MENTAL HEALTH IN ZIMBABWE

Findings from a comprehensive system analysis in Zimbabwe

2016

MESSAGE FROM THE DEPUTY-DIRECTOR

The findings from this independent, rigorous systems analysis of mental health in Zimbabwe are promising and exciting. They show that Zimbabwe has overall progressive policies, a motivated mental health workforce, and better infrastructure than many neighboring countries. As has always been the case, funding is the largest concern for mental health in Zimbabwe. This has also been worsened by suboptimal communication within the system. We hope that the findings and dissemination of this report can help to give stakeholders up to date information, and to help reinvigorate the discussion around mental health.

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"Many people think once someone is mentally ill, they are useless to the society, which is not true. We actually have many that are on treatment and are productive in functional society. People are not aware that some of the people they see in town actually may be on medication for mental illness."

—Study Participant

MENTAL HEALTH SHOULD BE A PRIORITY FOR ZIMBABWE.

Mental disorders make up 7.4% of the disability adjusted life years in 2010

and over 37% of healthy life years lost to noncommunicable diseases (Murray). This means that more healthy life years are lost to mental and behavioral disorders than either cancer or heart disease. Yet, mental health receives only 1% (or less) of health-related expenditures in low-income countries (Murray).

Fortunately, because of Zimbabwe's established mental health system, there are **cost-effective ways** to improve mental health in Zimbabwe.

1%

99%

● All Health-Related Expenditures
● Mental Health Expenditures
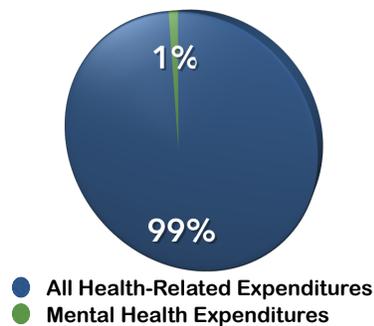
Mental disorders are one of the **top 5** causes of the disease burden in Africa.

Poor mental health hurts the economy

Mental illnesses cost low- and middle-income countries almost $900 billion in 2010 and are projected to cost over $2000 billion in 2030. A large portion of these costs are due to productivity losses, such as:

• Inability to work and contribute to society at full capacity

• Premature unemployment

• Long-term healthcare costs for mental illness symptoms (e.g. headaches)

Mental health interventions improve economic situations in low and middle-income countries, according to multiple controlled trials and intervention studies (Bloom et al., 2011).

HIV/AIDS, TB

HIV/AIDS and other chronic conditions exacerbate the risk of developing mental disorders, and vice versa, according to the World Health Organization. More than being a stressor for depression, HIV has an immunological effect on the brain that increases risk of mental illness.

"Mental health and cardiovascular diseases account for almost 70% of lost output, followed by cancer, chronic respiratory diseases and diabetes."

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BACKGROUND

Facilities exist. Policies are relatively progressive. Research is extensive. The workforce is motivated. Yet, missing pieces in the mental health system prevent the vast majority of Zimbabwe from accessing proper mental health care. The main missing pieces are funding and resources, creating a host of issues such as the inability to implement most of the Mental Health Act, poor staffing, drug shortages, and overcrowded hospitals and prisons.

For instance, a majority of nurses and occupational therapists who specialize and train in mental health are either: 1) diverted to other careers, or 2) driven to practice outside of Zimbabwe because of drastically low salaries, leaving only five clinical psychologists and 15 of 150 registered occupational therapists practicing mental health in Zimbabwe's public sector.

Patients who *can* access mental health care do not have medications to treat their illnesses. Due to drug shortages, many psychiatrists prescribe all patients—regardless of their disorder—the same out-dated, unspecific drug, often rife with side effects.

Funding and resources are only two of the missing pieces of Zimbabwe's promising but incomplete mental health system. There are other missing parts: Nurses are trained; opportunities are missing. Diagnoses are accurate; medications are not. Patients seek help; they are treated for headaches and high blood pressure, not the mental illness root cause.

"You know just the other day I was driving and I thought, let me start looking at the Daily News headlines as I am driving and see what kind of things, and every other day there is something related to mental health. You know, woman jumps from the 13th floor of the building. Husband rips his wife's tummy with a knife. And all those kind of related mental health stuff."

—Study Participant

METHODS

Filling in these missing pieces requires a coordinated effort by all parties. To understand precisely where the missing pieces are, we conducted the first comprehensive study of Zimbabwe's mental health system in 30 years. This study examines the Zimbabwean mental health system on a national level, from policies to care facilities to workforce and more.

First comprehensive study of Zimbabwean mental health system in 30 years.

