issues in Zambia.¹ The two NGOs teamed up and carried out an investigation, looking at the reality of people's lived experiences through the lens of international human rights law. Three monitoring missions were undertaken: one in 2011, another in 2012 and the final one in early 2014. The team visited five psychiatric hospitals, five traditional healing clinics and a mental health "settlement". Many people gave testimonies: most importantly people with mental health issues themselves.

This report presents the findings of the first human rights monitoring of Zambia's mental health services. The two NGOs will convene a process of engaging civil society, governmental representatives and other stakeholders to jointly develop recommendations for action on the basis of international human rights law. Our overarching aim is to secure equality, inclusion and justice for all people with mental health issues in Zambia.

Mental health services

Mental health care in Zambia is governed by an outdated legal framework. Psychiatric services are chronically under-resourced, overly-centralised and dominated by pharmacology. People with mental health needs are subject to pervasive stigma, often resulting in physical abuse in their homes and communities.

Traditional medicine does play a role in the provision of mental health services. Whilst 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.

Legal orders for detention in psychiatric facilities lack safeguards: there is no assessment by a mental health professional, no legal representation, and no involvement of the person concerned. Many others are detained in psychiatric hospitals without any legal basis at all.

The human rights reality of people with mental health issues in Zambia is far from the human rights standards the Zambian government signed up to under international law. Prompt completion of the planned legislative reform and greater resources to provide for a range of care options accessible at the primary level are essential components in developing more human rights compliant mental health services.

Delivery of mental health services to the 13 million people in Zambia has been thwarted by low levels of funding. Currently, less than one percent of the health budget is spent on mental health service provision. There is also a lack of up-to-date mental health statistics available, limiting understanding of mental health needs and hampering evidence-based development of services.

Human rights

Zambia has ratified United Nations and regional treaties containing obligations relating to the human rights of people with mental health issues, including the Convention on the Rights of Persons with Disabilities. In 2012, the Zambian parliament passed the Persons with Disabilities Act based on human rights principles.² A mental health bill is reportedly 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".³ Case law relating to people with mental health issues is entirely absent: people's rights and interests have not been legally defended, upheld or developed.

Community

Family members carry the burden of supporting people with mental health issues. Formal psychiatric services are inaccessible to the vast majority of people. Families have minimal support from their communities, given the intense stigma of people labelled as mad. No services are available to support carers, resulting in families struggling to cope and people with mental health issues being chained and tied up.

Many people with whom monitors spoke testified that they had been chained in their own homes or in their communities. Women told monitors that they were beaten by their husbands and in-laws, and that their relatives and others in their community had physically and sexually abused them. Men reported being bullied, teased, harassed and even stoned by people in their community. A staff member in a hospital told monitors that when someone walks naked in a village, "people might hit him as they think he's possessed. Most of our patients have physical injuries." He added, "relatives don't beat to kill, but others can do."

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- 1 In this report we refer to 'people with mental health issues' throughout to mean people with psycho-social (mental health) disabilities. People with psycho-social disabilities include those who experience mental health issues or mental illness, and/or who identify as mental health consumers, users of mental health services, survivors of psychiatry, or mad.
 - 2 The principles, outlined in section 4 of the Act, include: respect for dignity and autonomy, non-discrimination, recognition before the law, respect for physical and mental integrity, independent living, social inclusion, respect for difference and diversity, equality of opportunity, accessibility, gender equality, respect for the evolving capacities of children with disabilities and the preservation of their identities.
 - 3 Mental Disorders Act 1951.

Victims of violence who have mental health issues are invisible in the eyes of the criminal law. “If someone comes to the hospital with physical injuries there’s supposed to be a police report,” explained one psychiatric hospital staff member, “but if the person is a psychiatric case, the police aren’t involved. Nothing happens.”

Traditional healing

The head of the Traditional Healers’ Association told monitors that almost half of the association’s members were “cheats masquerading as healers”. This acknowledgment of the scale of quack healers echoed testimonies collected from family members desperate for help. One woman explained that she had taken her relative with mental health issues to 25 traditional healers. She said that she found it, “hard to estimate the financial cost of all this as there were payments and also we had to get and give animals – including two cows.” Monitors asked her what advice she had for the government. Her response: “Arrest these people as it’s a kind of stealing. People are being cheated.”

Monitors spoke to several people who have been “treated” for their mental health issues by traditional healers. One woman said, “[t]he tattoos were all over my body [...] it was painful.



Photo: Shutterstock

The first drugs were very painful, the drugs for the eyes. I would sleep the whole day not feeling well.” Other people agreed that the Zambian government must protect its citizens from those who carry out criminal assault in the guise of “treatment”.

Mental health services in the community

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, a country with a landmass larger than France. Costs and journey times mean that mental health services are completely inaccessible to the vast majority of the population. Outpatient psychiatry amounts to symptom management with cheap drugs. No other forms of support are offered. Clinical staff are so few in number 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 and intervention. This seriously undermines the ability of people with mental health issues to get the support they may need to fully participate in their communities.

Psychiatric wards

The country-wide practice of arbitrary detention and forced sedation falls short of Zambia’s commitments under international human rights law.⁴ According to a 2005 Mental Health Policy, there were 560 psychiatric beds in the country which has a population of 13 million. Working in the country’s mental health system are a total of five psychiatrists, two psychiatric social workers, two psychologists and no trained occupational therapist. All are based in the Lusaka, the capital city, which has a population of over 3 million. Despite the high levels of dedication of the meagre staff, mental health care is inevitably limited: on any mental health ward there are one or two trained nurses on duty at any time.

Many of the wards are overcrowded, in particular the acute wards at Chainama Hills Hospital and the male wards at the Ndola psychiatric unit. In-patient psychiatry can be characterised as achieving two things: containing people in decrepit dormitory wards, and sedating people with high doses of psychiatric drugs.

4 Zambia has ratified the International Covenant on Civil and Political Rights (ICCPR) and its First Optional Protocol, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).



Photo: Mattresses are given newly-admitted patients rather than being left on beds at Chipata Hospital. Nurses complained that people steal the mattresses so they are kept in a locked room. 26 October 2012 © MDAC.

Overcrowding is prevalent, resulting in patients having to share mattresses on the male wards at Ndola psychiatric unit and at Chainama Hills Hospital acute wards. There are insufficient 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. There is no information about health, mental illness or rights.

Seclusion rooms are squalid and do not even contain a bucket. In these rooms, detainees are required to defecate and urinate on the floor. People in seclusion are often dependent on other patients to bring food. Chemical restraints are widespread: sedatives are either injected or people are forced to swallow tablets. Psychiatric hospitals use handcuffs. Seclusion and restraints are subject to no review or appeal process, and there is no legal framework regulating these practices. None of the hospitals visited had any policy or operational guidance for staff, nor any note-taking when restraints or seclusion were used. There is no scrutiny by any independent body. Abuses take place behind closed doors and with impunity.

The physical health of patients is compromised by poor hygiene facilities, an inadequate diet and violence by other patients. Many people reported feeling unsafe. Healthcare is routinely denied to psychiatric 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.

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 psychiatric hospitals are breeding grounds for abuse. This report seeks to initiate a discussion on how the situation could change.

The 1951 Mental Health Act is in urgent need of repeal. It empowers magistrates to sign 14-day detention orders without obtaining the views of the person concerned. **Deprivation of liberty** and placement of people with mental health issues in psychiatric wards also happens outside of the law. Relatives frequently give proxy consent: an act which has no legal authority.

Mental health care in prisons appears to be minimal. Prisoners and people assessed as being "of unsound mind" during court procedures may be detained in forensic psychiatric facilities. Discharge is possible only when clinicians and a prison officer make a recommendation to the country's President. Under international law, these people are arbitrarily and unlawfully detained.





Photo: A traditional healer's centre in Chadiza District, Lusaka. 1 November 2012. © MDAC.

This report is the result of the first human rights monitoring ever to have taken place in Zambia's psychiatric facilities. It provides evidence of significant ill-treatment in those institutions, and should serve as a catalyst for efforts to focus investment in community-based support services.

3. Background to the report

Staff from the Mental Health Users Network of Zambia (MHUNZA – a membership organisation representing people who have experienced mental distress) and from the Mental Disability Advocacy Center (MDAC – an international human rights organisation headquartered in Budapest, Hungary and London, UK) had met several times at international conferences and training events. The directors of the two NGOs met each year for the past five years in Pune, India, both being faculty members on an international diploma course on mental health and human rights. In 2011 MHUNZA asked MDAC to help it conduct monitoring of human rights in Zambia, focusing on traditional healing practices.⁵ There were many anecdotes about what happened behind closed doors, but no documented evidence about what exactly traditional healers did to help (or in some cases exacerbate) people’s mental health issues. This was a startling data gap, given that traditional healers are the country’s frontline mental health practitioners. A long-standing supporter of MDAC in the UK kindly provided the funding for the investigation and this report.

Interviewees told monitors about their experiences with traditional healers, and also reported significant abuse and neglect in their communities, and in psychiatric hospitals. The scope of the investigation was broadened to cover communities and psychiatric hospitals, a useful expansion of scope given the mental health law reform process the country is going through.

MDAC conducted visits to Zambia in November and December 2011, October to November 2012 and January to February 2014. Monitors interviewed more than 100 people in and around mental health services across the country. They visited five of Zambia’s eight psychiatric facilities, the only functional mental health “settlement centre” and various traditional healers’ clinics. In addition they carried out a review of the law and policy and a literature review to assess existing information.

This report is the result of the first human rights monitoring ever to have taken place in Zambia’s psychiatric facilities. It provides evidence of significant ill-treatment in those institutions, and should serve as a catalyst for efforts to focus investment in community-based support services.

The findings of this report based on the direct observations of monitors and testimonies collected from those interviewed as part of the monitoring process. Monitors have not been able to verify every allegation made but have included information that is specific, consistent with their own observations and other people’s testimonies, and which they have deemed credible. More detail on the methodology can be found in Appendix 1.



Photo: Eyong Mbuem and Hannah Roberts of MDAC interviewing a family on their use of traditional healing in a local community, Livingstone. 29 January 2014. © MDAC.

⁵ The majority of studies that have explored the intersection between traditional healing and mental health issues to date have been conducted through the lens of anthropology, public health or psychiatry. Links with human rights have largely been overlooked, mentioned in passing or considered in a relativist manner [according to local interpretation of human rights]. See, for example: Atalay Alem, “Human rights and psychiatric care in Africa with particular reference to the Ethiopian situation”, *Acta Psychiatrica Scandinavica*, 101 (2000): 93–96.



Photo: Shutterstock

"The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."

Article 1, UN Convention
on the Rights of Persons with Disabilities

4. Context

This section outlines the resources available in Zambia, sets out the formal mental health system and informal care provided by traditional healers. It then assesses the obligations of the Zambian government on the basis of international law which it has voluntarily committed to, and the prevailing national legislative framework.



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4(A). Zambia

2014 marks the fiftieth anniversary of Zambia's independence in October 1964. It is a large country, with a landmass of 752,618 km² (for comparison, France has 551,695 km²). It has a population of just over 13 million people (51% female), growing at 2.8% annually.⁶ There are 73 ethnic groups, and seven recognised local languages in addition to the official language, English.⁷ The Constitution declares the country a Christian nation, with 75% of the population declared Protestant and 20% Catholic. Half a percent (0.5%) of the population are Muslim, two percent (2%) other religions and just under two percent report no religion.⁸ 61% of the population live in rural areas,⁹ making Zambia one of the most urbanised countries in sub-Saharan Africa. The literacy rate of people over 15 years is 61%, with a stark gender differential: 71% of men can read and write, but only 52% of women.¹⁰

Zambia is a lower middle-income country,¹¹ located at position 163 out of 186 countries worldwide in the 2012 UN Human Development Index.¹² Economic growth has not resulted in

significant poverty reduction: 60% of people live below the poverty line and 42% live in extreme poverty.¹³ 90% of those living in extreme poverty live in rural areas.

Life expectancy is low: 49 years for men and 53 for women.¹⁴ The HIV/AIDS prevalence has dropped one percentage point recently to 14.3% among the 15-49 age group, meaning that the target of Millennium Development Goal number 6 has been met.¹⁵ The rate is still high, and has resulted in an increase of single-parent households, children living without parental care and poverty. HIV likely increases the need for mental health support, and a study on mental health stigma in Zambia noted a connection with the stigma associated with HIV.¹⁶ Another factor that increases demand on mental health services is the influx of refugees and integration of ex-refugee groups due to political instability in neighbouring countries.



6 Republic of Zambia, Central Statistical Office, *Zambia 2010 Census of Population and Housing: Preliminary population figures* (Lusaka: CSO, 2011).

7 Republic of Zambia, *National Cultural Policy* (Lusaka: Ministry of Community Development and Social Services, 2003).

8 Republic of Zambia, Central Statistical Office, *Zambia 2010 Census of Population and Housing: National Analytical Report* (Lusaka: CSO, 2012).

9 Republic of Zambia, *National Cultural Policy*. June 2003.

10 The World Bank, *World Development Indicators: Education completion and outcomes* (2014)

11 The World Bank, *Data: Zambia* (2012).

12 United Nations Development Programme, *Human Development Index and its Components* (2012).

13 The World Bank, *Zambia Overview* (2014).

14 Central Intelligence Agency, *The World Factbook* (2013 estimates).

15 The target is to keep HIV prevalence below 15.6%. See United Nations Population Fund Zambia, *Preventing HIV and AIDS* (UNFPA Zambia, 3 January 2013).

16 Augustus Kapungwe et al., MHAPP Research Programme Consortium, "Mental illness - stigma and discrimination in Zambia", *African Journal of Psychiatry* 13 (2010): 192-203.

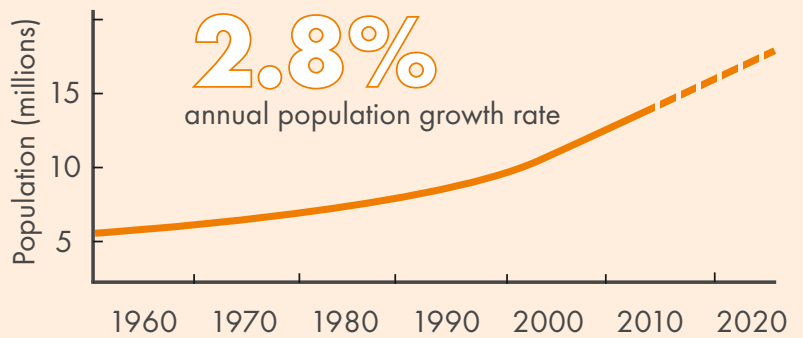
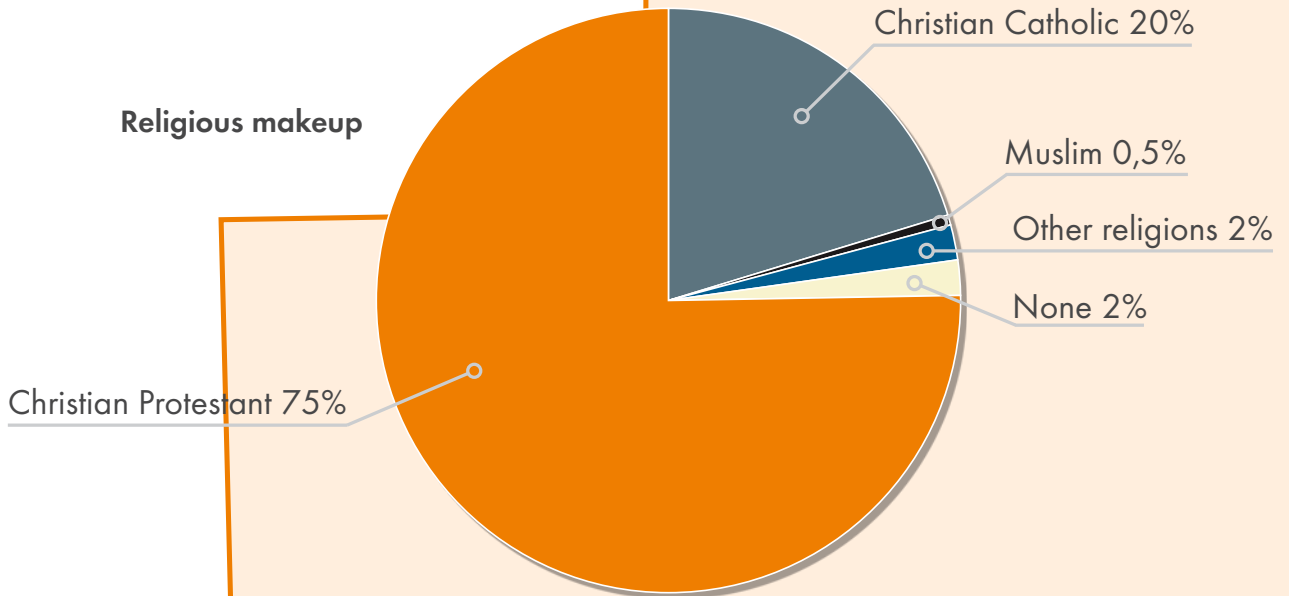
Key statistics

13,000,000 people

73 ethnic groups

8 Recognised languages
(official language - English)

Religious makeup

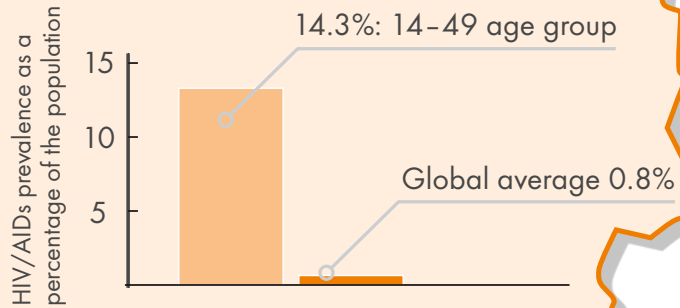


Landmass: 752,618 km²
(France = 551,965 km²)

Literacy (over 15 years)



HIV/Aids prevalence



Income



60% of the population are under the poverty line
42% of the population live in extreme poverty
(of those, 90% live in rural areas)

Life expectancy



Men - 49 years

Women - 53 years

Position 163 out of 186 in
Human Development Index

4(B). Mental health in Zambia

There are no official estimates of the number of people with mental health issues in Zambia,¹⁷ and nor is there a system for the routine collection of data. This hampers the development of services and breaches Article 31 of the Convention on the Rights of Persons with Disabilities, in which Zambia has undertaken to “collect appropriate information, including statistical and research data, to enable them to formulate and implement policies”. It is not only statistics which are lacking; academia and media have also shown little interest in people with mental health issues too.

