

Mental health in Zambia – challenges and way forward

Jedrin Ngungu¹ and Julian Beezhold²

¹Specialist Registrar, Norfolk and Waveney Mental Health Foundation Trust, email ngunguj@yahoo.com (former Acting Medical Director for a year at Chainama Hills Hospital, Zambia)

²Consultant Psychiatrist, Norfolk and Waveney Mental Health Foundation Trust

Zambia, previously called Northern Rhodesia, was a colony of Great Britain until 1964, when it gained independence and changed its name. It is a landlocked country located in southern Africa and shares its borders with Zimbabwe, Namibia, Botswana, Mozambique, Malawi, Tanzania, Congo and Angola. It has an area of 752 612 km², about three times the size of Britain, but a population of only 12 million.

The country is divided into nine provinces for administrative purposes, each with a provincial headquarters. Although there are 72 languages spoken in Zambia, there are seven main ones: Nyanja, Bemba, Lunda, Luvale, Kaonde, Lozi and Tonga. The official language is English, which is spoken by most citizens. Zambia is largely a youthful country, with 90% of its population less than 45 years old; only 2% are over 65.

Policy and legislation

Since 1992, the country has had five national development plans; the latest was the Fifth National Development Plan (FNDP) in 2006. In the first four plans, there was no mention of mental health. There is only a casual mention in the FNDP, in which the health agenda is dominated by infectious diseases (HIV, tuberculosis, malaria and diarrhoeal diseases) followed by child health and reproductive health. The strategy for mental health is less than coherent.

Zambia still uses the 1951 Mental Disorders Act in which patients are referred to as idiots, imbeciles and invalids. Since the early 2000s, there has been some effort to reform the Act and this reached the stage of a parliamentary draft bill in 2006. However, the draft bill is far from perfect as it is not based on the United Nations human rights charter, which is the bedrock of most current mental health legislation. The limited availability of mental health professionals to spearhead this agenda has contributed to the lack of progress. It has to be said, however, that there is almost no recourse to the Act in clinical practice, as most people are too ignorant to challenge their detention for treatment against their will.

Personnel

Zambia has only three psychiatrists for a population of 12 million. Two of these are not in clinical practice but are attached to the local university. There are no graduate

psychologists, occupational therapists or mental health social workers. The bulk of the work in mental health is carried out by clinical officers, who are specially trained medical assistants (see below).

Infrastructure and services

Zambia has only one psychiatric hospital, Chainama Hills Hospital, which is based in the capital city of Lusaka. It was opened in 1962 as a national referral centre. It has a capacity of 500 beds, divided into 380 general adult and 120 forensic. It is modelled after the asylums that characterised English mental healthcare more than 50 years ago. The wards are large halls with many patients in each. The beds are usually just mattresses placed on the floor.

Apart from Chainama, there are smaller units, called annexes, in seven provincial headquarters: Ndola, Mansa, Kasama, Kabwe, Chipata, Mongu and Livingstone. These provide a few extra beds and are staffed by clinical officers and psychiatric nurses.

In Zambia, therapy almost exclusively comprises the use of psychotropics; talking therapies are non-existent. However, this is not as problematic as it might be, given that almost all admissions are for psychotic illness (mostly acute psychotic episode, followed by schizophrenia and bipolar disorders). It is rare to see patients with depression unless they have psychotic symptoms as well. The country has no specific forensic, drug and alcohol or children's services.

Education and training

The University of Zambia's School of Medicine is the country's only medical school. It produces 40 graduates every year, half of whom never practise locally but leave the country. Whereas there is postgraduate training in surgery, medicine, paediatrics and obstetrics and gynaecology, there is no such training in psychiatry. To become a psychiatrist, one has to go abroad and herein lies one of Zambia's problems: the few who go for such training rarely return. (There are at least six Zambian psychiatrists working abroad.)