Our research was a combination of:

✦ Compiling all available public information on the Zimbabwean mental health system from 2013-2015

✦ Evaluating the mental health policies using the internationally approved Emerald consortium checklist

✦ Creating an interview system geared towards Zimbabwe's structures and policies based on an interview guide developed by the Emerald Project for international evaluation of mental health systems (http://emerald-project.eu/)

✦ Conducting 30 systematic interviews with policymakers, physicians, psychiatrists, researchers, NGO workers, administrators, nurses, traditional healers, government workers, and prison service workers

Data collection and analysis:

✦ All interviewers and researchers were trained in qualitative method.

✦ A researcher fluent in Shona conducted interviews in Shona.

✦ All 30 interviews were transcribed verbatim and coded according to a comprehensive code list developed by two senior researchers.

✦ Coding was done in order to distill key themes from the data. Each of the 30 transcripts was separately coded by two researchers to decrease subjectivity of coding. A third researcher reviewed all 30 coded transcripts to ensure consistency among code assignments.

✦ All opinions were cross-checked with documents and other interviews.

Our research allowed us to accurately study many facets of Zimbabwe's mental health system including policy and law, care facilities, forensic services, financing, workforce, belief systems, and NGOs.

POLICY, LAW, AND GUIDELINES

EXISTING MENTAL HEALTH DOCUMENTS

Mental Health Act (1996)
Mental Health Policy (2004)
Mental Health Strategy (2014-18)
Guidelines and Treatment Protocols for the Management of Common Mental Health Disorders in Primary Care (2012)
Statutory Instrument for Tobacco Control

Overall, the Mental Health Act, Mental Health Policy, and Mental Health Strategy surpass those of many other countries in sub-Saharan Africa (WHO, 2014), with a clearly visible trend of improvement across documents over time. **But the question is: are people using them?**

Mental health policies, acts, and strategies are not being implemented.

The Mental Health Policy, for instance, provides for universal access to psychiatric drugs. However, the lack of funding prevents almost all patients from accessing functional, up-to-date drugs to treat their conditions. In addition, many additional posts are due to be created according to the mental health strategy (2014-2018). However, **neither the strategy document nor participants in the study could explain how these future posts would be funded.**

Many participants believed that these documents could be updated to reflect the current situation and international human rights standards, but emphasized that the priority is that the current policies are implemented.

"Let's push for implementation of what we have, so in the next review, we know what works and what doesn't." —Study Participant

Service user and caregiver representation is inadequate.

In a future review, it will be essential to represent mental health service users and hands-on caregivers and nurses in the creation of these mental health documents, especially treatment protocols that deal directly with the complexities of clinical care.
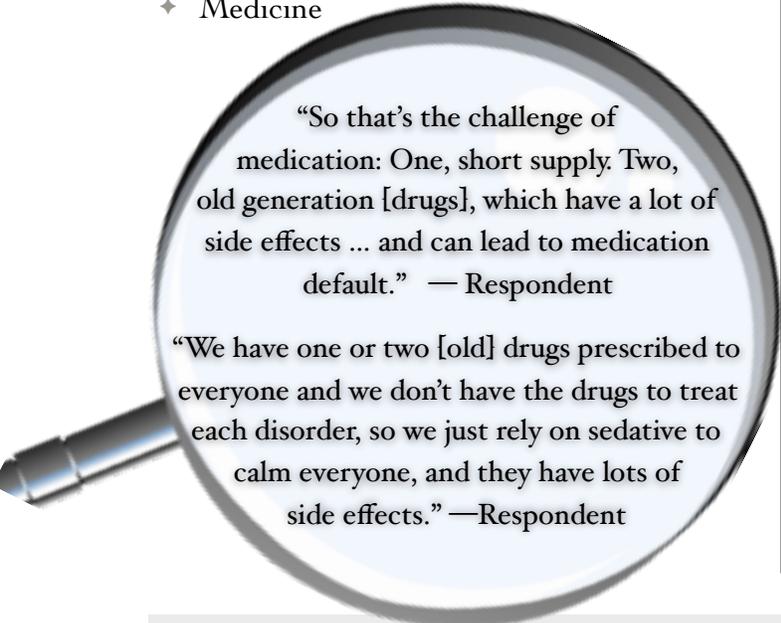
CARE FACILITIES

Sakubva Hospital in Mutare closed due to debilitated infrastructure

Medications for mental disorders in the public sector are "free" but unavailable. Alternatively, patients are given unaffordable prescriptions to source at their own cost in the private sector.