People with mental health issues in Zambia are more likely than others to be denied education and be unemployed or in a low income job.¹⁸ Gender-based violence for women with mental health issues is prevalent, as women are economically dependent on their spouses and can be forced to live in abusive relationships.¹⁹ Sexual abuse of girls is also a problem: over 6,000 girls were reportedly victims of sexual abuse (“defilement”²⁰) in the period 2010–2013.²¹ The Human Rights Commission has attributed the failure to reduce the rate to culture, early marriages and traditional healers.²² A 2011 UN report refers to an increase in the number of cases of sexual violence against girls and citing a figure of one in ten women having experienced sexual violence.²³ A UN expert committee on women’s rights has also expressed concern about widespread rape and defilement, pointing out that it happens in the public sector including in places of detention, and on private property including the home.²⁴ This report echoes those findings.

The World Health Organization (WHO) estimates that 80% of people with epilepsy live in developing regions,²⁵ but there are no recent statistics on numbers of people with epilepsy in Zambia.²⁶ Chainama Hills Hospital estimates that it provided services to 1,500 people with epilepsy in 2013.²⁷ Similarly there is a lack of data on substance abuse, with Chainama Hills Hospital reporting that it provided services to 1,800 people for alcohol-related abuse and 500 for other substances in 2013.²⁸



Photo: Shutterstock

17 The Mental Health and Poverty Project in 2008 estimated that about 2,667 patients per 100,000 population were admitted annually to the only tertiary referral psychiatric hospital and units across the country. Jason Mwanza et al., *Mental Health Policy Development and Implementation in Zambia: A situation analysis*. (WHO Mental Health & Poverty Project, 30 March 2008).

18 *Ibid.*

19 John Mayeya et al, “Zambia mental health country profile”, *International Review of Psychiatry* 16 (2004):63–72.

20 Section 138 of the Zambian Penal Code creates states that the offence of defilement will have been committed by “any person who unlawfully and carnally knows any child commits a felony and is liable, upon conviction, to a term of imprisonment of not less than 15 years and may be liable to imprisonment for life”.

21 “Over 6000 Zambian girls defiled between 2010-2013”, *Lusaka Times*, 23 July 2013, available online at: <http://www.lusakatimes.com/2013/07/23/over-6000-zambian-girls-defiled-between-2010-2013/> (last accessed: 08.07.2014).

22 *Ibid.*

23 UN Human Rights Council, Report of the Special Rapporteur on violence against women: mission to Zambia, Rashida Manjoo, 2 May 2011, A/HRC/17/26/Add.4, 7.

24 UN Committee on the Elimination of Discrimination against Women, Concluding Observations: Zambia, 19 September 2011, CEDAW/C/ZMB/CO/5–6.

25 World Health Organization, Fact sheet N°999: Epilepsy, October 2012.

26 A 2004 study looking at epilepsy prevalence in rural Zambia finds an unadjusted prevalence of 14.5/1000. See Gretchen L. Birbeck and Ellie M. Kalichi, “Epilepsy prevalence in rural Zambia: a door-to-door survey”, *Tropical Medicine & International Health*, 9 (2004): 92–95.

27 Statistics from the report office of Chainama Hills Hospital, 25 February 2014.

28 *Ibid.*

4(C). International law

The Zambian legal system is based on the old English common law traditions and recognises customary laws that comply with the values of the Constitution.²⁹ Several laws have been under revision since the September 2011 general election. These include the Constitution and the Mental Disorders Act 1951. The National Policy on Disability was approved in 2013 but is not yet public.

In many aspects, the Persons with Disabilities Act (PWDA) passed in September 2012 meets Zambia's obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD). The government has *ratified* a range of UN human rights treaties, which means it must uphold the rights guaranteed in those treaties.³⁰ It has also ratified a range of African human rights treaties and agreements.³¹

In September 2010, Zambia *signed* the Optional Protocol to the Convention against Torture, but has not yet ratified it. Upon ratification the government must establish a body independent from government to inspect all places of detention including mental health facilities. Similarly, Zambia has signed but not yet ratified the optional protocols to the UN treaties on disability, and on women, which would allow for cases to be taken to the UN treaty monitoring bodies in Geneva once domestic remedies have been exhausted.

Of particular significance is Zambia's ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD) in February 2010. The CRPD requires Zambia to submit reports on measures it has taken to implement it. The first state report was due in March 2012.³² At the time of finalising this report (June 2014) the government had not submitted the state report. The UN Committee against Torture reviewed Zambia in 2008 but did not mention psychiatric facilities when addressing torture in places of detention,³³ missing an opportunity to comment on the ill-treatment of people within Zambia's formal and informal mental health systems.

The CRPD came into force in 2008 and its purpose is to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity".³⁴ People with mental health issues are, for the purposes of the Convention, "persons with disabilities" and thus are entitled to the rights it sets out. The emphasis of the Convention is on removing disabling barriers which "may hinder [people's] full and effective participation in society on an equal basis with others".³⁵

UN Convention on the Rights of Persons with Disabilities (CRPD)

The CRPD sets out numerous obligations on the government to put in place laws, policies and processes in relation to:

- Promoting non-discrimination;
- Undertaking research;
- Making information accessible;
- Actively involve persons with disabilities in public in law reform;
- Take steps towards securing substantive equality for persons with disabilities;
- Ensuring recognition of legal capacity and providing supported decision-making;
- Providing access to justice for all;
- Ensuring that detention and deprivation of liberty is never based on disability;
- Secure the right to independent living and inclusion in the community;
- Providing health services as close as possible to people's communities;
- Rolling out an adequate standard of living for everyone; and
- Collecting comprehensive data.

29 Alfred S. Magagula, *The Law and Legal Research in Zambia* (2009).

30 Zambia has ratified the International Covenant on Civil and Political Rights (ICCPR) and its First Optional Protocol, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

31 The African Charter of Human and Peoples' Rights and its Protocol on the Right of Women, the African Charter on the Rights and Welfare of the Child, Cultural Charter for Africa and the African Youth Charter.

32 According to Article 35 of the CRPD.

33 UN Committee against Torture, Concluding Observation of the Committee: Zambia, 26 May 2008, CAT/C/ZMB/CO/2.

34 Article 1 of the CRPD.

35 *Ibid.*

4(C)(i). Freedom from torture, ill-treatment, exploitation, violence and abuse

Monitors have uncovered a number of forms of ill-treatment against people with mental health issues in Zambia. It is important to point out that some have been carried out without intent to harm. However, under international human rights law, all forms of torture,

inhuman or degrading treatment are prohibited in absolute terms.³⁶ In particular, the UN Convention against Torture and the CRPD both establish requirements on the government to protect everyone from abuse.³⁷ The CRPD's longest provision is focused on preventing and providing remedies for all forms of exploitation, violence and abuse.³⁸ The CRPD requires governments to mandate healthcare professionals to provide care, "on the basis of free and informed consent".³⁹ The UN Special Rapporteur on Torture has clearly stated that the "criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made".⁴⁰ The UN Special Rapporteur recommends banning seclusion and restraints. Even if applied for a short period these "may constitute torture and ill-treatment".⁴¹ Guidelines developed by medical and nursing bodies in other countries have detailed

how staff must prevent the need for restraints, emphasising prevention of distress with a focus on techniques such as enhanced observation, de-escalation methods and advance discussion with patients of their preferences.⁴² Although international practice varies, there is a growing evidence base that mental health care can and should be carried out in the least restrictive manner possible.⁴³



Photo: A resident of the Nsadzu Mental Health Rehabilitation Centre. 26 October 2012. © MDAC."

4(C)(ii). Right to health

The right to health also entails freedoms: the freedom to say no. The right also includes entitlements such as "early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities".⁴⁴ The duty is to "provide these health services as close as possible to people's own communities, including rural areas," and to "[p]rovide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons".⁴⁵

36 At the regional level, the African Charter of Human and Peoples' Rights (ACHPR) prohibits "all forms of exploitation and degradation of man" including torture, cruel, inhuman or degrading punishment and treatment (Article 5, ACHPR). It guarantees the best attainable state of physical and mental health, provides for special protection for the "aged and the disabled" and gives everyone the right to a "general satisfactory environment favourable to their development" (Articles 16, 18 and 24, ACHPR). These apply equally to people with psycho-social disabilities (Articles 2 and 3, ACHPR). Additional protection is provided to women with psycho-social disabilities through the Protocol to the ACHPR on the Rights of Women in Africa, which obliges States to provide special protection to ensure their right to freedom from violence, including sexual abuse, discrimination based on disability and right to be treated with dignity (Article 23 of the Protocol). It further prohibits all forms of exploitation, cruel, inhuman or degrading punishment and treatment and obliges states to adopt legislative, administrative, social, and economic measures necessary to ensure the prevention, punishment and eradication of all forms of violence against women (Articles 4(1) and 4(2)b of the Protocol). The African Charter on the Rights and Welfare of the Child (ACRWC) provides similar protection to children.

37 Articles 15 and 16 of the CRPD respectively. See also Article 11 of the CAT; Articles 7, 10(1) (2) & (3) and 16 of the ICCPR, and Articles 19(1) & (2) and 23 of the CRC.

38 Article 16 of the CRPD.

39 *Ibid.* Article 25(d).

40 UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, 1 February 2013, A/HRC/22/53.

41 *Ibid.*, at para 23.

42 See for example, Royal College of Nursing, *Violence: The short-term management of disturbed/violent behavior in in-patient psychiatric settings and emergency departments* (2005)

43 See, for example, Mental Disability Advocacy Center, *Cage beds and coercion in Czech psychiatric institutions*, (Budapest 2014), at Chapter 8.

44 Article 25(b) of the CRPD.

45 Article 25 of the CRPD.

4(C)(iii). Right to live in the community

Institutionalising people with disabilities is anathema to one of the core provisions of the CRPD, namely Article 19, which sets out the “equal right of all persons with disabilities to live in the community”. The provision specifies that everyone has the right to choose where and with whom to live, and places a duty on governments to take effective and appropriate measures to facilitate full enjoyment of this right. Access to regular services must be made available. A range of disability-specific community support services should be put in place, so as to prevent isolation or segregation from the community.

4(C)(iv). Right to legal capacity

The CRPD guaranteed that all people with mental health issues have a right to make decisions in their lives, and that they should be supported to make their own decisions. Article 12 of the CRPD requires that the government ensures that their decisions are recognised and protected.⁴⁶ Removing from people with mental health issues the right to make decisions about how to live their life exposes them to harm, including in healthcare settings where refusal to consent to treatment is ignored. MDAC’s research on the right to legal capacity in Kenya has found that relatives and medical practitioners frequently make decisions for people with mental health issues regardless of the will or preference of the person concerned, which constitutes a violation of Article 12.⁴⁷



Photo: A spiritual healer’s centre in Mumbwa, Central Province. 28 October 2012. © MDAC.

4(C)(v). Right to liberty

The CRPD stipulates that disability status cannot be a criterion in detention decisions,⁴⁸ a provision which is the focus of intense international debate.⁴⁹ The Committee on the Rights of Persons with Disabilities (CRPD Committee) has called on States to repeal laws and prohibit the detention of children and adults with disabilities with reference to their disability status. This includes ending involuntary hospitalisation and forced institutionalisation.⁵⁰

46 *Ibid.* Article 12 (1), (2) and (3).

47 In March 2014, MDAC produced a report on the right to legal capacity in Kenya. It found that decision-making rights of people with mental health issues were frequently restricted by custom rather than law, by family members and members of the local community. Mental Disability Advocacy Center, *The Right to Legal Capacity in Kenya*, (Budapest: 2014).

48 Article 14 of the CRPD.

49 See, for example, the written comments of the governments of Germany and Denmark to the draft general comment on Article 12 of the CRPD by the UN Committee on the Rights of Persons with Disabilities, 2014.

50 UN Committee on the Rights of Persons with Disabilities, General Comment No. 1, 11 April 2014, CRPD/C/GC/1; UN Committee on the Rights of Persons with Disabilities, Concluding Observation of the Committee: Azerbaijan, 12 May 2014, CRPD/C/AZE/CO/1.

4(D). National laws

Zambian laws affecting the rights of people with mental health issues include the 1996 Constitution, the Mental Disorders Act 1951, the Health Profession Act 2009, the Persons with Disabilities Act 2012 and the Medicines and Allied Substances Act 2013. There is no case law relating to people with mental health issues, indicating the challenges which people face in accessing justice, and perhaps also the level of willingness of human rights NGOs, lawyers and judges to take seriously the rights of people with mental health issues.

The Constitution prohibits discrimination⁵¹ and sets out an absolute prohibition on torture or inhuman or degrading treatment or punishment.⁵² It sets out the right to liberty, but a person reasonably suspected to be of “unsound mind” can be detained. This contradicts the constitutional right to non-discrimination and provisions on the right to liberty set out in the CRPD. The ongoing constitutional review process provides an opportunity for rectification.

The Mental Disorders Act 1951 is a piece of legislation from colonial times which labelled people as mad, disregarding their views about how they wanted to conduct their life. This law uses the offensive (and legally meaningless) terms “mentally defective”, “idiots”, “feeble minded”, “imbeciles” and “moral imbeciles”, all of whom can be lawfully detained against their will in their own and society’s best interests.⁵³ International human rights law, which Zambian governmental representatives have participated in developing, has thrown this outdated worldview into the dustbin of legal history.

To some extent the law has already been superseded by the 2012 Persons with Disabilities Act (PWDA), which states that its provisions “shall prevail to the extent of any inconsistency”.⁵⁴ The PWDA expressly transmits CRPD obligations into domestic law. It refers to services needing to be as close as possible to people’s own communities. It sets out the primacy of informed consent, rehabilitation, independent living and employment.

Its applicability may be unduly limited as it defines disability as a “permanent” impairment.⁵⁵ This is more restricted than the CRPD, which refers to disabilities as *including* long-term impairments. Some people with non-permanent mental health issues may not be entitled to the protection of the PWDA, a point which could be challenged in the courts.

At the time of writing (June 2014), a Mental Health Bill is yet to be finalised. The process of writing the Bill has included the public, and consultations with mental health service users – a process to be commended. The Bill will likely repeal the Mental Disorders Act 1951. The Bill’s preamble provides for respect, autonomy, non-discrimination and the right to self-determination for people with mental health issues. It sets out a community-based approach to mental health provision, establishes rights and responsibilities of patients, ensures that mental health services are available in prisons, establishes a National Mental Health Commission and a Mental Health Tribunal. The Bill’s provisions apply to both government and private facilities and individuals including traditional healers, carers, health providers, mental health users and the community.⁵⁶ Effective implementation of the law will require training of healthcare professionals and awareness-raising for everyone working in the formal and informal mental health systems.

The Health Professions Act 2009 requires doctors and nurses to be registered. It regulates their conduct by providing a code of ethics and establishing a disciplinary committee to which a person may lodge a complaint.⁵⁷ The Medicine and Allied Substances Act 2013 requires registration and regulation of pharmacies, health shops, and medicines. It regulates the manufacture, import and export, possession, storage, distribution, supply, promotion, advertising, sale and use of medicines.⁵⁸ Regulation of the formal mental health sphere makes the case more compelling for also regulating traditional healers who work outside any form of government regulation or control.

51 Constitution of Zambia, Article 23(1).

52 *Ibid.*, Article 15.

53 In 2011 the parliamentary Committee on Health, Community Development and Welfare noted that “Stakeholders bemoaned [...] the continued use of an out-dated piece of legislation, the Mental Disorders Act, 1951. They were of the view that the Act had contributed to the continued violation rather than promotion of human rights of people with mental disorders because it aims at safe-guarding members of the public from perceived dangerous, demonic possessed and sub-human persons with mental health problems.” Report of the Committee on Health, Community Development and Social Welfare for the Fifth Session of the Tenth National Assembly appointed on 23 September 2010.

54 Republic of Zambia, The Persons with Disabilities Act (PWDA), No. 6 of 2012, section 3.

55 Section 2, PWDA 2012.

56 *Ibid.*, section 2.

57 Health Professions Act 2009, sections 60 and 61.

58 Medicines and Allied Substances Act, Part IV.



Photo: Shutterstock

It's quite common for relatives to hit a patient, bring them here [a psychiatric ward], then the patient goes home and they are beaten again.

Clinical officer on a psychiatric ward outside Lusaka

5. The home and community

5(A). Family support and harm

People are quiet about sexual abuse. Sometimes the abuse is out of ignorance and relatives are overwhelmed.

A clinical officer

Family members are typically the primary carers for people with mental health issues in Zambia. The person with a mental health issue and a relative are often both out of work, meaning the financial burden for families can be significant.⁵⁹ Mental health services are limited to seven cities around the country. These are seriously under-resourced and inaccessible for the vast majority of the population. Families are frequently left struggling without any support.

Family members sometimes tie or chain people with mental health issues during a mental health crisis.⁶⁰ The family typically sees this as a pragmatic solution to contain a person for their own welfare and for that of people around them. Most traditional healers interviewed said that people with mental health issues were brought to them chained or tied by relatives. The same happens in psychiatric hospitals too. A young woman in a psychiatric ward commented:

I was tied to bring me here. I was bruised – on my wrists and, see, my ankles still have a sore. Before when I've been too weak to make a decision my brother has taken me to a traditional healer in a wheelbarrow. But I was tied to come here.

Many people said that chaining and tying was a necessity because there was no alternative. Family members spoke of the huge cost to get to distant psychiatric hospitals which meant that they were unlikely to seek help early or be able to move a distressed person.

