Foreign Report

Psychiatry in Zambia

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That a hospital in an African country has just celebrated 25 years of its existence may not seem a particularly newsworthy event but I hope that the story I have to tell will prove to be interesting and maybe even instructive for many more colleagues than those having a special interest in Africa. My own qualification for recounting the story is that I have worked at Chainama Hills Hospital since September 1964, just 15 months after it was opened.

But the account begins some 50 years ago. The year 1935 was significant for the then British territory of Northern Rhodesia (population: about 1.5 million, size: about four times the area of England) for its capital was transferred to Lusaka. In the medical field, a new Director of Medical Services took over, with these words of advice from his predecessor, "... and about African work Haslam, leave it to the missions; they have, and the government does not, a missionary spirit." There was no doubt of neglect of the mentally ill and in this same year, Sir Stewart Gore-Brown, a prominent member of the Legislative Council, was moved to say, "I wonder if Honourable Members realise—certainly the country does not—that we still, in this enlightened country, adopt the mediaeval practice of putting lunatics in prison and, when necessary, chaining them up." There was, however no immediate reaction and Dr Haslam, in surveying the state of the medical services 10 years later, had this to say about the need for a mental hospital, "... There is none in the country and despite acceleration of arrangements for transfer from our hospitals or prisons to Southern Rhodesia mental hospital near Bulawayo, it is still far too common to find the insane confined in gaols or making a nuisance of themselves in general hospitals. There is almost certainly in the villages a considerable number of mental patients who are by no means always well treated by their fellows, but whom the District Officer hesitates to submit to the ordeal of certification, confinement in a gaol and subsequent transfer hundreds of miles by train under an escort and across an inter-territorial border to an asylum where few if any of the staff or inmates can speak their language. I have made provisions for a mental hospital in my plans." He had also made provision for a number of specialists to be appointed, amongst them one psychiatrist.

At this time, much of the basic medical care was in the hands of 'medical assistants'. The first Zambian medical workers to be given any training at all were called 'itinerant medical orderlies' and they were wending their barefoot ways long before the Chinese variety. In 1936 a 'Native Medical Training School' was opened and during the next few years young men who had completed full primary education (and you had to be good, in more than one sense, to be able to get that far) were given a four-year course as medical assistants. Many more trainees were thrown off the course than qualified and in Annual Reports a constantly recurring theme was the 'intellectual conceit' of the trainees. With very few doctors and no nurse training (and very few expatriate nurses) these men shouldered the main burden of providing health care.

The building of an asylum was still said to be under active consideration in 1947 but in the meantime a 'mental annexe' was being built at Ndola General Hospital, about 200 miles north of Lusaka. It was over a year before it came in operation (admitting 17 male and three female Africans and two male and three female Europeans in 1949) and was thought to be such a useful place that another 'annexe' was built soon after in Livingstone, 300 miles south of Lusaka.

In 1947 a committee had been set up to examine the operation of the law on mental illness (the Lunacy Ordinance of 1927) and it also strongly advocated the building of an asylum. The committee felt that, "... in African rural and urban communities it is in the real interest of the communities and patients to keep the latter away for a long time". These ideas were not taken up however and it was to be another 15 years before a hospital was finally built.

After the establishment of the Federation of Rhodesia and Nyasaland in 1953 health became a federal responsibility and in 1954 a mental hospital of 285 beds was built at Zomba in Malawi. When a commission was looking at the health services five years later its operation (and that of a linked general hospital psychiatric unit in nearby Blantyre) was compared very favourably with the conditions at Ingutsheni Mental Hospital, Bulawayo, to which patients were still being sent from Zambia. Here, on the day the Commission members visited, they found 1,391 patients in accommodation designed for 690. Although whites were relatively well housed there was even more overcrowding of African patients than is suggested by the figures. Beds were provided only for the physically sick and many of the chronically ill and all criminal patients (there was a 'Broadmoor Ward') were permanently confined within the

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ward-building. The exact figures are not available but it seems that approximately 350 of the 1,400 patients at Ingutsheni came from Zambia.