Mental health care facilities lack:

✦ Food and water

✦ Bedding

✦ Medicine

"So that's the challenge of medication: One, short supply. Two, old generation [drugs], which have a lot of side effects ... and can lead to medication default." — Respondent

"We have one or two [old] drugs prescribed to everyone and we don't have the drugs to treat each disorder, so we just rely on sedative to calm everyone, and they have lots of side effects." —Respondent

	Facility	Location
Acute psychiatric wards in major teaching hospitals	Harare Psychiatric Unit

Parirenyatwa Annexe | Harare Hospital, Harare
Parirenyatwa Hospital, Harare |
| Acute psychiatric wards in provincial hospitals | Gweru Hospital
Chinhoyi Hospital
Marondera Hospital
Mutoko Hospital | Gweru
Chinhoyi
Marondera
Mutoko |
| Chronic facilities | Ngomahuru Hospital | Masvingo |
| Halfway homes, rehabilition centers, and day care facilities | Ingutshenti Central Hospital | Bulawayo |
| | Tariro
Beatrice
Tiravanhu
Southern
Belleview
Makhandeni
Rukariro
Ngomahuru Halfway Home
Queen of Peace
Chinhoyi Halfway Home | Harare
Beatrice
Ruwa
Harare
Bulawayo
Bulawayo
Mutare
Masvingo

Gweru
Chinhoyi |
| "Special institutions" (forensic facilities) | Chikurubi Prison
Mlondolozi Prison | Harare
Bulawayo |

General health and mental health practitioners need to work together.

General health practitioners often treat symptoms of mental illness, like hypertension and headache. However, without addressing the root cause, patients cannot escape the cycle of recurring symptoms and healthcare costs. Thus, we must:

• Train all general health practitioners in mental health

• Check for mental health in the general doctor's office

• Train general health practitioners to refer patients to mental health practitioners

We must also use these same strategies to integrate mental health services into other health services like HIV/ AIDS and community care (i.e. lay health workers screening for and treating mental health).

FORENSIC SERVICES

The Mental Health Tribunal, which decides a patient's legal rights and release date, meets infrequently.

Prisons are under-resourced:
- overcrowded
- minimal psychiatric care
- little food
- poor living conditions

CURRENT SITUATION

Patients are stuck in under-resourced facilities for **years** past the official 21 day review period.

"Some of them may not have committed any serious crime. They are there because their families cannot accommodate the 'nuisance' and they would rather have them in that institution."
—*Study Participant*

"You would find somebody sitting in prison for 10 years and they are still waiting for that [initial] mental health assessment."
—*Study Participant*

DUE TO LACK OF CHRONIC CARE FACILITIES AND COMMUNITY BASED PROGRAMS...

Patients do not stay in care long enough.

Mental disorder is not effectively treated, and patients are charged with minor crimes (e.g. petty theft).

Police who are unaware of the Mental Health Act are tasked with bringing in patients to Mlondolozi or Chikurubi, "special psychiatric institutions."

FINANCING

Budget proposals go through many checkpoints before the Ministry of Finance allocates funds for mental health.

Public Mental Health Facilities → Provincial Medical Director (PMD) → Department of Mental Health Services → Permanent Secretary and Minister of Health → Ministry of Finance

1. Funding is inequitable.

2. Economic downturn created resource constraints throughout the system, but especially mental health.

3. Funding priorities are rehabilitation services, drug supplies, and salaries for healthcare workers.

"All the other disciplines have a fixed line budget whereas mental health is, it doesn't actually have a budget because when you do sort of going to the details of things you find that you get bits and pieces from here and there. It doesn't amount to more than 1% it's usually less than 1% that goes directly to mental health and often it's going towards institutions. It's not going to the community."
—*Study Participant*

Funding for mental health in Zimbabwe is disproportionately low, compared to other diseases and disorders.

Yet...

✤ More healthy life years are lost to mental disorders than either cancer or heart disease.

✤ Depression is one of the leading causes of morbidity and disability in Zimbabwe, especially among women and other vulnerable populations (Pitorak et al., 2012).

✤ HIV infection, economic woes, unemployment, and and other stressors exacerbate mental illness. In turn, mental illness decreases productivity and adherence to HIV medication and causes premature unemployment (Pitorak et al., 2012).

✤ HIV has an immunological effect on the brain that heightens risk of mental illness. (HIV-positive persons are more likely to experience depression than HIV-negative counterparts.) (Kaaya et al., 2013)

✤ Approximately half of HIV-positive persons are mentally ill (Pitorak et al., 2012).