Patients and nurses in psychiatric facilities emphasised both the pressure on families and the abuse that arises as a result of this. A nurse in Chainama Hills Hospital said:

Most patients have been physically and/or sexually abused at home. Physical abuse is most common. Sometimes it's very obvious with bruising. People are quiet about sexual abuse. Sometimes the abuse is out of ignorance and relatives are overwhelmed.

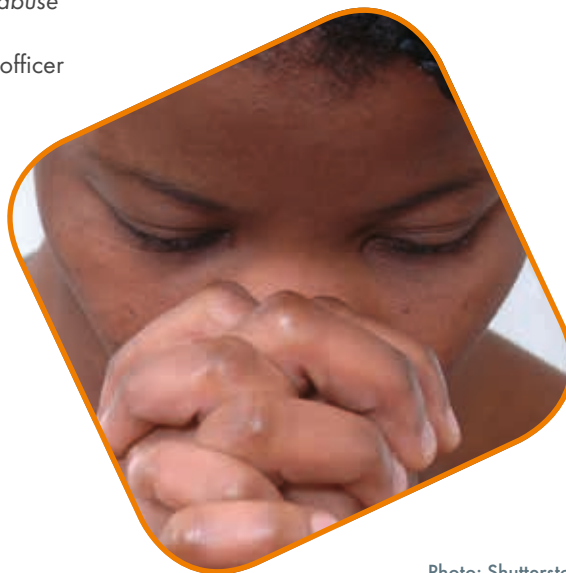


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This was similar to the experience of a clinical officer in a psychiatric ward outside Lusaka:

The relatives usually beat them, not necessarily in self-defence. It's quite common for relatives to hit a patient, bring them here, then the patient goes home and they are beaten again.

A 40-year old spouse of a woman with mental health issues explained:

[My spouse] used to be chained when she was at [her parents' home] by her relatives. Whenever she ran from home and attempted to take her clothes off, they would get hold of her and chain her [...] They used strings made from tree barks [...] her hands were chained to something stationary so that she couldn't move away. [...] One of her relatives would beat her sometimes because, when she was taken ill, she would take her clothes off.



Photo: Shutterstock

5(B). Community violence

Neighbours laugh at me and my husband. They say we're mental, we'll kill our child, we're criminals.

A young mother with mental health issues

The pervasive stigma about mental distress, previously reported in many studies, was confirmed by our investigation as being a serious and lifelong impediment for people perceived as having a mental health issue, and for their families.⁶¹ Many people told monitors about the difficulties they faced in their communities:

Testimonies

It's a big problem. Neighbours laugh at me and my husband. They say we're mental, we'll kill our child, we're criminals.

Young mother with mental health issues

The community are difficult. He's come back running from them. Last November he was hit and had a broken tooth. But if we keep him inside he becomes violent. He's been beaten several times in the last year.

Mother of a young man with mental health issues

The challenge is that people have this perception that if you are a person with mental health disability... they do not consider you as part of society.

Representative of the Ministry of Community Development, Mother and Child Health

Stigma is real and is there, you find that in an African setup maybe somebody has a mental challenge they will say 'Alipena' meaning he or she is mad or 'Chofunta' meaning that guy is crazy, he has got no brains.

Church pastor

I think people have a lot of stigma and discrimination [...] if I'm walking; people are pointing fingers and are laughing.

48-year old woman with mental health issues

61 Kapungwe et al., MHAPP Research Programme Consortium, "Mental illness - stigma and discrimination in Zambia", 2010, 192-203.

Stigma is not only an emotional and social affliction but causes increased levels of violence. MHUNZA conducted a focus group discussion with people with mental health issues and their relatives to identify human rights violations in the community.⁶² Women reported being beaten by their husbands and their in-laws, and talked about physical and sexual abuse by their relatives and others in their community. Male participants reported being bullied, teased, harassed and stoned by community members.

The results of abuse were apparent when monitors met a female patient at Chainama Hills Hospital whose face was swollen. She said that she had been beaten in her local community. In a different ward, monitors met an elderly carer who explained how he took his male relative to a school, “but he was beaten, and then he’d fight back, so he had to leave.” A clinical officer out of Lusaka set out the stark reality:

Most of our patients have physical injuries. [...] We had one patient that was beaten in town in 2009, he died the same day. The following year one patient absconded and was found dead in a brutal killing. Relatives don’t beat to kill, but others can do.



Photo: A man at Livingstone Psychiatric Hospital who spent most of his days like this since 2004 because his relatives have neglected him. 29 January 2014 © MDAC.

5(C). State inaction

It’s not worth reporting being raped.

A woman with mental health issues.

A former patient was abandoned by her family and now lives in a disbanded psychiatric unit. She makes and sells floor mats during the day and returns to the old psychiatric unit in the evening to sleep. “If something happens to her in here, no one will know,” said a psychiatric clinical officer.

The frequency of such attacks is unknown: victims of such assaults typically do not report them to the authorities. Monitors visited the victim protection unit at the central police station to obtain data but were told that the unit receives only cases of domestic violence and does not record mental health issues.⁶³ One woman explained that her daughter, an outpatient of the main psychiatric hospital, was raped and murdered in the community and there was no response from the police. Another woman said that it was not worth reporting being raped as the police would never take her story seriously given her psychiatric history. A clinical officer confirmed that, “[i]f the person is a psychiatric case, the police aren’t involved. Nothing happens.”



Photo: Former psychiatric facility in Livingstone closed in October 2013. 29 January 2014 © MDAC

Medical care following abuse is scarce. Healthcare services seem to put people with mental health issues at the bottom of the list of priorities (see section 7(G) of the report, below). Attitudinal shifts of healthcare workers have not been found since 2007 when researchers from King’s College London showed low rates of help-seeking and poorer quality of physical healthcare among people with mental illnesses in Zambia.⁶⁴

62 MHUNZA held a focus group in Lusaka on 23 March 2011. Ten women with mental health issues participated (age range, 18–60 years) as did six men with mental health issues (age range 25–58). Nine relatives also took part (age range 42–67).

63 MDAC/MHUNZA visit, 6 February 2014.

64 Graham Thornicroft, Diana Rose and Aliya Kassam, “Discrimination in health care against people with mental illness”, *International Review of Psychiatry*, 19 (2007): 113–122. The paper notes that, “[p]eople with mental illness often report encountering negative attitudes among mental health staff about their prognosis, associated in part with ‘physician bias’. ‘Diagnostic overshadowing’ appears to be common in general health care settings, meaning the misattribution of physical illness signs and symptoms to concurrent mental disorders, leading to under-diagnosis and mistreatment of the physical conditions.”

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Photo: A selection of traditional healers' flyers collected by MDAC and MHUNZA, November 2012.

When you get there sometimes they say you should go find and eat a small lizard, if not that then you need to catch and eat a small snake. When you eat that snake, while it's alive, that's when you'll get better.

18-year-old woman with mental health issues

6. Traditional healers

The World Health Organization (WHO) defines traditional medicine as

*a diversity of health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral-based medicines; spiritual therapies; manual techniques; and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness. The comprehensiveness of the term [...] and the wide range of practices it encompasses make it difficult to define or describe, especially in a global context.*⁶⁵

Traditional healing has been described as is “an integral part of culture, represents a sum total of beliefs, attitudes, customs, methods and established practices indicative of the worldview of the people”.⁶⁶



Photo: Women from Church of Zambia praying for female patient in the B Ward in Chainama Hospital. 30 October 2012 © MDAC.

6(A). Traditional healing and mental health

Traditional healing – sometimes called ‘African medicine’ – acknowledges the interconnectedness of the physical world and spirituality.⁶⁷ Mental health issues are understood as possession by evil spirits. They are “disturbances in the relationship between people and divinity, divine punishment for past actions, or an unbalance due to social issues”.⁶⁸ Compared to psychiatric services, traditional medicine is readily available and thus more accessible to the general population.⁶⁹

Many traditional healers promise effective solutions. Indeed, in 2001 the World Health Organization referred to the “demonstrated efficacy” of traditional and complementary/alternative medicine in relation to mental health.⁷⁰ Others question the efficacy and ethics of traditional healing practices in various parts of Africa.⁷¹ Researches on traditional healing in Zambia have previously focussed on HIV and other sexually-transmitted diseases, epilepsy and how to build trust between traditional healers and healthcare workers.⁷²

- 65 World Health Organization, *Legal Status of Traditional Medicine and Complimentary/Alternative Medicine: A world wide review* (Geneva: WHO, 2001), 1-2.
- 66 Olaniyi Bojuwoye, “Traditional Healing Practices in Southern Africa: Ancestral Sprits, Ritual Ceremonies, and Holistic Healing” in *Integrating Traditional Healing Practices Into Counseling and Psychotherapy*, ed. Roy Moodley and William West, (Thousand Oaks, CA: SAGE, 2005), 61.
- 67 Bojuwoye, “Traditional Healing Practices in Southern Africa: Ancestral Sprits, Ritual Ceremonies, and Holistic Healing”, in Roy Moodley and William West, *Integrating Traditional Healing Practices Into Counseling and Psychotherapy* (eds.), (Sage Publications Ltd.: 2005), at pp. 61-72.
- 68 See, for example, Sorsdahl et al, “Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa” (*African Journal of Psychiatry*, 13(4) (Sep 2010): 284-290); Human Rights Watch, “*Like a Death Sentence: Abuses against persons with mental disabilities in Ghana* (2012), available online at: <http://www.hrw.org/reports/2012/10/02/death-sentence-0> (lase accessed: 09.04.2014).
- 69 Jean Nagelkerk and Marian M. Tabi, “Nursing in Ghana”, *Journal of Nursing Administration*, 24 (1994): 17-18; Tholene Sodi, “Towards recognition of indigenous healing: Prospects and constraints”, (*Journal of Comprehensive Health*, 7 (1996): 5-9); Michelle Cocks and Valerie Møller, “Use of indigenous and indigenized medicines to enhance personal well-being: A South African case study”, (*Social Science & Medicine*, 54 (2002): 387-398); Christa Rautenbach, “Some comments on a new legislative framework for female traditional healers in South Africa”, (*Emory International Law Review* 22 (2008):113).
- 70 World Health Organisation, *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A worldwide review*. (Geneva: WHO, 2001): 4. See also “Minister stresses traditional medicine in mental health”, ANGOP - Agência Angola Press, 6 October 2013, available online at: http://www.portalangop.co.ao/angola/en_us/noticias/saude/2013/9/40/Minister-stresses-traditional-medicine-mental-health.87e51efb-8b75-45c3-a784-5e4bc5dca805.html (last accessed: 09.07.2014).
- 71 Ae-Ngibise et al., The MHAPP Research Programme Consortium, “Whether you like it or not people with mental problems are going to go to them’: A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana” (*International Review of Psychiatry*, 22(6) (2010): 558-567); Ursula Read, Edward Adiibokah and Solomon Nyame, “Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana”, (*Globalization and Health*, (2009): 5-13); Human Rights Watch, “*Like a Death Sentence: Abuses against persons with mental disabilities in Ghana*”, *supra* note 68; Ehab Sorketti, Nor Zuraida Zainaland and Mohamad Hussain Habil, “The traditional belief system in relation to mental health and psychiatric services in Sudan” (*International Psychiatry*, 9(1) (2012): 18-19).
- 72 MDAC and MHUNZA literature on traditional healing and mental health in Zambia.
- 73 Chidi Oguamanam, “Between Reality and Rhetoric: The Epistemic Schism in the Recognition of Traditional Medicine in International Law” (*Saint Thomas Law Review*, 16 (2003): 59).

International law recognises traditional healing as an indigenous knowledge system.⁷³ The right to participate in cultural, religious and scientific life of the community is guaranteed in human rights law at the United Nations⁷⁴ and African levels.⁷⁵ These official documents speak of the value of collaboration between practitioners of conventional and traditional medicine.⁷⁶

Traditional healers are reported to fear their medicines being stolen.⁷⁷ They doubt western medical doctors' ability to cure,⁷⁸ and think that physicians do not treat them with respect for their contribution to community health. Examples of collaboration include Basic Needs in Northern Ghana which initiated a programme of collaboration with traditional healers in mental healthcare, aimed at cross-referrals and mutual understanding.⁷⁹ This project showed the potential for successful partnership.⁸⁰

Religion plays an important role in mental health in Africa,⁸¹ but in Zambia the church appears to be minimally connected to mental healthcare in terms of providing in-patient treatment centres or prayer camps.⁸² However religious leaders have a critical attitude to mental health services, and their focus on prayer-as-cure inhibits the uptake of services and treatments. Some people monitors spoke to explained that relatives paid churches to pray for their mentally ill relatives. Since 1990, new Pentecostal and charismatic churches are on the rise,⁸³ and some people have argued that the popular trend of African Pentecostalism needs to be challenged since in the long run it may reinforce beliefs in witchcraft and demon possession, instead of bringing liberation.⁸⁴ Even mainstream churches have developed influential charismatic wings which have become

affected by the quest of Pentecostalism and encourage people to rely on prayer.⁸⁵ The lack of community psychiatric services further drives people to seek relief from churches. Hospitals allow religious people to come and pray for patients inside hospitals. Monitors witnessed this at Chainama Hills Hospital B-ward and at Kabwe Hospital psychiatric wards.

Frequently people go to traditional healers before accessing mental health services. Most people with mental health issues in Zambia have seen a traditional healer ("Ng'anga") 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. A representative of the Human Rights Commission explained that due to the scarcity in rural areas of conventional medicine, people, "tend to rely on traditional healers and sometimes they take advantage of the vulnerability of the patient".

Data on the numbers of traditional healers and their practices are lacking. The WHO 2001 "Strategy for the African Region on Promoting the Role of Traditional Medicine in Health Systems" estimates that one in five people living in rural areas in developing countries depend on traditional medicine for their healthcare needs. The Zambian 2005 Mental Health Policy records that 70-80% people with mental health issues consulted traditional healers before seeking help from conventional health practitioners.⁸⁶ Many people with whom monitors spoke explained that the overall use of traditional healers was reducing as society had become increasingly more exposed to modern medicine and had greater understanding and access to conventional treatments.



74 Article 27 of the Universal Declaration of Human Rights (UDHR), Article 1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and Article 27 of the International Covenant on Civil and Political Rights (ICCPR). See also International Labour Organisation (ILO) Convention No. 169 of 1989, part 5 under the title 'social security and health'. Articles 23 and 24 of the UN Declaration on the Rights of Indigenous Peoples 1993 (UNDRPI) guarantees the right to traditional medicines and practices including the right to the protection of vital medicinal plants, animals and minerals.

75 Articles 17 and 29 of The African Charter on Human and Peoples' Rights (ACHPR), Article 6 of the African Cultural Charter (ACC) and Articles 3, 13 and 21 of the African Charter on the Right and Welfare of the Child (ACRWC), The Protocol on the Rights of Women in Africa. The latter explicitly prohibits harmful practices in Articles 2 and 5.

76 Kenneth Ae-Ngibise et al., MHAPP Research Programme Consortium, "Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana", *supra* note 71; Ehab Sorketti, Nor Zuraida Zainaland Mohamad Hussain Habil, "The traditional belief system in relation to mental health and psychiatric services in Sudan", *supra* note 71.

77 Santuah F. Niagia, "Traditional medicine gets healthy recognition" (*The Lancet* 359 (2002): 1760).

78 Katherine R. Sorsdahl, Dan J. Stein, D.J. and Alan J. Flisher, "Traditional healer attitudes and beliefs regarding referral of the mentally ill to Western doctors in South Africa" (*Transcultural Psychiatry* 47 (2010): 600).

79 *Supra* note 71.

80 *Ibid.*

81 Human Rights Watch, "Like a Death Sentence: Abuses against persons with mental disabilities in Ghana", *supra* note 71.

82 *Ibid.*

83 Bernhard Udelhoven, "The changing face of Christianity in Zambia: new church of Bauleni Compound" (Faith and Encounter Centre Zambia, 2010), available online at: http://www.fenza.org/docs/ben/changing_face.pdf (last accessed: 09.07.2014).

84 *Ibid.*

85 *Ibid.*

86 Republic of Zambia, Mental Health Policy 2005, 5.

6(B). People's experiences of traditional healing

We have to live with quackery.
President of the Traditional Health
Practitioners' Association of Zambia

Traditional healers are common in Zambia. They openly advertise their talents in solving all types of life problems: from bad breath to erectile dysfunction. Their location in the heart of local communities and their immediate availability and readiness to attend to complaints means there is high demand for their services, including in dealing with mental health issues, and particularly in rural areas where mental health services are non-existent.

Some interviewees were reluctant to tell monitors that they had attended a traditional healer. This may be because conventional healthcare practitioners frown on traditional practices. Interviewees may have wanted to avoid being perceived as primitive for using healers. They may not have wanted to reveal their experiences of humiliation especially by traditional healers whose reputation are increasingly characterised by the general public as 'quackery'.⁸⁷

Many Zambian communities use traditional healers as they offer support in times of crisis by simply being available and offering something plausibly useful. Research on traditional healing in Ghana has found that traditional healers offer counselling and community support which can enable personal empowerment.⁸⁸

Monitors spoke with the president of the Traditional Health Practitioners' Association of Zambia (THPAZ). He was keen to emphasise that, "Western colleagues are overwhelmed by the numbers of people with mental health issues. I can counsel for one hour, but they have to see 20 people in an hour. Valium and sleeping may not be the only solution. Counselling is paramount."

The variance in practice of traditional healers in Zambia is startling. Some healers act unethically: they provide no effective healing, a point acknowledged by the THPAZ president who estimated that,

[s]lightly more than half of our 40,000 members are doing a good job, approximately 22,000. The others are spoiling. Because of the economic situation our profession is infiltrated by cheats who masquerade as healers. We have to live with quackery.

There may be more quacks, as many traditional healers are not members of THPAZ – it is impossible to estimate how many of these non-registered 'healers' operate in the country. The Association has a complaints mechanism but its president acknowledged that it was insufficient, partly because the association's district representatives do not want to lose revenue. The president told monitors that no traditional healer in Zambia has been sued for malpractice, and there has never been a prosecution for abuse of people with mental health issues.