In 1959 the Federal Ministry of Health reported that mental observation centres (still usually called 'annexes') had been attached to more general and district hospitals. Apart from the one at Livingstone they were all prison-like with high barred windows and heavy doors giving access to rows of small cell-like rooms. By this time a similar annexe had been built at Lusaka hospital and, surrounded by barbed wire, it was known simply by that name—the 'Wire'. There was still no psychiatrist and there were just four expatriate registered mental nurses in the whole of Zambia—population now about 2.5 million. Although it was announced that the mental hospital would be built in 1960, the attitude of the health authorities to the mentally ill can be gleaned from these quotations from the 1960 Ministry Annual Report:

"Lunatics have rained about our ears from all sides, some of them for the second time (or more) in a year. It is felt that the present system of certification, adjudication and transfer to Bulawayo is very cumbersome and the long wait between adjudication and receipt of a warrant of removal is very tedious to all concerned. Many of the patients are returned to their village for supervision by the headman. They are the ones who have really no mental disease and are eccentrics with a 'government must help me' complex. A large boot directed to the appropriate part of the anatomy would be very helpful for some of these and save a lot of time and trouble, however politically undesirable."

"At Fort Roseberry (now Mansa) there was again an increase in the daily average number of patients.... What however contributed far more to our difficulty than the increase in patients, was the consequent increase in relatives... The nuisance and frustrations these people cause must be experienced to be believed...."

Initially only three wards were built at Chainama Hills Hospital and being modelled on the ones at Ingutsheni they were prison-like. They might have been worse, however, for in the original design it was intended that the dormitories should have sloping floors with a trough down the middle for easier cleaning. All the windows were covered with a heavy metal mesh thus heightening the prison-like atmosphere but only one room in each word-block was equipped as a 'seclusion room' with barred windows and a heavy iron door (the original intention had been to have seven or eight such rooms in each admission ward). The wards were, of course, 'closed'. It was thought that this one small hospital of 260 beds would be able to serve the whole country and that one psychiatrist (without any other medical assistance) would be able to cope with all the work involved. Since there was still no nurse training in the country two missionary nursing orders were invited to provide the nursing services.

It was some months before a psychiatrist could be found and he could manage only the in-patient work. Perhaps because of a high level of cerebral syphilis he did a routine lumbar puncture on all admissions and the ECT sessions must have been long and arduous; treatments were given without muscle relaxant or anaesthetic and the usual course was of 10, 12 or more applications, the end-point for stopping treatment being the patient's 'confusion'. But the number of admissions was initially very small since there was hardly room; all the Zambian patients who had been confined in Bulawayo were returned to Zambia once the new hospital was opened and many had been away for so long and with inadequate documentation that it proved very difficult to trace relatives.

The hospital's first psychiatrist left after just nine months and I joined the staff at this time, together with a colleague from South Africa. One of our first tasks was to begin touring the country on a regular basis. The old Dakota ("the safest aircraft in the world") was in service then and we were often flying three weeks out of four. But besides being reliable the Dakota was noisy and slow and unable to climb over thunder-clouds and without the range to fly round them; all too often in the rainy season it had to prove its safety. And so after a 12 hour visit to some centre the return journey could be tedious, to say the least.

After arriving at a provincial airfield we would visit the hospital and prison and perhaps go off by Land Rover or boat to visit some less accessible unit. And the result was seen in an increase in the prison population of 'lunatics'. It seemed that as people heard that something was being done for the mentally ill they brought them to the annexes which (at that time) could only overflow into the prisons; the prison admission rate went up from about 300 per year in 1964 to over 1,000 in 1967. It was obvious that we needed to train staff and open mental health units in as many hospitals as possible. We could not train nurses, for there was no nurse training in Zambia at that time, and so we chose to develop a psychiatric version of the medical assistant, whose training and work I have described above. They were just right for the job of course for they were prepared to work more or less without supervision, expected to be working in far distant rural localities and had a strong community orientation—of which more later.