Similarly, there is no graduate training for psychologists, social workers or occupational therapists. What is available is training for psychiatry clinical officers and nurses. This is based at Chainama Hills College of Health Sciences, which is located in Lusaka just adjacent to Chainama Hospital. Clinical officers are the mainstay of mental health services in Zambia.

These are medical assistants who spend 3 years studying medicine before graduating to work in general medicine. After about a year, some of the clinical officers return to Chainama College for an extra year, to become psychiatry clinical officers.

Challenges and way forward

Government policy and legislation

While some progress has been made in putting forward the mental health agenda for government policy, much remains to be done to convince not only government but also parliament of the importance of a robust mental health policy and infrastructure. Successful lobbying cannot be achieved by locals alone but requires the help of international partners such as the World Health Organization and the World Psychiatric Association.

Human resources

There is a serious deficit of trained personnel in the medical field. This is even more pronounced in mental health. Zambia needs more psychiatrists just to help build capacity in the mental health services, let alone to run such services. There is also a need for other mental health professionals, including psychologists and occupational therapists. To address this deficit, local training must be developed. Training people overseas, as has been proved over the years, is not a viable option. The establishment of training facilities will be expensive, nonetheless.

Infrastructure

There is a need to have mental health beds in every district. Every district has a general hospital and, to keep costs down, some of these could be allocated to psychiatry.

Stigma

High levels of stigma exist not only against those who are mentally ill but also against their families and those working in the mental health services. Many patients are disowned by their families. Most long-stay patients in Chainama Hospital have no contact with their family members. The 'out of sight out of mind' mentality is prevalent.

Public awareness campaigns are needed. These could be targeted at schools, colleges, workplaces and other public areas. One or two charities are trying but, with limited capacity, little is being achieved. The government may decide to make this one of the priorities for mental health. It is certainly an achievable goal which, unlike the above, does not require massive funding.

Sources

- Haworth, A. (1988) Psychiatry in Zambia. *Bulletin of the Royal College of Psychiatrists*, 12, 127–129.
- Mayeya, J., Chazulwa, R., Mayeya, P. N., et al (2004) Zambia mental health country profile. *International Review of Psychiatry*, 16, 63–72.
- Mwanza, J., Sikwese, A., Banda, M., et al (2008) *Phase 1 Country Report. Mental Health Policy Development and Implementation in Zambia: A Situation Analysis*. WHO. Available at http://www.who.int/mental_health/policy/development/Zambia%20Country%20report.pdf (last accessed January 2009).

ORIGINAL PAPER

Correlates of lifetime alcohol abuse and dependence among older community residents in Brazil

Gerda G. Fillenbaum,¹ Sergio Luís Blay,² Sergio Baxter Andreoli² and Fabio Leite Gastal³

¹Center for the Study of Aging and Human Development, Duke University Medical Center, and Geriatric Research, Education and Clinical Center, Veterans Administration Medical Center, Durham, NC, USA, email gjf@geri.duke.edu

²Department of Psychiatry, Federal University of São Paulo, Brazil (Escola Paulista de Medicina – UNIFESP)

³Invited Professor, Medical University of Minas Gerais/UFMG, Brazil

Misinterpretation in major surveys of alcohol use disorder as described by DSM-IV (Hasin *et al*, 2007) has raised serious questions regarding the extent of alcohol use disorder, and the relationship between alcohol abuse and alcohol dependence. While the adverse social, physical and mental effects of alcohol misuse are well known (Council on Scientific Affairs, 1996), there is little information on the determinants of alcohol abuse (societal impact) and alcohol dependence (physiological impact). We therefore examined their separate

and combined associations with demographic, social and health characteristics in a representative community-resident sample aged 60 years and over. We hypothesised that, while for each of the three groups (those with alcohol abuse, those with alcohol dependence, and those with both) there would be associated demographic characteristics, abuse would be more closely associated with social characteristics, dependence with health characteristics, and the combined presence of abuse and dependence with both social and health characteristics.