Monitors spoke to several people who have been treated by traditional healers. The majority said they were taken by a relative rather than deciding to go there themselves.⁸⁹ Traditional healers said that relatives give consent, explaining that patients claim they are not sick. This was confirmed as a typical practice by the THPAZ president. A Ministry of Health representative told monitors that, "it's up to the relatives now who are making decisions on behalf of these patients. So, on that one, we can't say it's voluntary because it's the relatives who are making decisions over their relative". It appears that a person's rights are denied by giving greater importance to the views of relatives than of people with mental health issues themselves.



Photo: A traditional healer in Zambia, 1 November 2012. © MDAC.

87 Very few interviewees indicated that they would in the future look to use a traditional healer. This may in part be due to MDAC/MHUNZA interviewees not being fully representative as they predominantly came through links with psychiatric facilities, and members of Mental Health Users Network of Zambia.

88 Astrid Berg, "Ancestor reverence and mental health in South Africa", (Transcultural Psychiatry 40 (2003): 194-207); Ae-Ngibise et al, The MHAPP Research Programme Consortium, "Whether you like it or not people with mental problems are going to go to them": A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana", supra note 71; Olaniyi Bojuwoye, "Traditional Healing Practices in Southern Africa: Ancestral Spirits, Ritual Ceremonies, and Holistic Healing", supra note 71.

89 This is similar to experiences of use of psycho-social disability services in other countries e.g. Barbara J. Burns, Kimberly Hoagwood and Patricia J. Mrazek, "Effective treatment for mental disorders in children and adolescents" (Clinical Child and Family Psychology Review 2 (1999): 199-254).

How do traditional healers treat mental health issues?

Then I started complaining that I'm seeing visual hallucinations. Then she [traditional healer] said, 'Then we'll start putting medicine in your eyes. Then we will cut your hair and put a tattoo.' And the tattoos were all over my body [...] It was painful. First, drugs were very painful, the drugs for the eyes, I would sleep the whole day not feeling well.

48-year old woman with mental health issues

They gave her water and medicines which were to be boiled [...] First she was tattooed on the head and herbs rubbed in, then some of it was cooked and she was covered with a blanket and the hot pot placed under the cover. Then the hot steam would spread in there and she would sweat, but still nothing happened/changed.

40-year old spouse of a woman with mental health issues

When you get there sometimes they say you should go find and eat a small lizard, if not that then you need to catch and eat a small snake. When you eat that snake, while it's alive, that's when you'll get better [...] They wanted to tattoo me but my mother refused.

18-year old woman with mental health issues

Monitors were told that some healers ask patients to do tasks which are impossible – like eating a live snake or lizard – in order to get money from them but without actually having to do anything. The majority of people monitors interviewed were dissatisfied with treatments by traditional healers. They said these treatments did not improve their health, and they cost considerable sums of money:



Photo: A small lizard © MDAC 2014.

We went to four different healers, but as he [her husband] didn't improve, we resorted to continuing at the hospital. There was no benefit to going to a traditional healer, just cost. We spent over 1,100 Kwacha [132 EUR]. It had been my decision to take him as people told me that it was witchcraft affecting my husband.

Wife of an older man with mental health issues

We first tried a traditional healer in 2007. We've been to three in total. They didn't help. So instead I just locked her in the house – for over a year. Then someone said to take her to the hospital. We saw the first healer for two months, but then he just left. I'd given him money, a blanket and a bowl. The second one wanted to take her to a graveyard, to dig a hole there, and to wash her in it, to wash the ghost out. I didn't want that. The third one was for six months. We had to sell things to pay for that one: our TV, plates. He took her clothes, all the pots, and a dish.

Mother of a young woman with epilepsy and mental health issues

We took him to 25 traditional healers. It's hard to estimate the financial cost of all this as there were payments and also we had to get and give animals – including two cows. The government should arrest these people as it's a kind of stealing. People are being cheated.

Grandmother of a young man with mental health issues



6(C). Abuse by traditional healers

We are aware of traditional healers using sex as a form of treating women with mental health issues.

Representative of a disabled people's organisation

Several people told monitors that traditional healers had abused them. A community leader explained that, "a traditional healer will try to beat a patient, because always they associate any kind of ailment, like you know, [with] demon possession, and sometimes like a spirit has gotten into you, so you have to be beaten." A representative of a disabled people's organisation explained the types of cases which his organisation deals with:

We have received about four cases from different parts of the country where a person has been locked up for more than two weeks by a traditional healer, and of traditional healers chaining those mental health users to their own beds or to a tree. We are aware of traditional healers tattooing mental health users without their choice, throughout their body using a razor blade, and administering very itchy or painful medicine on those cuts. We are aware of traditional healers using sex as a form of treating women with mental problems. [...] Some pour very hot water on them so that the 'affliction' comes out when they start going into fits.

It was not possible to verify whether the abuses alleged are currently happening, because the instance of people staying (sleeping overnight) in traditional healing centres seems to have reduced significantly over the last few years. Only two interviewees reported recent inpatient care at traditional healers; others reported short visits, or occasional over-nighters, or having the healer spend the night at the family home. Reduced levels of over-night stays decreases the risk of abuse within traditional healing settings, although it also increases the pressure on families, thereby elevating the risk of abuse at home.

Many people told monitors how unpleasant, and in many instances useless, the treatment given by traditional healers was, but did not report direct abuse. Three out of twenty people with mental health issues interviewed by monitors that they had been chained or beaten by traditional healers. Other informal interviews also revealed negative experiences. One interviewee told monitors that he was once chained for a week and was told that he would be unchained if he stopped being violent. He also reported that he was beaten. When asked whether he had the power to ask for the beating to stop, he responded:

Yes, I had the power to tell them that, stop beating me, but they were telling me that, we are beating you because you are violent, but you stop being violent, we are going to stop beating you. I said I will stop but you know, I was not. I was mentally disturbed, I was not controlling myself. Sometimes, it is just coming like that, then you will be violent, but later on the sense comes in and you stop.



Photo: A woman with mental health issues, forced to live for many years in the Nsadz settlement, Eastern Province, Zambia. 26 October 2012 © MDAC.

Other people told monitors about their experiences:

When I was put in an enclosed space, they fed me in there, but they kept me there for some time, they bound my legs and my hands, they used inshishi [ropes, fibre from the tree]. I don't know if it was two days or a day [...]. The healing itself was traumatising, very traumatic.

28-year old woman with mental health issues

I slept, they wanted to chain me, the traditional healer. They wanted to chain me but I wasn't violent, I was fidgeting because of the medicine I drank.

18-year old woman with mental health issues

I was given some liquids. One was mixed with chicken excreta. I never liked it. The one for drinking would make me vomit massively. I couldn't refuse as I also needed to get better so I had no option even if it was uncomfortable. My sister made me go to get better. I can't go back now, there was no help there, we were just giving money.

Young woman with mental health issues (exact age unknown)

Monitors visited four traditional healers and a spiritual healing centre. All the healers confirmed that they carry out forced treatment, and restrain "violent" people in distress, on the basis of 'consent' given by relatives who typically bring the person to the healer. All the healers confirmed that they would use chains if they had more space for inpatients. The expectation was that relatives would assist with chaining and tying. In the now-defunct Kitwe in-patient centre, monitors saw chains on a tree and pole, in October 2012.

Chaining

Prior to 2009 one traditional healer in Kitwe offered an in-patient service. A THPAZ representative commented: "There is one lady there who ties people with mental health problems, with chains [...]; yes, that is our member unfortunately. Because of the unpredictable behaviour of some of the psychiatric cases, she chains them, but under human rights it's illegal. You do not chain a patient against their will. [...] Sometimes they run away and the healers lose a patient and the relative will question her, 'Where has our patient gone to?' So, she fears that they might run away, they might fight and beat the doctor. So she will chain them."

One psychiatrist commented: "I went there some few years back, I found some patients tied, which is pathetic in our age [...]. So we arranged that a clinical officer trained in mental illness goes there every week to unchain these people, give them medicine, but the traditional healing can continue, whether it is prayers or whatever medicines, but our clinical officer goes there once a week to give them psychotropic drugs and at least they are unchained. I think chaining at this stage is not good."



Photo: A man holds up a chain, Kitwe traditional healing centre, October 2012. © MDAC.

There are no guidelines or other national policies regulating traditional healers. Restraints and seclusion are used arbitrarily, and provision of food and water is optional, as are toilets. The Constitution sets out that no person should be subjected to torture or inhuman or degrading treatment. The Persons with Disabilities Act mandates informed consent in the private sector as well as public services,⁹⁰ and if it becomes law, the Mental Health Bill 2013 will regulate traditional healers.⁹¹

These current and potential laws may not be enough. The Zambian government is under a duty to immediately end all abuse and ill-treatment by traditional healers. As explained in section 4(C) above, international law binding on Zambia prohibits all forms of exploitation, violence and abuse including in the healthcare sector. Traditional healers are private individuals not carrying out their duties in the name of the State (unlike government-funded and run psychiatric facilities which are examined in section 7 of this report, below). The CRPD clarifies that the State is still responsible for eliminating discrimination against people with disabilities by any private entity, including traditional healers.⁹²

In Zambia, anyone can set themselves up as a traditional healer and charge for 'treatments'. Some healers carry an annual trading license from the local government: accreditation that is not compulsory and amounts to nothing more than an administrative formality. Various professional associations including THPAZ are open to herbalists, diviners, spiritual healers, faith healers, traditional birth attendants and any other people who practise traditional medicine.⁹³ The associations require various criteria to be met.⁹⁴ The members are required to provide patients with information before treatment commences, to give patients the opportunity to accept or decline each treatment, to maintain confidentiality, and to refrain from advertising.⁹⁵ A human rights officer from a disabled people's organisation dismissed the current framework as ineffective, telling monitors there is a "serious need" for regulating traditional healers; a view shared by everyone who monitors spoke to in Zambia.

90 Section 27(d), Persons with Disabilities Act.

91 Clause 2(1), Mental Health Bill 2013.

92 Article 4(1)(e) of the CRPD.

93 Clause 3(1) and 5(1) of THPAZ Constitution, 2001.

94 Criteria include being an adult, law-abiding citizen, having at least primary education, and being a member of a recognised association of traditional health practitioners in the community of practice.

95 The restriction on advertising is intended to promote healers working on the basis of their reputation and to reduce opportunities for transient charlatans. Provisions are also made for the protection of children and patients of the opposite sex, with a relative being required to be present during treatment.

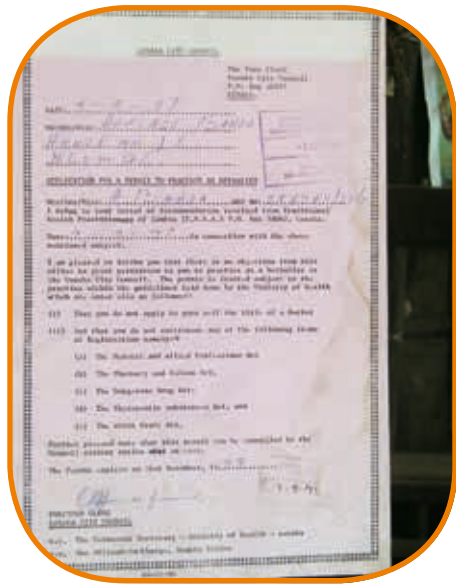


Photo: A traditional healer's practice licence, 1 November 2012. © MDAC.

The African Union Commission has also developed a framework for action and recommendations on combatting harmful traditional practices, which includes development of domestic laws and policies.⁹⁹ The African Union has extended the decade of African Traditional Medicine (2001-2010) to 2011-2020.¹⁰⁰ Various articles address the use of traditional healers for mental health issues in the region and the need for regulation.¹⁰¹

Internationally, there are few examples of codes of conduct for traditional healers in relation to mental health treatments.¹⁰² A code could establish basic minimum standards, and a governmental authority could provide a repository of promising practices where healers could provide examples of care which uphold human rights standards. A code could also lay out practice guidelines on how to manage emergency situations where someone's life is at risk, particularly in the absence of any formal mental health services.

The president of THPAZ said even though his association has a self-regulatory scheme (consisting of a constitution and code of ethics), the government could establish conditions under which traditional healers should practice. He suggested collaboration with the local hospitals and psychiatric facilities, finding alternatives to chaining, and eliminating forced treatment. Additional emphasis could be put on obtaining informed consent for treatment from patients, including the right to refuse interventions, he said. This would preclude the reported practice of traditional healers covertly putting medicine into a patient's food or drink, a practice condoned by the THPAZ code of ethics. He also spoke of the need to record treatments in writing, so that healers can later be held to account.

The WHO Regional Committee for Africa has recommended to African countries that they legislate to regulate traditional medicine within the framework of national health legislation and that they allocate funding to develop programmes.⁹⁶ Zambia has no such legal framework, although its commitment to implement one was affirmed during a WHO regional meeting of ministers of health in 2013.⁹⁷ Preparations are reportedly underway but as yet have not considered issues related to the treatment of people with mental health issues.⁹⁸



Photo: Scarring. 2013. © MDAC.

96 See WHO Regional Committee for Africa, Promoting the role of traditional medicine in health systems: A strategy for the African Region, 9 March 2000, AFR/RC50/R3. See also AFR/RC34/R8, September 1984, and the WHO Traditional Medicine Strategy 2014-2023.

97 MDAC/MHUNZA interview with a traditional medicine focal point person, WHO Zambia Country Office, Lusaka, Zambia: 4 February 2014.

98 *Ibid.*

99 Developed at a Pan-African conference on celebrating courage and overcoming harmful traditions, Addis Ababa, Ethiopia, 5-7 October 2011.

100 African Union, Draft Windhoek Declaration on the Impact of Climate Change on Health and Development in Africa CAMH/Min/Draft/Decl.(V), Fifth Ordinary Session of the Conference of Ministers of Health, Windhoek, Namibia, 17-21 April 2011.

101 Ae-Ngibiseet et al., The MHAPP Research Programme Consortium, "Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana", 558-567. See also Sorketti, Zuraidda and Habil, "The traditional belief system in relation to mental health and psychiatric services in Sudan", *supra* note 71. A 2001 WHO review identified a variety of practices requiring regulation, licensing and registration, and the need for training in the field of traditional medicine: World Health Organisation, "Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A worldwide review" (Geneva: WHO, 2001).

102 For example mental health/disability are not specifically referred to at all in the recent WHO Traditional Medicine Strategy 2014-2023.



Photo: A traditional healer's practice licence, 1 November 2012. © MDAC.

Most patients refuse to take drugs. When they refuse you mobilise people to manhandle them, then you administer the drug as injection. This happens almost every day.

Staff member at Chipata Hospital

7. Psychiatric hospitals

In 2008 the WHO Mental Health Poverty Project issued a sharp critique of Zambia:

People with mental disabilities [in psychiatric facilities in Zambia] 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 [involuntary servitude] 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 and degrading treatment.*¹⁰³

This section of the report sets out MDAC and MHUNZA's investigation of the formal mental health system in Zambia, through the lens of international human rights law.

7(A). History and context

Formal mental health care was introduced in the late 1920s and admissions and discharge were set out in the Mental Disorders Ordinance 1951. Little has changed since these colonial era origins, and the ethos of confinement plagues the mental health system today.¹⁰⁴ As antipsychotic medications became available and affordable, the Chainama Hills Hospital opened in 1962 as the country's only mental hospital. In 1981 the government tried to integrate mental health into primary healthcare. This was unsuccessful because it was underfunded and there was resistance from Chainama Hills Hospital staff who wanted to continue working in the hospital.¹⁰⁵

In 1992 the government initiated the "Basic Health Care Package", but mental health was not listed as a priority.¹⁰⁶ Although the Zambian cabinet adopted a mental health policy in 2005,¹⁰⁷ there was no stakeholder participation, the policy was not evidence-based, and contained no analysis about the needs of people with mental health issues.¹⁰⁸ As a result the document had little traction and led to little change.

Improvements to mental health services were listed amongst the objectives of the National Health Strategic Plan 2011–2015.¹⁰⁹ De-centralisation of mental health services to district level was planned through the Ministry of Community Development, Mother and Child Health. This too, seems to have made no difference. Mental health provision continues to be centralised at Chainama Hills Hospital and seven other government-run hospitals dotted around the country.¹¹⁰ There are very few mental healthcare services in primary healthcare.¹¹¹ A handful of non-governmental organisations provide small-scale mental health support services, ranging from peer support to rights advocacy.¹¹² Monitors found evidence of only four mental health service-user groups that have been active in providing peer support, livelihood services or rights advocacy. They are increasingly consulted by the government on legislative and policy development.¹¹³

103 Jason Mwanza et al., "Mental Health Policy Development and Implementation in Zambia: A situation analysis", 59–60, 30 March 2008, *supra* note 71.

104 Ministry of Health, *Mental Health Policy* (Lusaka: MoH, 2005).

105 Information from the 2005 Mental Health Policy, 4.

106 Interview with John Mayeya, Director of Mental Health, Ministry of Health, 3 February 2014. See also Civil Society for Poverty Reduction, *An Easy Look at Zambia's Poverty Reduction Strategy 2002–2004* (Lusaka: CSPR, undated).

107 Republic of Zambia, Ministry of Health, *Mental Health Policy* (Lusaka: MoH, 2005).

108 Jason Mwanza et al., "Mental Health Policy Development and Implementation in Zambia: A situation analysis", 54–55, 30 March 2008, *supra* note 71.

109 Republic of Zambia, Ministry of Health, *National Health Strategic Plan 2011–2015* (Lusaka: MoH), Objective 5.1.2.10.

110 Other hospitals identified as providing outpatient mental health services are University Teaching Hospital (Lusaka), Choma General Hospital (Choma), St Francis Hospital (Katete District) and Senanga General Hospital (Senanga District).

111 There have been several general health care reforms since the late 1980s, focusing on decentralisation to regional and district health structures. See, Catharina Hjortsberg and Chris N. Mwikisa, "Cost of access to health services in Zambia" (*Health Policy and Planning*, 17 (2002): 71–77); and Jason Mwanza et al., "Mental Health Policy Development and Implementation in Zambia: A situation analysis", *supra* note 71; M. A. Omar et al, Mental health and Poverty Research Programme Consortium (MHaPP) "Mental health policy process: A comparative study of Ghana, South Africa, Uganda and Zambia", (*International Journal of Mental Health Systems* 4 (2010):24).