There were calls to build a second mental hospital in Zambia's main conurbation—the copper mining area, and we resisted these. Chainama had to be extended because we needed more room (we had not yet found relatives of all those returned from Ingutsheni) because we needed open wards and because we needed a special forensic section. The main hospital now had 380 beds and the forensic section 120. But Chainama's function was already changing for besides training medical assistants we soon had medical students (our first doctors graduated in 1973) and with them (at last) nurses, social work students and others. But even before medical students arrived we had started a weekly case conference, which has gone from strength to strength, setting the pace for thoroughness in investigation, presentation and discussion. In these days we have an attendance of more than 80 students and staff but the hospital itself is half empty.

With the training of enrolled psychiatric nurses as well as medical assistants (now more properly called Clinical Officers) and with the introduction of psychiatry and

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mental health into the curricula of most health workers, we were ready for the advance which led to the emptying of our wards. We saw all health workers as being involved in health care, including, for example, the 'health assistants'—mosquito sprayers who, being workers who regularly go into peoples' houses and discuss health matters, have excellent opportunities for finding those who are usually kept hidden when strangers are in the village. And we began to make our clinical officers more mobile by giving some of them bicycles so that they could back up and support the work of their general colleagues. All this began *before* Alma Ata—the usually quoted beginning of the modern revolution in primary health care. In fact our initiative fitted very easily into Zambia's own plan and the mental health service is now fully integrated. For instance instead of relying only upon mosquito sprayers there are now the (unpaid) community health workers who, of course, receive part of their training from our professional mental health staff members. What has happened in Lusaka, which has increased fourfold in size since 1960, while the hospital itself is only half full, has been seen also all over Zambia as we have established our community-oriented service. Our workers (we have trained over 400 clinical officers) now operate from many hospitals and health centres, working closely with their general-worker colleagues, not only looking after the mentally ill but visiting homes with nutrition workers, giving talks in schools and increasingly taking their work into the communities they serve.

The changes have been reflected at Chainama in another way however. In deciding upon priorities in mental health care, country-wide we saw that back-up resources would be needed for the grass-roots workers, including general medical workers and leading community members. And so we established our National Mental Health Resource Centre at the hospital with a professional staff of six who collect statistics, organise workshops and courses, produce a newsletter and other materials and run the Lusaka community mental health service. Our 'cultural dance troupe' is also located at the centre (we really ought to write a formal paper soon on the ways in which our patients benefit from drumming)—and I have an office there too, as well as in the School of Medicine.

However we face one major problem in running our service: there is hardly any money available. During the early days we could travel whenever we wished, could find funds for putting up buildings and there was no shortage of drugs. Now we can travel only occasionally and we are at present pleading for just one Land Rover in order to cover the country. We hope a 'mental health' vehicle will be included in Zambia's next WHO Programme budget. Yes, we can and do move with others, but then we may wish to stay longer at some place when our colleagues are ready to move on. It is fortunate that many of the young men and women we have trained are reasonably self-sufficient. But I must admit that we are a little jealous of neighbouring countries which have developed their mental health work more recently and have far greater physical resources than we ever had. Knowing the quality of their staff they will probably be able to cope with adversity just as well as our own, should economic disaster ever strike.

The most recent event in the life of the hospital (and potentially a future heavy burden) is the advent of the acquired immune deficiency syndrome. We are already regularly admitting patients with AIDS or ARC (AIDS-related complex) and I am running a teaching clinic for the training of counsellors at the University Teaching Hospital; at this clinic alone we enrol five to eight new patients per week. At a recent weekly academic (post-graduate) meeting at Chainama we took a long and careful look at the various serological tests currently being used and we are awaiting more materials (which might be adapted for use in Zambia) for early detection of dementia; I will soon have to be working with my colleagues and the Resource Centre staff on yet another special programme for our clinical officers.

And what of the future? The effects of HIV infection are likely to be with us for a long time. The age structure of the population is changing and we will have to be planning for the care of the elderly while we continue to face a massive increase in population and consequent demand for services; Zambia's population now stands at over 7.5 million. And so we will need to go on adjusting the functions of the hospital to meet new needs. But we can be certain that service and teaching functions will continue and that it is very likely that Chainama will have at least another 25 years of life.

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