WORKFORCE

- There are only 5 clinical psychologists in the public sector

- There are only 2 psychiatrists outside of Harare

- 15 of 150 trained occupational therapists actually practice mental health in Zimbabwe

Vast majority of the country is without specialist care.

Some recent graduates in mental health psychiatry, nursing, and occupational therapy emigrate to other countries, such as South Africa, *even though they went through schooling or trained in mental health,* for three main reasons:

✦ Poor compensation

- PEPFAR, USAID, MOHCC, and international funders support much larger salaries in HIV/AIDS and TB.
- Some rehabilitation home staff volunteer and pay their own food and transportation expenses.

✦ Work-related stigma

Mental health stigma makes psychiatry one of the least popular specialties among Zimbabwean medical school graduates.

✦ Hiring freeze

In 2013, a universal hiring freeze affected mental health workers. Empty positions have not been filled since then.

Zimbabwe needs to prioritize the recruitment and retention of mental health workers. Because most mental health patients do not need specialist care, we must also build up the non-specialist, non-professional workforce, with a focus on lay health workers and supervisory support structures.

"... when we qualify as psychiatrist we all open up our private rooms, we want to make money, we want to survive and that's normal, isn't it. And often we forget about that aspect of service [that] really promotes a discipline or speciality and that's what promoted ophthalmology. It's the service because they are going out in the community, they are going out in the rural areas and they are doing all these cataract operations for free." —Study Participant

	Registered number	Approximate number in workforce
Psychiatrists	19	14
Clinical Psychologists	25	N/A
Mental Health Nurses	463	N/A
Occupational Therapists	150	15

BELIEFS ABOUT MENTAL DISORDERS

"They believe this person who is mentally sick, if I take this person into my house, what he has will come for me. That's why you find that many of our patients here are shunned. Once they suffer mental illness no one wants to take responsibility because they feel like probably the spirits are, or something, so if I take responsibility that same thing will come to me as well. So, once it's like that people don't want to be responsible. That's one major problem that we have in terms psycho-social support. Some just come and dump their relatives and disappear. They give wrong phone numbers and wrong addresses and they disappear for good because they don't want to have anything with this person anymore."

—Participant 1

Currently, traditional healers, faith healers, and mental health professionals rarely cooperate, **even though they treat patients with similar symptoms**.

Many participants called for **greater coordination between healers and mental health professionals**. This involves:

✦ Referrals between traditional healers, community care, and mental health clinics on a constant basis with follow-up

✦ Social support from faith healers and traditional healers, who can prevent released mental health clinic patients from going back out into the streets and relapsing

Governing bodies of traditional healers and faith healers:

Zimbabwe African National Traditional Healer's Association (ZINATHA)

Traditional Medical Practitioners Council (TMPC) – Ministry of Health

Apostolic Faith Mission

"Many people think once someone is mentally ill, they are useless to the society which is not true. We actually have many that are on treatment and are productive in functional society. People are not aware that people that some of the people they see in town actually may be on medication for mental illness."

—Study Participant

RESEARCH

Existing Training/Research Programs:

Training/research program	Description
Mental health diploma for nurses	18 month diploma program for registered nurses to qualify as psychiatric nurses at Ingutcheni Hospital in Bulawayo
Mental health diploma for physicians	12 month diploma for physicians offered by the University of Zimbabwe College of Health Sciences Department of Psychiatry
MMed in Psychiatry	36 month master's degree for physicians to qualify as psychiatrists at the University of Zimbabwe College of Health Sciences Department of Psychiatry
IMHERZ: Improving Mental Health Education and Research in Zimbabwe (2010-2015)	A grant from NIH/PEPFAR to the University of Zimbabwe, which has helped foster a community of mental health researchers
Friendship Bench	Large community-level cluster randomized, controlled trial examining task-shifting at 50 sites throughout the country
African Mental Health Research Initiative: AMARI	Research, leadership, and advocacy training program for selected master, PhD, and post-doctoral mental health research fellows from Ethiopia, Malawi, South Africa, and Zimbabwe
PERFECT: Promoting Excellence in Research and Faculty Enhanced Career Training (2015-2020)	Research training for junior faculty in HIV/AIDS, women's health, mental health, cardiovascular diseases/stroke, respiratory, haematology, and dental/craniofacial disorders
TENDAI study	A pilot trial in Harare to assess an integrated intervention to treat depression and improve adherence to antiretroviral therapy

Priorities for future research:

✦ Economic burden

✦ Forensic system

✦ Substance use prevalence and treatment

✦ Prevalence, screening, and treatment of child and adolescent disorders

✦ Health systems research

✦ Strategies for taking existing interventions to scale

✦ Indigenous solutions to mental health

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