112 Mental Health Association of Zambia, Mental Health Users Network of Zambia, Christian Organisation for the Mental Patients, Saint Francis Mission Livingstone and Prisons Care and Counselling Association.

113 The four groups who have been consulted are Mental Health Users Network of Zambia, Mental Health Association of Zambia, Care Ministry for the Mentally Ill and Christian Organisation for the Mental Patients. Some of these include professionals and carers as members of the group.

Funding allocated to mental health services is excruciatingly low. According to the 2013 national budget analysis, 11.3% of the country's budget is spent on health.¹¹⁴ This falls short of the 15% required by the Abuja Declaration.¹¹⁵ Of the 11.3%, Zambia spends less than one percent on mental health.¹¹⁶ It is difficult to track how even this small sum is spent, because most mental health units receive funding to cover the items which they "need"; they have no annual budget as such.¹¹⁷

The government covers approximately 60% of each person's healthcare costs, with the remaining 40% met by development partners and patients' fees.¹¹⁸ 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%. It is therefore heavily reliant on external funding from donors such as the World Health Organization and the UK Department for International Development.¹¹⁹



7(B). Warehousing

As you can see it looks like a prison.
Nurse in Charge, male ward, Ndola
Psychiatric Unit

There are 560 psychiatric beds in Zambia.¹²⁰ Chainama Hills Hospital is the country's only specialised psychiatric hospital. Psychiatric wards exist in seven general provincial hospitals spread around the country. In addition, the University Teaching Hospital in Lusaka provides outpatient mental health services.¹²¹

The seven psychiatric wards visited all had two wards of the same type (either open or closed) separated by the gender of the patients (their carers could be of any gender). Chainama Hills Hospital had locked acute wards and open wards for rehabilitation for men and women, and a dedicated "high cost" ward for fee-paying patients.¹²² The locked facilities at Ndola Unit and Chainama Hills Hospital were overcrowded.

When monitors visited the 22-bed male ward of Ndola Unit in October 2012, it had 45 patients including 14 "lodges" (people considered fit for discharge waiting for a relative to pick them up).¹²³ The head of the unit described the situation as "chaotic" – the number has gone up to 60 people in the past. "As you can see, it looks like a prison," he said.¹²⁴ In January 2014 when monitors visited again, some walls had been painted but overcrowding was still apparent.

In Chainama Hills Hospital acute wards (male and female) nurses were at pains to acknowledge that the number of patients was more than the bed capacity as can be seen below in Table 1, showing occupancy in regional hospitals, and Table 2 showing occupancy at Chainama Hills Psychiatric Hospital.

114 Zambia's 2013 National Budget Analysis, available online at: <http://www.africaymca.org/k2africanews/item/1194-zambias-2013-national-budget-analysis> (last accessed: 09.07.2014).

115 In April 2001, African Union countries met in Abuja, Nigeria, and pledged to increase government funding for health to at least 15% of GDP. In its 2012 Universal Periodic Review by the UN Human Rights Council, the Zambian government said it would take all necessary steps to honour its commitment under the Abuja Declaration.

116 Jason Mwanza et al., "Mental Health Policy Development and Implementation in Zambia: A situation analysis" 30 March 2008.

117 Interview with John Mayeya, Director of Mental Health, Ministry of Health, 3 February 2014.

118 Jason Mwanza et al., *Mental Health Policy Development and Implementation in Zambia: A situation analysis*. 30 March 2008.

119 *Supra* note 118.

120 Republic of Zambia, *Mental Health Policy 2005*, 5.

121 Others are: Choma General Hospital (Choma), St Francis Hospital (Katete District) and Senanga General Hospital (Senanga District).

122 'High cost' patients at Chainama Hills Hospital were required to deposit 600 Kwacha (approximately 72 EUR), from which 40 Kwacha (approximately five EUR) was the daily rate for a room, 90 Kwacha (approximately 11 EUR) for nursing care, 50 Kwacha (approximately 6 EUR) for each review by a doctor, and 100 Kwacha (approximately 12 EUR) for a review by a consultant. The patient paid an additional fee when the deposit was exhausted. Among the other psychiatric units, only Ndola psychiatric female wards offered 'high cost' beds in smaller wards.

123 The staff informed monitors that they receive patients from the Central, Luapula, North Western and Copperbelt provinces.

124 Visit on 23 October 2012.



Photo: Ndola closed male ward with small prison-like windows and no outdoor space. The psychiatric facilities contrast with the main hospital visible behind, 24 October 2012. © MDAC.

With the exception of the newly-renovated Livingstone unit, other psychiatric hospitals consisted of large dilapidated wards where nearly all patients slept in one room. Half the patients at Ndola Unit male ward and a quarter of patients at Chainama Hospital acute wards did not have their own bed: many slept on the floor, and many shared mattresses, some of which were filthy without sheets. In Ndola Unit the two toilets and one shared showering area lacked any respect for dignity: patients could not freely or privately use the showers, and the toilets lacked doors and were frequently in use. The overcrowding and prison-like windows of the Ndola Unit male ward meant that there was little fresh air.

In contrast, Livingstone had wards which opened in October 2013. They comprised smaller units with three to four people sharing each room with its own bathroom. Staff had requested the new facility long ago because of the dilapidated state of the old wards. The building was constructed in four months after the mental health staff threatened the hospital administration that they would stop admitting patients to the old ward and would instead admit patients to the general hospital wards.

The Ministry of Health reportedly plans to demolish Chainama Hills Hospital and build a new facility. Construction of new wards at Ndola should have started, but have been delayed.¹²⁵

The tables below show the occupancy at the time of the visits in October 2012 for Chipata Hospital and at January and February 2014 for psychiatric units in Ndola, Kabwe, Livingstone and Chainama.



Photo: Side room in the Ndola closed male ward used for sleeping, as the main dormitory was so over crowded, 24 October 2012. © MDAC

Table 1: Mental health provision in provincial hospitals

Hospital/Psychiatric Unit	Ndola Unit – closed wards		Kabwe Unit – open wards		Chipata Unit – open wards		Livingstone – mixture of open and closed	Total bed capacity and number of patients on day of visit
	F	M	F	M	F	M		
Bed capacity (number of beds on day of visit by monitors)	15	22	7	9	20	28	18 (M=12 and F=6)	119
Number of patients on the day of visit by monitors	8	45	3	7	2	6	3 (1 M and 2 F)	74
Reported average number of patients by officer in charge of ward	15-20	45-60	3-5	10-13	12	18	40 (M=30 and F=10)	N/A
Age range of patients	15-40	15-50	15-50	15-66	20-32	18-40	M=16-35 F=22-38	N/A
Average length of stay	1 month	1 month	2 weeks	3 weeks	1 months	1 month	M= 5 days F=8 days	N/A
Longest length of stay.	2-3 months	3 months	3 weeks	30 years ¹²⁶	3 months	3 months	2 months (3 years for those abandoned by their family)	N/A

¹²⁵ Interview with Head of Clinical Care, Chainama Hills Hospital, 3 January 2014 and Head of Ndola Psychiatric Unit, Ndola, 27 January 2014.

¹²⁶ One person with an intellectual disability was abandoned by relatives.

Table 2: Mental health provision in Chainama Hills Psychiatric Hospital

Ward	A – high cost	B – female acute	C – male acute	E – male open	F – female open	Forensic F ¹²⁷ (in B ward)	Forensic M	Total bed capacity and number of patients
Bed capacity (number of beds on day of visit by monitors)	7	50	36	25	15 ¹²⁸	3	20	156
Number of patients on the day of visit by monitors	3 (1F & 2M)	35	50	8 ¹²⁹	5 ¹³⁰	2	17 ¹³¹	120
Reported average number of patients by officer in charge of ward	10-15	55 to 60 ¹³²	40-60	20	15	2	23	N/A
Age range of patients	23-50	20-45	13-70	35-60	Children to 45	37- 60	22 - 55	N/A
Average length of stay	2 weeks	1 month	1 month	5 years	1-3 weeks	Sentence dependent	Sentence dependent	N/A
Longest length of stay	5 years	25 years	20 years	30 years	10 years ¹³³	33 years (HEP)	32 years (HEP)	N/A

7(C). Dilapidation

The building and infrastructure are in a deplorable state.
Zambian Parliamentary Committee on Health, Community Development and Social Welfare

In 2010 the Parliamentary Committee on Health, Community Development and Social Welfare described the general condition and infrastructure of psychiatric facilities as dilapidated.¹³⁴ Apart from Chainama Hills Hospital acute wards and newly-built Livingstone facility, monitors found that psychiatric units at other hospitals (Ndola, Kabwe and Chipata) were not maintained and had the oldest-looking facilities in the hospital compared to non-psychiatric wards. The Parliamentary Committee reported that Ndola psychiatric unit (built in 1932) was in a deplorable state: the building had huge cracks and broken windows. Some of the wards had been closed for over 20 years, awaiting renovation. Monitors saw all these during their visits and both acute and non-acute patients were locked in one large dormitory of roughly 7 meters by 25 meters.



Photo: Chipata psychiatric hospital, 26 October 2012. © MDAC.

127 This was not a ward, but a small room inside Ward B which served as a female forensic ward. A prison officer was employed as a guard.

128 Seven beds were for children and eight beds for other patients (women to be discharged and patients with both mental health issues and medical conditions).

129 Out of the eight, two patients had absconded, and two were on leave visiting their families.

130 One child and four adults.

131 Six so-called HEPs ("At His Excellency's Pleasure") who were serving sentences and 11 people who were under observation to ascertain whether they were fit to stand trial; regulated by sections 160 to 167A ("Procedure in Case of the Insanity or Other Incapacity of an Accused Person") of the Criminal Procedure Code Act, Chapter 88, Volume 7 of the Laws of Zambia.

132 In case of overcrowding, patients were transferred to ward F.

133 This is the length of stay of the only "child" on the ward, who was, at the time of the visit, in his mid-20s.

134 The Committee visited Kabwe General Hospital, Ndola Central Hospital, Mansa General Hospital, Kitwe Central Hospital (which only provided outpatient mental health services) and Chainama Hills Hospital to check on infrastructure, drug supply and mental health staffing levels.

Services vary considerably across the country's psychiatric facilities. "Closed wards" are locked, staff control entry and exit of patients who were not allowed to stay with carers or relatives. On "open wards", patients and relatives walked around freely, coming and going. Relatives were expected to stay at the hospital to care for their loved ones. Open wards had seclusion rooms that could be locked. The few patients who arrive alone were expected to call for their relatives. The hospital's role was to contain the patient and administer medication, while relatives provided other care and support, and ensured that patients did not escape. A clinical officer talked to monitors about the revolving door nature of psychiatric admission: patients were given "medicine and some sort of care, but nothing to prepare them for living outside."

At Ndola, male patients had no access to outdoor space and were only allowed out of the ward once a week for something called "occupational therapy", which meant watching television. The barred windows allowed little natural light to come into the room. Only a few of the windows opened minimally to let in fresh air. There were run-down toilets and washing facilities which afford no privacy. A concentrated smell of urine, faeces and body odour filled the air.

Like other psychiatric units, there was no children's ward but in October 2012, monitors were informed that children (including boys) were admitted to the female ward with their carers. In January 2014 monitors were able to look into the in seclusion room at Ndola male ward. They saw a child of approximately 12 years old with an intellectual disability. Staff informed them that the boy had hit other patients. He was placed in seclusion reportedly to save him from being beaten up by other patients.

Open wards of other facilities were problematic. At Kabwe hospital, both the male and female open wards lacked a sink, everyone had to share one outdoor ground tap. At Chipata, the toilets in the male ward had reportedly not been flushable since 2001. The only acceptable washing facilities monitors found on their visits were in the "F Ward" at Chainama Hospital.



Photo: One of the two toilets used by 45 patients at Ndola closed male ward, 24 October 2012. © MDAC.



Photo: Toilet in the male psychiatric ward in Chipata hospital. 26 October 2012 © MDAC

7(D). De-habilitation

■ *When you refuse medication, it's forced.*

Patient at Chainama Hill Hospital

At Chainama Hills Hospital, a patient told monitors that staff, "give you whatever medication they want. You have no choice." With so few resources, clinical care is often poor. Staff informed monitors that there was a high incidence of drug and alcohol abuse by male patients: some estimated that two thirds of male patients abused drugs or alcohol,¹³⁵ a claim which was impossible for monitors to test, as no data is kept. From a human rights standpoint, it is alarming that the majority of patients seemed to be detained against their will simply for substance misuse, perhaps in the absence of mental health issues.

Monitors observed that in-patient treatment was overwhelming dominated by pharmacology: therapeutic supports ranged from minimal to non-existent. Electro-convulsive therapy was carried out at Chainama Hills Hospital until 2012 when the ECT machine was de-commissioned (a new one had been ordered). Patients were not given any choice over whether to accept medication, or what sort of medication to take. A patient at Chainama told monitors:

When you refuse medication, it's forced, and in order for you to be discharged you just have to cooperate. If not, the report that will be written will keep you in the facility.

In all hospitals staff told monitors they forced treatment on patients. At Chipata a staff member said, "most patient refuse to take drugs. When they refuse you mobilise people to manhandle them, then you administer the drug as injection. This happen almost every day."

In all hospitals nursing and clinical officers were too few in number and too overworked to offer individual attention to patients. Instead they focused on administering drugs and managing the ward. Occupational therapy activities were minimally available, for example to a handful of in-patients a day at Chainama. At provincial hospitals the activities available amounted to little more than watching television or working in the garden (such as at Chipata). Occupational therapy was completely absent at Kabwe where staff said there is no space.



Photo: The dark interior of Ndola Hospital male psychiatric ward before the inside was painted. Faces blurred to protect identities, 24 October 2014. © MDAC.

Monitors saw televisions at Ndola's occupational therapy room, one on the wards at Chipata, and one at Chainama rehabilitation wards, with another in the nurses' room on the acute wards. Newspapers and telephones were nowhere available for patients. Patients in closed wards told monitors that they could not contact their families or friends unless a nurse was kind enough to lend them their own mobile phone. Many patients pleaded for phones from monitors to make calls.

No books, pens or paper were available. There were no leaflets or any other information on mental health, human rights or anything else, clearly constituting a restriction of freedom of expression.¹³⁶ Other inappropriate practices infringing on the rights of patients were also witnessed. At Kabwe hospital monitors witnessed a visiting chaplain try to convert a patient of a different faith.¹³⁷

Food consisted of porridge for breakfast, beans and nshima¹³⁸ for lunch, and beans and cabbage for dinner. Only exceptionally were other food items – like meat, fruit or vegetables – provided.¹³⁹ There was no variety in diet, nor any nutritional oversight. This is particularly concerning as some people are detained for months or years – and, in some cases, for decades.

135 Interview with the Head of Clinical Care and Psychiatrist, Chainama Hills Hospital, 3 January 2014.

136 Article 21 of the CRPD states that governments must, "take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas".

137 Article 18 of the International Covenant on Civil and Political Rights states that "[e]veryone shall have the right to freedom of thought, conscience and religion. [...] No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice."

138 Food made from ground maize.

139 There were reports that chicken was available once a week at Kabwe.



Photo: Nshima and beans: the default everyday food in many mental health wards, October 2012. © MDAC.



Photo: Shutterstock

None of the patients on any of the psychiatric wards had access to a kitchen, with the exception of a few female patients at Chainama Hills Hospital as a form of occupational therapy. Very few wards had cabinets for patients to keep their possessions, and the few that did exist were often removed by staff on the pretext of preventing damage. During monitoring visits, most patients were observed to be sleeping or resting on a bed, while others wandered around the ward. One patient at Chainama Hills Hospital B-ward encapsulated the boredom which characterises in-patient admission: *“At six in the evening they send you to bed for more sleeping.”*

7(E). Unlawful detention

If I annoy my brother he could go to the magistrates. Then I’m back in hospital.

Man with mental health issues

On closed wards most patients were detained without any legal authority, but expressed their desire to leave. They were therefore unlawfully detained as their liberty had been arbitrarily restricted.¹⁴⁰ Patients were considered “voluntary” whether or not they wanted to be there, because their relatives had volunteered them to be detained for treatment.¹⁴¹ Hospital staff told monitors that patients sometimes did not know whether they are on a detention order or are entitled to walk out. Staff did not tell patients about their rights.

A staff member thought about educating patients of their human rights:

What you are proposing is a two way thing. You may come and educate them but that also has its own disadvantages, because once you open that Pandora’s box there will be a queue, even when it comes to eating beans. They will say we ‘were told that we are not to eat beans every day’. That will create a lot of problems because some of the patients are very intelligent, they are aware, not that everybody is not educated, just that the mental health problem has made them low. But when you open up their mind, you will see a lot of litigation.

¹⁴⁰ Dr Simenda Francis estimated that one in ten in-patients had a detention order.

¹⁴¹ Relatives were required to sign “form 51”, which was used to consent or withdraw consent against medical advice. A psychiatric clinical officer said that if form 51 was not signed, patients could refuse medication. Another said that it was used as a ‘legal basis’ for forced treatment since relatives signed that the hospital could administer ‘life-saving’ interventions. However, they also reported that some patients do sign it.

Patients in closed wards were kept under lock and key.¹⁴² Monitors saw three closed wards in Zambia where 107 people were detained: the majority unlawfully deprived of their liberty. On open wards relatives had to ensure that patients did not leave the hospital: such situations also constitute detention. As far as MDAC/MHUNZA could establish, no cases have ever been taken to court about detention in psychiatric hospitals.

The Mental Health Disorders Act 1951 allows a magistrate to authorise detention in a psychiatric hospital for up to 14 days, "if satisfied upon information on oath that a person is apparently mentally disordered or defective and is (a) dangerous to himself or to others; or (b) wandering at large and unable to take care of himself".¹⁴³ No medical or other opinion is required. No opportunity is given in law for the person concerned to express their opinion, to say anything, let alone to have a qualified lawyer interrogate the evidence upon which the person's liberty is removed and bodily integrity violated. There is no system of appeal to any judicial or semi-judicial body.

Monitors visited the magistrates' court in Lusaka and found that obtaining a detention order takes a few hours after relatives of the patient-to-be complete a form and sign an affidavit. This affirms their name and address, their relation to the patient, the property owned by the patient, and that the relative believes the patient has a mental disorder.

An officer of the court is then supposed to conduct an interview with the relatives. The magistrate officer who receives applications and conducts such interviews informed monitors that typical symptoms of mental disorder reported by relatives include sleeplessness, moving up and down, extreme quietness and violence. She had five years experience of working in the sector, and said that she knew of only one application that had been rejected because the application was not from a relative.

Monitors concluded that judicial detention orders are exceedingly easy to obtain.



Photo: "Rights of patients" leaflet on a noticeboard on E Ward, Chainama Hospital, 30 October 2012. © MDAC.



Photos: Ndola Male Ward (left) and Chainama B Ward entrance right), 24 and 30 October 2012 © MDAC.

142 Security guards were present at the gates to the wards of Chainama Hills Hospital's acute wards and Ndola wards. Some carried a baton and handcuffs. They said the baton was to deter patients from approaching the gates.

143 Mental Health Disorders Act 1951, sections 7, 8 and 9.

144 *Ibid.*, section 10. See also the detention order form: the magistrate "may, in his discretion, himself interrogate the patient [...] and shall, whether or not he makes such interrogation, direct any two medical practitioners to examine the patient."



Photos: Entrance of Ndola male ward (left) and female ward (right), 24 October 2012. © MDAC.

A detention order allows a person to be detained in a psychiatric unit for up to 14 days. During this time two medical practitioners are required to examine the patient and report back to the court on whether the patient is – using the statutory language - “mentally normal” or “a mentally disordered or defective person”.¹⁴⁴ Monitors documented that this process was not followed. A magistrate officer told monitors that she had never seen any such assessment from doctors about persons subject to judicial detention orders. Staff at the hospitals confirmed this.

Instead of following the law, what happens at the expiry of the 14-day period is one of three things:

- the hospital discharges the patient; or
- relatives apply for another order from the magistrate; or
- the patient continues to be detained without any legal basis.

Staff told monitors that if they consider a patient to be well enough to be discharged before the expiry of the 14-day order they keep the patient detained until the 15th day. This makes no sense. If a clinical officer thinks the patient is not mentally well enough, the patient will remain detained until the clinical officer changes their mind. Outside Lusaka there are no psychiatrists, so decisions on detention are made by non-medically qualified personnel based on a rudimentary perception of symptoms, without any appeal or external review mechanism. A person who had experienced being a patient at a psychiatric hospital told monitors, “I live with this all the time. If I annoy my brother he could go to the magistrates. Then I’m back in hospital”.

In Livingstone, monitors saw an 18-year-old boy who was brought to the hospital by his father with a detention order. This was the boy’s second admission in two months. During his first admission he left the hospital and went home, so the father obtained a detention order to ensure the boy stayed in hospital. The father bought a padlock to lock the boy inside a room. Hospital staff told monitors that staff had asked the father to cancel the detention order but the father refused. The boy told monitors that everything was fine but that he was not allowed to move around.



Photo: Chainama Hospital male acute ward, February 2014. © MDAC.



Photo: The room where the 18-year-old had to spend 14 days, Livingstone psychiatric hospital, 29 January 2014 © MDAC.

7(F). Restraints and seclusion

You just have to behave.
Patient at Chainama Hills Hospital

There is no legal or regulatory framework for the use of restraints or seclusion. None of the psychiatric facilities monitors visited had a policy on their use.¹⁴⁵ Restraints and seclusion are used on patients on detention orders and those who are classed as voluntary patients. Monitors observed widespread use of seclusion in rooms with appalling physical conditions.

Staff-patient ratios were very low. Staff told monitors about the difficulty of handling a patient who they perceived to be aggressive. Patients at Chainama Hills Hospital's acute wards said that some staff occasionally slapped or hit them. Staff said that they used restraint and seclusion to manage patients who "keep walking around and disturbing other patients" and at the request of relatives. Some patients at Chainama said that, "you just have to behave" to avoid restraint and seclusion. Without a complaints mechanism and anything being written down, patients had no opportunity to for allegations of ill-treatment investigated by an independent authority.

Restraints on the psychiatric units included chemical restraints with sedatives, manual restraints (staff holding down patients), and handcuffs in units without seclusion rooms, such as at Chipata. Staff at the Kabwe unit told monitors that when all seclusion rooms were occupied by patients, additional patients considered as requiring seclusion would instead be restrained by being tied with ropes or chains which family members used when transferring patients to the hospitals.¹⁴⁶

Seclusion rooms were prevalent. Chainama Hills Hospital had at least five in each of the acute wards. At the new Livingstone wards there were no seclusion rooms and the small bedrooms allowed for a less threatening environment. Ndola Unit had two "closed" seclusion rooms (locked with a padlock) and one open seclusion room (used for observing newly-admitted patients on the male ward) and one closed seclusion room on the female ward. Kabwe Unit had one seclusion room used by both male and female wards located on the male ward. Chipata Psychiatric Unit, as well as the Chainama Hills Hospital male forensic ward, and wards E and F had no seclusion facilities. Instead of seclusion, ward staff reported using handcuffs and chemical restraints at Chipata and on the Forensic Ward, while patients from wards E and F at Chainama were sent to wards B and C respectively to be placed in seclusion.

The sizes of seclusion rooms ranged from two to six square metres. There was no access to toilet facilities or a bucket. Patients were forced to defecate and urinate on the same floor space that they were required to sleep. While some patients said that they were naked in seclusion rooms, monitors observed others with clothes or uniforms in seclusion rooms. Monitors observed that patients in seclusion on the two acute wards of Chainama Hills Hospital were dependent on fellow patients to bring them food at meal times. Patients explained that they always rely on fellow patients to provide them with drinking water while in seclusion. Some patients reported avoiding drinking water when in seclusion to reduce the humiliation of urinating in such a small place where there was no drainage.



Photo: Seclusion room at Kabwe psychiatric unit (left) and open seclusion room at Ndola with a man under observation (right), 24 October 2012. © MDAC.

¹⁴⁵ The Mental Health Disorders Act 1951 is silent on the subject, with powers to apply restraints and seclusion being instead inferred as part of detention.

¹⁴⁶ Interviews with psychiatric clinical officers at the Kabwe psychiatric wards, Kabwe, Zambia: 24 October 2012 and 26 January 2014.

Monitors found no evidence that staff informed patients in seclusion why they were there, for how long they would be there, or about their rights. There was no mechanism by which the patient could appeal a seclusion decision. At the Ndola male ward, monitors observed a man handcuffed in a closed seclusion room. Staff said that he would be there for fourteen days because he was on detention order. Staff at Chainama Hills Hospital told monitors that they secluded people for up to 14 days, adding it is usually one day for patients not on detention orders.

A patient detained at Chainama Hills Hospital explained:

I woke up in the seclusion room without any of my clothes on me or in the room. Other patients gave me water. One day the staff gave me some porridge. I had to go to the toilet in the corner of the room to avoid being seen. If I talked they said I was showing off.

Another patient on the male acute ward at Chainama could not remember how long he had been in seclusion but pleaded with monitors to ask the nurses to remove him so that he could drink water and shower.



Photo: Two seclusion rooms in Ward C of the Chainama Hills Hospital. A man slept during the lunch period on an empty floor (left). A patient was given food by a fellow patient, sending the plate under the door after eating (right), 29 October 2012. © MDAC.

7(G). Denial of healthcare

The health of patients in psychiatric wards in Zambia is seriously compromised by poor hygiene facilities, inadequate diets and endemic violence and abuse. Even among healthcare professionals operating in psychiatric facilities, patients with mental health issues were stigmatised.

Mental health staff consistently referred to the lack of medical attention to their patients given by general medical staff. Monitors learned about a liaison process for patients in general hospital wards who showed signs of mental health issues to be seen by mental health staff and vice versa. This did not work in practice. Staff at mental health wards told monitors that consultation requests sent to general medical assistance went unanswered and healthcare needs of those on mental health wards also went unaddressed.

Deaths

On the wards at Kabwe and Chipata, staff told monitors about the death of two patients following denial of healthcare.

At Kabwe, a 30-year-old man reportedly died in August 2012 from a haemorrhage two weeks after being admitted to the hospital because doctors from the regular part of the hospital failed to attend to him, despite mental health staff requesting their assistance.

At Chipata, a 29-year-old man reportedly died from pneumonia four days after mental health staff requested a medical team to attend. They received no response from the medical team.

There was no investigation in either of these cases. Staff told monitors that deaths are only investigated when relatives request this.

During a visit in October 2012, monitors saw a woman on the female ward at Kabwe who had suffered serious burns all over her neck and a large portion of her chest. The nurse said that she had been brought to the psychiatric unit the previous night by community volunteers who claimed to have found her in that state. She was taken to the psychiatric ward because she had a mental health consultation card. The day after, a consultation request was sent to the general hospital section to attend. Monitors called the psychiatric nurse a month later to find out what happened. She explained that no doctor had shown up to examine the woman, who was discharged after three weeks in the hospital. Monitors could not ascertain the state of the woman's wounds upon discharge.

At Chainama Hills Hospital, monitors learned that the "F Ward" had a sick bay to treat patients who developed physical illnesses. The nurse told monitors, "our patients are being rejected from general hospital wards". In the "B Ward", a nurse informed monitors about a female patient who suffered from diarrhea and was sent to Levy Mwanawasa General Hospital for treatment. There, the healthcare staff asked Chainama staff to take her back to the psychiatric ward, "because she was touching things."

Despite active cleaning regimes (especially at Chainama Hills Hospital), hygiene was observed to be very poor. Across the mental health units there were shared open showers and a lack of sinks and soap. Patients moved between beds and shared beds, mattresses did not have sheets, toilets were broken and did not flush, and seclusion rooms lacked toilet facilities altogether.



Photo: A woman at Kabwe. Her burns were left unattended for three weeks, and then she was discharged, 24 October 2012. © MDAC.

A woman detained on the B ward at Chainama told monitors:

If the woman next to you has her period there's blood on the ground in the shower, it's not pleasant. I contacted TB on the ward. I'm HIV positive.

7(H). Inadequate staffing

The CRPD places a duty on the Zambian government to establish a mental health system which is at least staffed so that patients are safe. This entails training professionals so that they are aware of patients' rights.¹⁴⁷ The Persons with Disabilities Act obliges the Ministry of Health to "include the study of disability and disability-related issues in the curriculum of training institutions for health professionals to develop appropriate human resources to provide general and specialised rehabilitation services".¹⁴⁸

The Ministry of Health has encouraged people to become mental health professionals. Two psychiatrists were due to qualify in 2014, with another seven in training. The Ministry informed MDAC/MHUNZA of plans to introduce a two-year BSc for 40 clinical officers of psychiatry and registered mental health nurses in the coming years. No training was available for occupational therapy or for psychiatric social work.

The major problem with regards to mental health staff, however, is not the lack of training opportunities. It is the lack of people. During MDAC/MHUNZA's investigation five psychiatrists were working in Lusaka. In the city there were two psychologists, two psychiatric social workers and no specialised occupational therapists. There were no psychiatrists outside Lusaka. Access to psychologists was limited, and those that did exist tended to look after patients in the nearest hospital, rather than providing therapy in the community. Social workers and occupational therapists were in scarce supply.¹⁴⁹ The whole country has around 200 clinical officers. These people are not doctors but have a diploma with specialisation in psychiatric care that entitles them to screen, prescribe and administer medication. There are only 200 registered mental health nurses. Non-specialised and lower grade staff members filled the massive staffing gap.

¹⁴⁷ Article 4(1)(i) of the CRPD.

¹⁴⁸ Section 29, PWD 2012.

¹⁴⁹ Various studies have identified the problem of a lack of staff in Zambian psychiatric services. For example, one study showed there were 0.44 mental health personnel per 100,000 head of population working in public or private facilities in Zambia, predominately based at the Chainama Hills Hospital. Alice Sikwese et al., "Human Resource challenges facing Zambia's mental health care system and possible solutions: Results from a combined quantitative and qualitative study" (*International Review of Psychiatry*, 22 (2010): 550-557).

Staff said that psychiatry was off-putting to many potential staff, in part because of stigma.¹⁵⁰ Low levels of staffing lead to serious human rights violations. Nurses said that they did not feel safe on the wards because there were so few nurses on duty. An acute ward at Chainama Hills Hospital had between 30 and 60 patients, with just two trained nurses or clinical officers and one nursing assistant on duty at any one time. At Kabwe, the male ward had up to 16 patients plus family members, with only one nurse on duty, and sometimes there were no staff on duty at all. Nurses complained about their deplorable working conditions and they noted that psychiatric wards had far poorer conditions than other wards, raising mental health equity issues.



7(I). Outpatients: distance and cost

■ *If I don't have transport, I stop coming here. Then I relapse.*
Patient at Chainama Hills Hospital

Previous sections of the report looked at issues within psychiatric hospitals. This examines challenges that people faced receiving mental health support and services in the community.

The CRPD requires governments to ensure that healthcare is provided as close as possible to a person's home, including in rural areas. Similarly, the Persons with Disabilities Act requires the government to, "take appropriate measures to ensure access for persons with disabilities to health services that are gender sensitive and to health-related rehabilitation and shall, in particular, prescribe measures to [...] provide health services as close as possible to people's own communities, including rural areas".¹⁵¹



Picture: Approximate travel distances, by road, between Zambia's provincial psychiatric units and Lusaka's Chainama Hills Hospital. © MDAC.

150 See also Kapungwe et al., MHAPP Research Programme Consortium, "Mental illness - stigma and discrimination in Zambia", 192-203.

151 Sections 20(2)(f), and 27(c) of the PWDA respectively.

Mental health provision at the primary healthcare level is practically non-existent. There is no system which tracks data, records services or provides information on community services.¹⁵² Access to mental health services is centralised in hospitals at eight sites across Zambia, a country with a landmass bigger than France.¹⁵³ People and their families have to travel considerable distances to these hospitals. A patient from Petauke district will cover almost 200km to access services at Chipata Hills Hospital. Someone referred from Chipata to Chainama Hills Hospital would travel just under 600 kilometres.

In the absence of local services, patients and their relatives emphasised the time and money needed to travel to mental health appointments, in addition to the money required to cover the cost of appointments and prescriptions. People reported journey times to Chainama Hills Hospital of up to two hours each way at a cost of 50 Kwacha for return trip (approximately six EUR).

As a result some people simply did not attend mental health reviews. One patient explained, "If I don't have transport, I stop coming here. Then I relapse." Sometimes family members attend without the person affected. A staff member said that the absence of the patient, "puts us in a hard position – we don't want to prescribe without seeing the patient, but we don't want not to help". During a mental health crisis, support is far away and inaccessible for most. The sister of a young man with mental health difficulties told monitors:

When he relapses, and when he's violent, if our father is not at home, we run away. Hopefully he's OK when we come back and we can try to bring him here, but it's a long way and costs money, so that can be difficult.

Some hospitals have made limited attempts to bring mental health services closer to patients. For example, although medication is prescribed in hospitals, it may be administered at a local health clinic at bi-monthly reviews. At Lusaka's Chainama Hills Hospital, staff told MDAC/MHUNZA that they carry out some community psychiatry every Friday in a few of the city's 35 clinics. Similarly in Livingstone, mental health professionals coordinated with the St Francis Care Centre, an NGO, to join their mobile clinics once a week.



Photo: Shutterstock

The Ministry of Community Development, Mother and Child Health recently appointed a mental health focal point to coordinate mental health services at district level. Plans were in place for all new district hospitals to have two or three mental health staff. Six such hospitals exist at the time of writing this report.¹⁵⁴ The mental health focal point planned to conduct a situation analysis to understand what exists in terms of mental health services at the primary level. It seemed that funding to implement these plans was uncertain.

Any efforts to integrate mental health into primary health care should be encouraged. A shift from hospital to community-based care and training healthcare staff to offer quality mental health services can "contribute to the reduction of stigma and the promotion of human rights for people with mental health problems", according to African experts.¹⁵⁵

The Mental Health Bill 2013, if passed, requires each health facility to ensure availability of mental health services at all levels of care, improve financial and geographical accessibility and provide services that are acceptable and of adequate quality. It further requires mental health services to be provided on an equal basis with physical health care.¹⁵⁶ The future National Mental Health Commission will have the task of facilitating the development of community-based mental health services, and the current institutional-based model of incarceration.¹⁵⁷

152 Interviews with the Head of the Department of Mental Health at the Ministry of Health and the Mental Health Coordinator at the Ministry of Community Development, Mother and Child Health: 3 and 4 February 2014.

153 There were psychiatric wards at general hospitals in Mansa (Luapula Province), Kasama (Northern Province), Lewanika (Western Province), Livingstone (Southern Province), Ndola (Copperbelt Province), Kabwe (Central Province) and Chipata (Eastern Province). The North Western Province did not have any psychiatric facilities. In addition there were the dedicated Chainama Hills and University Teaching Hospitals in Lusaka.

154 Interview with the Mental Health Focal Point/Coordinator of the Ministry of Community Development, Mother and Child Health: 4 February 2014.

155 Lonja Mwapeet al., "Integrating mental health into primary health care in Zambia: a care provider's perspective" (*International Journal of Mental Health Systems* 4 (2010): 21).

156 Clauses 16(1) and (2) of the Mental Health Bill 2013.

157 *Ibid.*, clause 7(15).

7(J). Outpatients and consent

We don't give patients adequate information on the drugs and the side effects.

Clinical officer

On discharge from Chainama Hills Hospital, roughly three quarters of patients were treated as outpatients. They travel to the hospital for periodic reviews. Due to the sheer volume of patients attending outpatient clinics, a clinical officer spends around five minutes with each patient. During each consultation the clinical officer asked rudimentary questions to find out some minimal information in order to write a prescription. Clinical officers had no time to discuss anything further, let alone provide counselling or talk through the patient's social or family problems. The Head of Clinical Care of Chainama Hills Hospital explained that outpatient provision only extends to symptom management: "we just try to maintain the patients' functionality, and to document this."

Outpatient reviews were prescription routines without any involvement of patients, meaning that community-based care boiled down to chemical containment. Clinical officers did not inform patients of the potential benefits and risks of different drugs, or discuss treatment options – usually because no options were offered. No written material on medications was provided. Pills were typically issued in transparent plastic bags without any accompanying printed information. A clinical officer confirmed that:

[w]e don't give patients adequate information on the drugs and the side effects. When they get side-effects they then turn to healers or the church, and they may be against our medicine.



Photo: Shutterstock

Old 'first-generation' antipsychotic drugs were prescribed, although fee-paying patients had access to second-generation medication. Staff said that this was due to financial constraints and a lack of a laboratory that would allow staff to monitor the patients' bloods. That said, there is only one drug – Clozapine – which requires a laboratory to carry out regular blood tests.

3

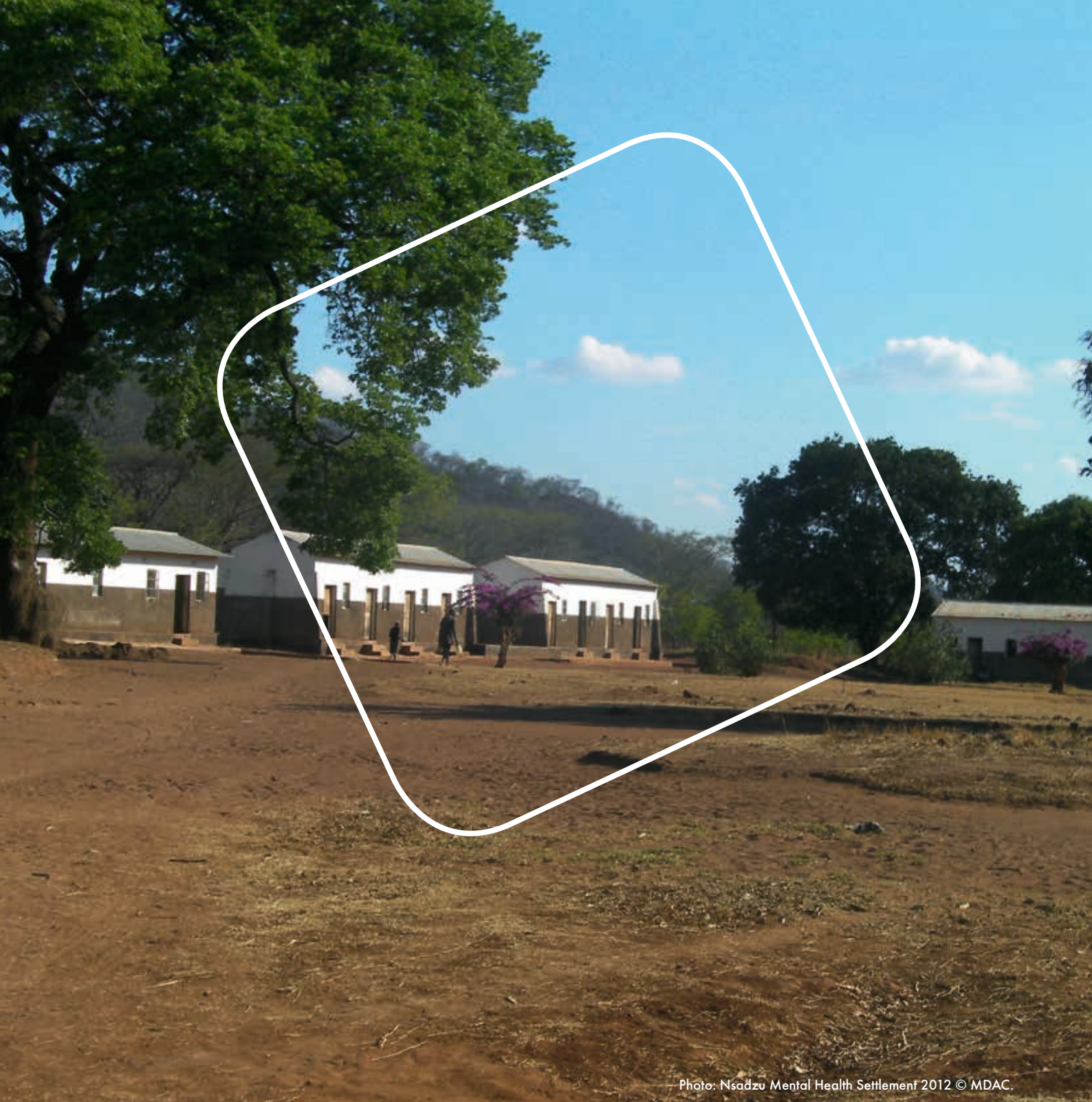


Photo: Nsadzu Mental Health Settlement 2012 © MDAC.

I do not think the residents will ever go back.

Staff member at Nsadzu Mental Health Settlement

8. Nsadzu Mental Health Settlement

In 2010, the Parliamentary Committee on Health and Social Development described Zambia’s three psychiatric “settlements” as “deplorable”. The Committee found that they “do not receive adequate funding to enable them to function efficiently and effectively.”¹⁵⁸ Monitors visited one of these centres – Nsadzu – in Chadiza District in the Eastern Province. Previously a lepers’ colony, the settlement is far from any urban area. The settlement’s purpose was to provide rehabilitation, family reunification and reintegration into the community for people with mental health issues abandoned by their families.

The Nsadzu centre was built in 1972. It had three houses for staff. Of the 19 patient blocks, 16 were hostels for residents. Each block had four rooms. Ten blocks were for men, six for women. Two enrolled mental health nurses worked at the centre, a security guard and general worker. A clinical officer of psychiatry was based 16 kilometres from the centre and occasionally reviewed residents.

Staff described the settlement as a dumping ground. A staff member working there for 15 years said, “I do not know if I will say [the settlement] is for rehabilitation or is for torment because I do not think the residents will ever go back.” She explained that, of the settlement’s 26 residents, she could only remember one patient receiving a visit by a relative, and only one resident having gone home.



Photo: Nsadzu Mental Health Settlement. 26 October 2012. © MDAC.

Table 3: Capacity and occupancy of the Nsazdu Rehabilitation Centre.

Nsazdu Settlement	Female section	Male section
Number of beds	48	80 ⁹
Number of residents on day of visit	5	21
Average number of residents (reported by staff)	5-7	17-19
Age range of patients	25-50	20-65
Average length of stay (reported by staff)	7 years	10 years
Longest length of current patient (reported by staff)	15 years	35 years

The settlement had no electricity, and the water supply was a hand pump bore-hole. The buildings generally looked maintained but furniture, bedding and kitchen utensils were grossly insufficient. There were benches and tables in the dining hall. The rooms observed had just mattress on the floor. A resident in a wheelchair told monitors that he could not use the toilets because they were not accessible. He had to use the bushes instead.

Some of the residents had been there since 1978. They could go on leave if approved by their relatives, but the staff said this had never happened. A young man living at the centre told monitors the following:

Under my circumstances I have no choice other than living here, but if I have a chance in a flash of a second I will leave this place.

¹⁵⁸ The three mental health ‘settlements’ were Nsadzu (Eastern Province), Litambya (Western Province) and Kawimbe (Northern Province).

¹⁵⁹ There were 40 single male rooms and 24 single female rooms. Staff said that each room had capacity to accommodate two people if the number of residents increased.

My family members are initiators of my coming to the centre. I was in grade 11 and used to smoke marijuana. My brother in-law (husband of the elder sister) did not like me for that and an opportunity came when I became violent after smoking and I was admitted in Chainama hospital for two weeks. When I got home the house of our late father had been sold and the agreement we had with my sisters about sharing the proceeds was not kept. So, in the exchange of bad words, my brother in-law went and obtained a detention order for me and that's how I found myself back in Chainama.

When I was pushed in to Chainama my brother in-law and sister convinced the hospital to find a place for me and when the hospital mentioned Nsadzu they said that was the best place for me. After the decision was reached with the hospital to send me to Nsadzu, I stayed at the F ward in Chainama for three months before being taken to Nsadzu.

Residents (particularly male) only interacted with the community in a limited way, by fetching wood, water and harvesting crops – for which they apparently got paid. A resident told monitors this was hard work for many residents who were elderly. Residents were prohibited from drinking alcohol and smoking 'dagga' (marijuana).

All residents are on medication and seven of the eight residents monitors spoke to did not know the name of the drugs they were required to take. Staff accepted in principle that residents could decide about things such as food (the choices in this regard were not obvious to monitors) but for psychiatric medication staff were content to continue to override residents' refusal to consent.

One of the female residents told monitors that she once had a relationship with a male resident who wanted to marry her. She became pregnant and was taken to the hospital where she was subjected to a forced abortion. Nurses told her to end her relationship. Staff confirmed this was the only pregnancy the settlement had ever had. The nurse in charge told monitors that, "residents must live like brothers and sisters since building relationship is not allowed in the centre".

Residents complained about the food: cabbage and beans every day. The resident who used a wheelchair told monitors that he relied on other residents to bring him food because he could not physically access the place where the food was handed out. Sometimes residents forgot, and he was forced to stay hungry, he reported. Monitors saw a resident roasting a rat to eat before dinner. Another resident told monitors that he had been in the settlement for three months and in that time meat had only been served once.

The isolated and impoverished lives of residents at Nsadzu settlement are a serious concern. The conditions represent a serious breach of Zambia's obligations under Article 19 of the CRPD, which sets out the right to live in the community for every person with a disability.



Photo: A resident roasts a rat in the kitchen of Nsadzu settlement, 26 October 2012. © MDAC.



Photo: Residents eating dinner at the Nsadzu settlement, faces blurred to protect identity, 26 October 2012. © MDAC and MHUNZA.





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Building a Sustainable Human Rights Culture Together

Photo: Zambian Human Rights Commission. July 2014. © MHUNZA.

“Establish a framework, including one or more independent mechanisms, to monitor implementation”

Article 33(2) of the UN Convention on
the Rights of Persons with Disabilities

9.

Complaints and inspections

9(A). Complaints mechanisms

None of the facilities visited had internal complaints mechanisms, which allowed people who have been abused to complain to the authorities. There were no external complaints mechanisms such as a healthcare ombudsperson. Patients can report complaints to the Human Rights Commission, but apparently this has never happened.¹⁶⁰

There is no clearly defined mechanism for patients whose rights are seriously jeopardised to raise the alarm. It is a serious violation of human rights where the state removes a person's liberty and then keeps them incommunicado, and where they are prevented from raising the alarm. Unsurprisingly, no legal challenges have ever been made about psychiatric facilities in Zambia.

A complaint system is important because, without one, there will be a lack of information about urgent improvements required to bring the system into compliance with basic human rights standards. It was disappointing to learn from numerous staff the way in which they discounted the possibility that their patients could be sexually abused.¹⁶¹

Patients in closed wards told monitors of physical abuse. A female patient in the B Ward in Chainama Hills Hospital explained how ward staff and a security guard had beaten her with their hands and baton until her face became swollen. Monitors saw a female patient at Ndola psychiatric unit slapping another patient; student nurses watching did nothing. One of the staff at Chainama Hills Hospital told monitors that patient-on-patient fighting was common in all psychiatric hospitals. Some patients told monitors that wards were unsafe. A female patient said:

When I'm in the hospital I prefer to be locked up [in a seclusion room] because of the uncertainty of the environment. Patients come from the male ward, they come in and abuse. I can't fight. At night staff might be very tired and not bother to come out and help you.



Photo: MDAC's Eyong Mbuem and Hannah Roberts with a psychiatric clinical officer in the newly-constructed psychiatric unit at Livingstone Hospital, 29 January 2014. © MDAC and MHUNZA.



Photo: Male patient at Kabwe psychiatric unit complaining to carers, 24 October 2012. © MDAC.

¹⁶⁰ Constitution, Article 125 and 126. See also Human Rights Commission Act, 1996.

¹⁶¹ At Chipata, staff spoke of a woman who disclosed during a music workshop that one man had been raping her. This was not investigated. In all facilities, staff noted they could do nothing more than talk to patients and tell them not to engage in such behaviour again.

9(B). Independent inspections

Article 33 of the CRPD requires governments to establish a framework, including one or more independent mechanisms, to monitor implementation of the Convention. It also states that, “civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process”.¹⁶² Further, Article 16(3) of the CRPD sets out how every facility and programme designed to serve people with disabilities should be monitored by an independent body.

The World Health Organization wrote a report on mental health services in Zambia in 2008.¹⁶³ In 2011 a parliamentary committee visited five facilities, “to check on infrastructure, the drug supply situation and staffing levels”.¹⁶⁴ These one-off efforts need to be replaced by regular visits by an independent body, so as to comply with the CRPD.

The Zambian Human Rights Commission (HRC) was established in 1996 as an independent body with powers to investigate allegations of human rights abuses, to visit prisons and other places of detention and related facilities.¹⁶⁵ It suffers from chronic understaffing and underfunding.¹⁶⁶ It lacks the authority to initiate litigation. The HRC once visited the forensic ward of Chainama Hills Hospital but has never fulfilled its mandate in monitoring psychiatric facilities and has never looked at the human rights of people with mental health issues. Some of its staff members said that the Commission has received only two complaints on mental health issues: one employment matter and one family abuse allegation.

The Zambian Agency for Persons with Disabilities (ZAPD) is supposed to establish a registration system for facilities providing services to people with disabilities, and monitor and evaluate the provision of services.¹⁶⁷ The Director General should appoint inspectors but there is no requirement that inspection reports be made publicly available.¹⁶⁸ ZAPD staff told monitors in an interview in January 2014 that following restructuring, its monitoring capacity has increased, and it will carry out visits to formal institutions such as psychiatric wards and to informal facilities such as traditional healers. He said that the agency acknowledges how it needs to strengthen its capacity on human rights monitoring methodology.¹⁶⁹

The 2013 Mental Health Bill mandates the future National Mental Health Commission to facilitate the monitoring and evaluation of mental health services.¹⁷⁰ The Bill sets out how it should liaise with the Health Professions Council to inspect mental health facilities,¹⁷¹ and should inspect every health facility.¹⁷²



162 Zambia has signed (but has not yet ratified) the Optional Protocol to the Convention against Torture (OPCAT), thereby acknowledging that places of detention should be monitored by an independent inspectorate.

163 Jason Mwanza et al., *Mental Health Policy Development and Implementation in Zambia: A situation analysis*, 59–60, 30 March 2008.

164 Parliamentary Committee on Health, Community Development and Social Welfare, 23 September 2010.

165 Established by Article 125 of the Zambian Constitution. Also sections 9 and 10 of the Human Rights Commission Act 1996. As of December 2011, when it was last reviewed, the Human Rights Commission had A-status with the International Coordinating Committee of National Human Rights Institutions. ‘A-status’ means full compliance with the Paris Principles (related to the status and functioning of national institutions for the protection and promotion of human rights), and are usually accorded speaking rights and seating at human rights treaty bodies and other UN organs.

166 In April 2011, the Special Rapporteur for follow up on concluding observations of the UN Human Rights Committee (the ICCPR treaty monitoring body) referred Zambia for follow up due to, among other issues, the appropriateness of additional resources allocated to the needs of the HRC, and because powers of the HRC had not been revised since 1996. In 2008 the UN Committee against Torture expressed concern that the Zambian HRC lacked the financial and human resources to conduct visits, and noted that it did not have powers to take action against persons found guilty of abuse, since it could only make recommendations to authorities. It also expressed concern about the failure on the part of the government to implement the HRC’s recommendations. UN Committee against Torture, Concluding Observations: Zambia, 26 May 2008, CAT/C/ZMB/CO/2. See also African Commission on Human and Peoples’ Rights report on its promotional mission to the Republic of Zambia 14 to 18 April 2008’ UN Committee on Economic, Social and Cultural Rights (CESCR), Concluding Observations of the Committee: Zambia, 23 June 2005, E/C 12/1/Add 106, paragraph 12.

167 Sections 14(1)(k), (n) and (o), and section 52(1) of the PWDA.

168 *Ibid.*, sections 57(1) and 58(2).

169 Interview with ZAPD Information/Communication Officer: 31 January 2014.

170 Clause 7(13) of the Mental Health Bill.

171 *Ibid.*, clause 7(8).

172 *Ibid.*, clause 21(2). The relevant laws include the Health Professions Act 2009, Nurses and Midwives Act 1997 and Medicines and Allied Substance Act 2013.



Photo: Staff expressed their regrets to monitors that the windows of the psychiatric ward at Ndola Hospital were built so high up, saying that they had had a limited understanding of mental health issues in the past, 24 October 2012. © MDAC.



Photo: MHUNZA staff inspect a seclusion room at Kabwe Hospital, 24 October 2012. © MDAC.





Picture: Zambian coat of arms.

The President may at any time by order discharge from detention any person detained during the President's pleasure and such discharge may be absolute or subject to conditions, and if absolute the order under which he has been detained shall cease to be of effect accordingly.

Section 164(1), Criminal Procedure Code

10. Criminal justice

Many people with mental health issues live in prison, either on remand (before trial), or post-sentencing, known as “on HEP” (on His Excellency’s Pleasure). The prison service reports approximately 17,000 prisoners, more than double the 8,000 capacity, with overcrowding made worse by some urban prisons significantly overpopulated.¹⁷³ In 2009 the number of prisoners was 15,300 people accommodated in prisons built to accommodate 5,500 people before the country’s independence in 1964.¹⁷⁴

People alleged to have committed criminal offences and who are judged to be “of unsound mind” may be detained at forensic psychiatric facilities.¹⁷⁵ Chainama Hills Hospital has one male forensic ward with a capacity of 20 and a further three female forensic beds. Another 30 forensic beds are in Livingstone. Discharge from these places happens only when the senior psychiatrist issues a report recommending discharge and a prison officer recommends release to the country’s President (unless a prisoner on remand is found not guilty, in which the person is freed).¹⁷⁶ This system means that the detention of people with recognised mental health issues is dependent on the executive arm of the State, without any judicial oversight.

The President may issue a pardon. In 2012 approximately 200 prisoners were pardoned: none were forensic patients.¹⁷⁷ The absence of any structured system of review, independent assessment, representation of patient’s views, or appeal mechanism leaves patients at risk of arbitrary detention.

Mental healthcare in prisons is minimal. Psychiatrists visit prisons in Lusaka every few months, and prescribe psychiatric medication. In 2011 the Global Initiative on Psychiatry, with MHUNZA’s involvement, undertook an assessment of the situation of prisoners with mental health issues in Zambia targeting four prisons including the forensic ward at the Chainama Hills Hospital. The resultant report concluded that mental health care, detection and treatment are generally unavailable in prisons.¹⁷⁸

Representatives of the access to justice department of the Ministry of Justice told monitors that they have no system in place to support people with mental health issues within the judicial system. State-funded legal aid is provided upon request to people who the legal aid committee, court or the director of legal aid board assessed as having insufficient means to pay for a lawyer and when justice is served by providing representation.¹⁷⁹ Lawyers are most often available only at the provincial level and there are not enough to meet demand.

No records are kept of the number of cases involving victims of crime who have mental health issues. Criminal justice professionals told monitors that victims with mental health issues are invisible for law enforcement agencies, a long way from the statutory requirement to ensure “equal and effective protection and equal benefit of the law without discrimination”.¹⁸⁰



173 Interview with Prisons Secretary, Ministry of Home Affairs: 3 February 2014.

174 Aids and Rights Alliance, Prison Care and Counselling Association, and Human Rights Watch “Unjust and Unhealthy” (Zambia: April 2004).

175 Sections 160, 163 and 167(3) of the Criminal Procedure Code. The Zambian Paralegal Alliance Network is researching mental health issues within the criminal justice system. Interview with Phillip Sabuni: 25 January 2014.

176 Recommendations consider the availability of family support and supports within the community, and the ability of inmates to live independently in the community. It is notable that none of these facilities have any occupational therapy or rehabilitation programmes to prepare inmates for release.

177 Interview with nursing officer in charge of Chainama East forensic unit, 31 October 2012.

178 Global Initiative on Psychiatry, “Assessment of the situation of prisoners with mental illness in Zambia”, March 2011 (Unpublished). The assessment was conducted by Co Bleeker, Robert Hollander, Carola Koorneef from Global Initiative on Psychiatry, Sylvester Katontoka of MHUNZA and Godfried Malabeka from Prison Care and Counselling Association from 14 to 19 March 2011.

179 Sections 8, 9, 11 and 14 of the Legal Aid Act, 2005.

180 Article 8(2) of the Persons with Disabilities Act 2012.

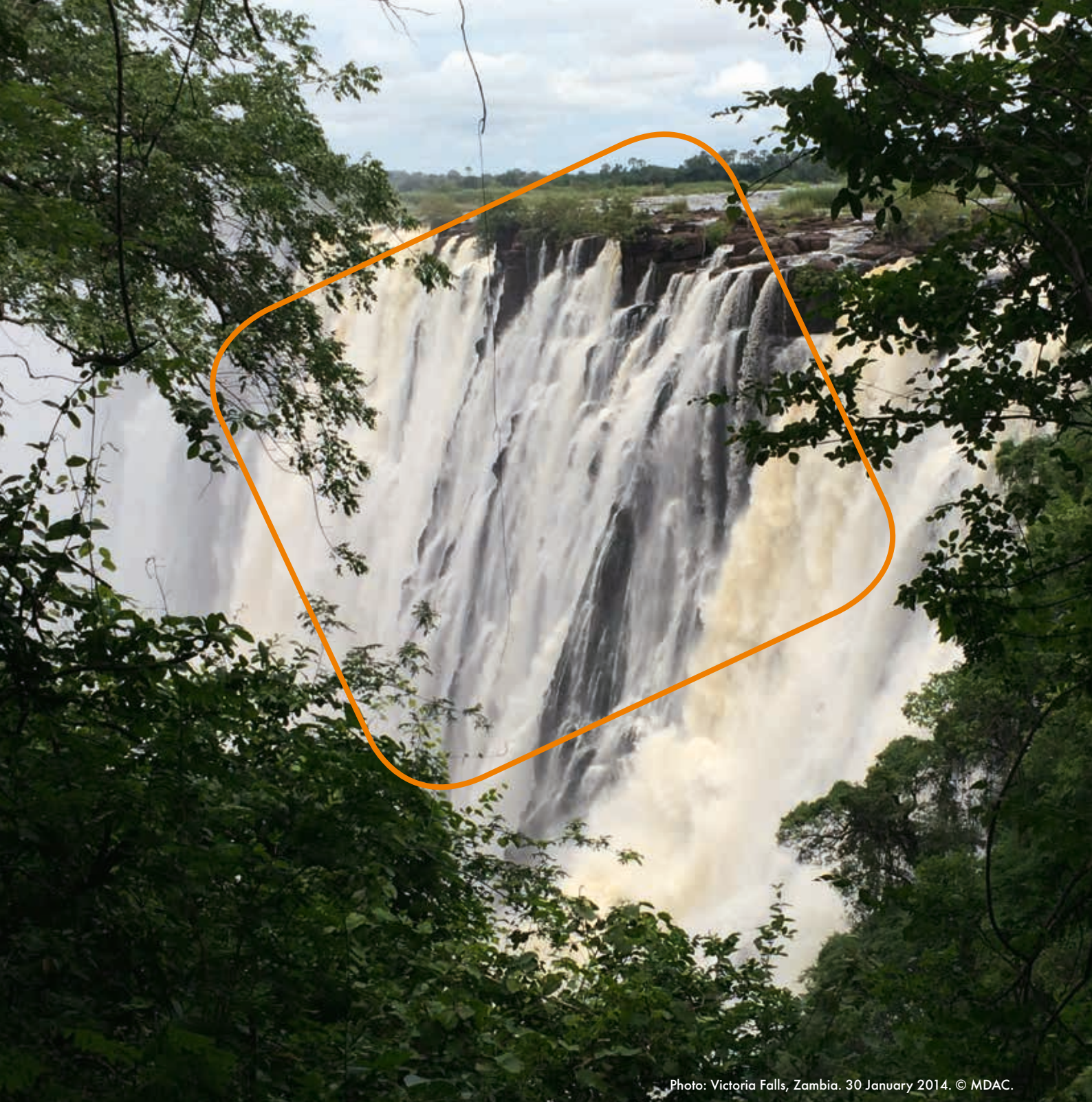


Photo: Victoria Falls, Zambia. 30 January 2014. © MDAC.

Often the true need is for a person to be supported in regaining his or her place in the community – to find a home, lead a life that is meaningful to oneself and develop ways to deal with crisis.

A Framework for Change, MHUNZA and ZAFOD, 2012.

11. Concluding comments

The mission statement of Chainama Hills Hospital is to improve “the mental health status of our patients and the people of Zambia in order to contribute to overall economic development.” This usefully makes explicit the link between upholding the human rights of people with mental health issues and macro-economic development. If a person cannot access supports for their mental health issues, they will likely lose their jobs. Similarly, if a person is harmed by psychiatric hospitals or traditional healers and not provided with access to remedies, they will be traumatised and may not be able to look after their family.

There is widespread acknowledgment among many people from different sectors that mental health services in Zambia – both formal psychiatric services and those provided by the traditional healing sector – have significant shortcomings. Various plans are underway for improvement, including a Mental Health Bill, development of mental health services at the primary healthcare level, and plans to demolish some decrepit psychiatric wards.

A strong argument can and should be made for increasing the tiny amount of spending on mental health services. The budget currently available should be spent in a different way, with more investment into community support services, and into awareness-raising at the grassroots level. Funding an independent inspectorate and ensuring access to justice when things go wrong are both good investment choices which will pay dividends in terms of preventing injustices. Involving a wide range of people with disabilities in law and policy reform as the government rolls out these reforms will reduce the likelihood of gaps and duplication, and will make implementation more likely to be successful.¹⁸¹

Without fundamental changes to the way mental health services are organised, professionals will be forced to continue practices which result in serious human rights violations and which are laid out in detail in this report. Without change, people with mental health issues in Zambia will continue to be denied their basic rights: to health, to liberty, and to freedom from torture, exploitation, violence and abuse.

There is already wide agreement that people are not receiving the care and support they are asking for, because the government’s focus (and the funding) is directed almost entirely to confinement in psychiatric wards where pills and little else are provided. The main message of this report is that the government’s attention and their budgets must be directed towards establishing and maintaining a range of services in community settings.

The government plans to build new mental health facilities. It should think again. Constructing new facilities will recreate segregation where little else beyond a roof and medication will likely be provided. Instead, the government should empower people to make choices about their own lives, including their mental health care. It should provide opportunities for people to live, with choices equal to others, in their community, as set out so powerfully in Article 19 of the UN Convention on the Rights of Persons with Disabilities, which Zambia has ratified.

This report may be the first comprehensive analysis of mental health in Zambia through the lens of human rights. But it is not the first to conclude that community services are the solution. In 2012, the Mental Health Users Network of Zambia and the Zambia Federation of Disability Organizations issued a report about mental health. In this report they say:

*[R]emoving people from the community to address their mental health needs through an institutional model often results in breaking the bonds of social support with family, friends, co-workers and community members – relationships which are so fundamental in creating sustainable pathways to health and well-being. Institutionalization in psychiatric facilities often results in a ‘revolving door’ – every time a person has a mental health crisis they end up back in the institution; and in stigmatisation, loss of relationships and little or no long-term recovery. Psychiatric institutions may have little to offer in response to the real needs, and are often accessed only because of the absence of any other mechanism to respond to an individual’s situation. Often the true need is for a person to be supported in regaining his or her place in the community – find a home, lead a life that is meaningful to oneself and develop ways to deal with crisis.*¹⁸²

Zambia has much to build upon including an active mental health service user network, impressive and committed mental health professionals, leaders of traditional healing who are willing to introduce rights-based regulation, and experience of collaboration with civil society which has produced the Mental Health Bill.

Addressing the issues identified with law, regulations, enforcement, attitudes and resourcing gives every person interested in mental health and disability in Zambia the opportunity to uphold and reaffirm their commitment to human rights. Ending abuses in the community, in traditional healing and in psychiatric facilities, and instead rolling out community support services for people with mental health issues will benefit the people of the nation. Zambia can serve as an example to Africa, and beyond.

181 Article 4(3) of the CRPD states: “In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.”

182 Mental Health Users Network of Zambia (MHUNZA) and Zambia Federation of Disability Organizations (ZAFOD), *A Framework for Change: General principles and key concepts and implications for the Mental Health Bill*. Pathways to Health, Human Rights and Community-based Supports Protecting and Promoting Legal Capacity and Transforming the Mental Health System in Zambia (draft available to the authors, September 2012), 11.

Appendix 1:

Methodology and acknowledgements

Interviews were undertaken with people with mental health issues, their family members, representatives of local communities and local authorities, traditional healers, representatives of traditional healers' associations, mental healthcare staff, and representatives of various governmental ministries.

MDAC and MHUNZA researchers carried out 57 semi-structured interviews that usually lasted one hour. These were recorded, transcribed and typically sent to the interviewee for amendment and approval. All interviewees were assured of anonymity to promote frank reporting. Out of the 57 interviews, 20 were conducted with people with mental health issues (half were female, half male). Another ten were carried out with their family members, and again there was a gender balance.¹⁸³ Five family members interviewed were spouses, three were parents, and two were extended family members. Three interviews were conducted with refugees. Interviews with people with mental health issues and their families were selected on the basis of a wide geographic and ethnic spread.¹⁸⁴ In addition, over 50 unstructured interviews were conducted in January and February 2014 with people with particular experiences and an interest in discussing their experiences with traditional healers and psychiatric services.

Meetings were conducted with:

- a. Representatives of disabled people's organisations, including people with mental health issues and from the Zambia Federation of Disability Organizations (ZAFOD).
- b. Representatives of the relevant government ministries (the Health Promotion Focal Point Person for Traditional Healers and the Chief Mental Health Officer, at the Ministry of Health; Chief Cultural Affairs Officer at the Ministry of Chiefs and Traditional Affairs - now under the Ministry of Tourism; the Head of Human Rights and International Treaties Section at the Ministry of Justice; two Access to Justice Programme Specialists at the Ministry of Justice, the Prison Secretary at the Ministry of Home Affairs, two Senior Social Welfare Officers and the Focal Point Person for Mental Health at the Ministry of Community Development, Mother and the Child, and the Administration Secretary at the Ministry of Local Government).
- c. Representatives of other relevant state agencies: the Executive Director and the Information Officer of the Zambian Agency for Persons with Disabilities, the Executive Director of the Zambia Institute of Natural Medicine and Research and the Executive Director of the Legal Aid Board.
- d. Representatives of regulatory bodies, including the Director General and an Inspector of the Pharmaceutical Regulatory Body, now called Zambia Medicines Regulatory Authority.
- e. Representatives of traditional healing associations (two representatives of the Traditional Health Practitioners' Association of Zambia) and two traditional healers.
- f. Mental health professionals including two psychiatrists, the Head of Clinical Care and a Consultant Psychiatrist at Chainama Hills Hospital.
- g. Human rights professionals, including the former Director, the current Chairperson, a Legal Officer and an Information Officer at the Human Rights Commission.
- h. Representatives of local community organisations, including three representatives of the Ward Development Committee.
- i. Representatives of other NGOs, including the Executive Director of the Non-Governmental Organisations Co-ordinating Council, the Executive Director of the Legal Resource Foundation, the Executive Director of the Paralegal Alliance Network, and the Executive Director of the Prisons Care and Counselling Association.
- j. Representatives of faith communities, including the President and Senior Pastor of the Life of Christ Church.
- k. Representatives of the international organisations such as the Health Information Promotion Officer, and the Traditional Medicine Focal Person at the World Health Organization office in Zambia.

¹⁸³ The age range of interviewees with mental health issues was 18 to 67, with the average age being 41. The age range for interviewees who were family members of people with mental health issues was 37 to 86.

¹⁸⁴ Five interviews were conducted in Lusaka (Lusaka Province), four in Kitwe (Copperbelt Province), and six in Chipata (Eastern Province). In total, interviews were conducted at six sites, three of which were rural (Chipata, Solwezi/Meheba Refugee Camp and Chongwe) and three were urban (Lusaka, Kitwe and Livingstone). Interviews were conducted with native Bemba, English and Nyanja speakers.

Permission to visit psychiatric facilities was sought and granted by the Permanent Secretary of the Ministry of Health. Five facilities were visited in five provinces: Central, Copperbelt, Eastern, Southern and Lusaka.¹⁸⁵ Monitors visited Chainama Hills Hospital which is the only tertiary care psychiatric hospital in the country. The “Nsadzu mental health settlement centre” was also visited.¹⁸⁶

Traditional healing facilities providing services to people with mental health issues were identified based on interviews. Monitors visited five traditional healing centres, including a faith healer’s centre.¹⁸⁷ None had anyone staying there who had mental health issues, reflecting the tendency for treatments to be given on an outpatient basis.

Visits to psychiatric facilities and traditional healers were guided by a checklist developed by MDAC and adapted from a toolkit for monitoring human rights in mental health and social care institutions.¹⁸⁸ Information was gathered through observation and unstructured interviews with patients, staff and visiting family members. Literature searches were carried out to find available reports on the facilities. Data was analysed using manual analysis methods for qualitative data. Interview guides, checklists, protocols and consent forms are available from

MDAC upon request.

In-country research was coordinated by Eyong Mbuen (MDAC Project Manager) and included Paul Chungu (Mental Health Association of Zambia), Sylvester Katontoka (MHUNZA National Coordinator) and Hannah Roberts (independent mental health writer and MDAC Consultant). Om Shanti (MDAC intern) did desk research on traditional healing literature. Reima Ana Maglajlić (former MDAC Research and Monitoring Director) provided input into previous drafts of the report. Eyong Mbuen and Hannah Roberts wrote the final report, which was edited by Steven Allen (MDAC Advocacy and Communications Director) and Oliver Lewis (MDAC Executive Director).

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Eyong Mbuen and Hannah Roberts wrote the final report, which was edited by Steven Allen (MDAC Advocacy and Communications Director) and Oliver Lewis (MDAC Executive Director).

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MDAC and MHUNZA would like to thank the Ministry of Health for their support in providing access to facilities, and the staff of the facilities which were visited. In particular ward staff were extremely open and frank about the challenges of their work, and the strengths and shortcomings of services offered. The two NGOs would also like to thank traditional healers, government and other stakeholder representatives who gave their time to the study. Finally, and most importantly, MDAC and MHUNZA thank the many people directly affected by mental health issues in Zambia who shared aspects of their lives with strangers who shared aspects of their lives with strangers. We hope that this report does justice to their stories.



185 Chainama Hills Hospital, Lusaka (the only tertiary care referral hospital in the country); Chipata Psychiatric Unit, Chipata General Hospital, Eastern Province; Ndola Psychiatric Unit, Ndola General Hospital, Copperbelt Province; Kabwe Psychiatric Unit, Kabwe General Hospital, Central Province; and Livingstone Psychiatric Unit, Livingstone General Hospital, Southern Province.

186 Nsadzu mental health settlement centre, Chadiza District, Eastern Province (the only functioning of the three officially listed mental health rehabilitation centres in the country).

187 Traditional healer Lagabisolomi, commonly known as Kwa Mbomba compound located in Kitwe. The healer specialised in providing in-patient treatment to people with psycho-social disabilities, but stopped in 2009 due to ill-health. Traditional healer Jeremiah Arunk, Chizanga Township, Lusaka Province. Traditional healer Mizyu, located at Kayama Township in Lusaka Province. Traditional healer Maut, in N’yombe, Garden Township in Lusaka Province. Spiritual healer George Kagoda, Paradise Spiritual Church in Mumbwa district, Central Province.

188 The Institutional Treatment, Human Rights and Care Assessment (ITHACA Project Group, *ITHACA Toolkit for Monitoring Human Rights and General Healthcare in Mental Health and Social Care Institutions*, (Health Service and Population Research Department, Institute for Psychiatry, King’s College London, London: 2010), available online at www.mdac.org.

Notes

