HUMAN RIGHTS BASED MONITORING OF MENTAL HEALTH SITUATION IN MALAWI

ACKNOWLEDGEMENT

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ACRONYMS

CRPD	:	Convention on the Rights of Persons with Disabilities
CSOs	:	Civil Society Organizations
EU	:	European Union
GBV	:	Gender Based Violence
HRBA	:	Human Rights Based Approach
ICCPR	:	International Covenant on Civil and Political Rights
ICESCR	:	International Covenant on Economic, Social and Cultural Rights
MEHUCA	:	Mental Health Users and Careers Association
MPS	:	Malawi Police Service
NGOs	:	Non-Governmental Organizations
WHO	:	World Health Organization
YONECO	:	Youth Net and Counselling

Executive Summary

This report provides findings of a Human Rights Based Monitoring mission into Mental Health in Malawi that the Commission conducted with financial support from the European Union (EU) Chilungamo Programme in April 2022. The goal of human rights monitoring was to understand the status of mental health issues and the existing mechanisms in place to address the situation. This was achieved through the following specific objectives:

a) To establish challenges that persons with mental health issues experience in their homes and communities.
b) To ascertain interventions put in place by the government through District Councils to fight mental health related issues.
c) To establish whether persons with mental health issues have access to social services.
d) To assess whether services provided to persons with mental health issues meet the required human rights standards.
e) To identify other services available for persons with mental health issues.

In terms of methodology, the mission used a mixed method approach where Key Informant Interviews (KIIs) were conducted with representatives of key institutions dealing with mental health issues in selected District Councils. Individual interviews were also conducted with community members to get their experiences and perceptions of mental health. The mission also recorded information from hospital and police reports especially on suicide, suicide attempts and suicidal behavior.

As one way of building the capacity of communities and stakeholders, sensitization awareness-raising campaigns on human rights and mental health issues were also conducted.

The Commission engaged duty bearers from such offices as the District Hospitals, Malawi Police Services, District Social Welfare Offices, District Labour Offices, Zomba Mental Hospital, private mental health institutions, NGOs, and CSOs dealing in mental health matters such as Mental Health Users and Careers Association (MEHUCA), YONECO, Americare, Salvation Army, International Office of Migration, Global AIDS Alliance, Medicines San Frontier, and Baylor just to mention a few.

In terms of findings, the Commission established the following:

a) There is a shortage of critical anti-psychotic drugs in most hospitals leading to condition re-lapses;

b) Lack of properly designed mental health interventions at the primary level;

c) Closure of the Bwaila psychiatric ward has greatly impacted mental health service delivery and overwhelmed referral systems;

d) Malawi has for a long time been using outdated legislation – the Mental Health Act of 1948;

e) Gaps noted in the Penal Code on the criminalization of sex with Persons with Intellectual Disabilities;

f) Poor Monitoring and Evaluation (M&E) framework on Mental Health Programming and Policy implementation;

g) Lack of prioritization of Mental Health Issues in District Development Plans leading to uncoordinated programming of mental health interventions;

h) Almost all districts visited registered low staffing levels to facilitate the provisioning of timely and strategic mental health services;

i) Lack of or little knowledge on mental health matters by key mental health stakeholders, some personnel in the sector and community members; and

j) Suicide cases continue to rise by over 50% between 2019 and 2021due to increased emergencies, pandemics, and changes in life style.

The report makes a number of strategic immediate and long-term commendations to Government and more specifically to Ministry of Health, Ministry of Local Government (District Commissioner, Director of Planning and District Health Services Officers), Department of Civic Educations and Malawi Human Rights Commission and other stakeholders for an effective and efficient mental health system.

1.0 Background

The World Health Organisation (WHO) defines mental health as a "state of well-being in which every individual realises his or her own potential, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to her or his community." This definition implies that mental health is reliant on the wide array of support and resources that facilitate individual engagement at the highest level of gainful employment and in other community roles. These factors include among others, health, the availability of adequate housing, just and favourable conditions for work, and freedom from discrimination, all of which are enshrined in international human rights laws. There are thus significant connections between mental health and human rights.

Mental Health is one of the public health areas that is mostly neglected. 13% of the world's population is affected by mental health and substance use disorders. This number could increase as people around the world adjust to a new normal amid the corona virus pandemic. Globally, one person dies every 40 seconds by suicide and Malawi is no exception. Recently there has been an alarming increase in suicide cases, with the majority of them being men. Economic recession has increased suicide rates because of the stress and hardship that COVID-19 has created. Other factors contributing to these mental health disorders are social stigma, isolation, chronic disease, disability and human rights abuse among others.

Every year on 10th October, the world commemorates the World Mental Health Day. The overall objective of this day is to raise awareness of mental health issues around the world and mobilize efforts in support of mental health. The day was first observed on October 10, 1992 as an annual activity of the World Federation for Mental Health with the aim of promoting health advocacy and educating the public on relevant issues. Malawi joined the rest of the world on 10th October, 2021 in observance of Mental Health Day under the theme; 'Mental Health in an unequal World'.

It is important to note that mental health, just like any other public health issue, is a human rights concern as enshrined under Chapter IV of the

World Health Organization, Mental Health: a state of well-being. (August 2014). Available at: http//http//www.who.int/features.factfiles/mental_health/en/

Constitution of the Republic of Malawi (the Constitution) specifically bordering on the right to life, human dignity and non-discrimination of the general population. Again, section 13 of the Constitution provides for principles of national policies which includes the provision of enough health care, commensurate with the health care needs of Malawian society and international standards of health care. Unfortunately, Malawi has not adequately invested in mental health, as such, it is difficult to provide psychosocial support services.

Due to the shocking rise of suicide cases in Malawi, the Commission took proactive action by conducting an investigation and monitoring exercise with a focus on mental health issues in selected districts of Malawi where suicide cases have been recorded.

2.0 Human Rights Based Approach to Mental Health

Mental health, human rights and legislation are inextricably linked. Everyone has the right to the highest attainable standard of health (herein "right to health"), which includes both physical and mental health. Countries have corresponding obligations to respect, protect and fulfil this right and its social determinants for all, without discrimination of any kind. Yet, in most parts of the world, access to quality care and support is scarce. Many people with mental health conditions and psychological disabilities, in particular, face wide ranging human rights violations and discrimination, including in mental health care settings. Often, discrimination practices are underpinned by legal frameworks, which fail to uphold human rights and to acknowledge the pernicious effects of institutionalisation, the over-emphasis on biomedical approaches and treatment options, and the use of involuntary psychiatric interventions.

The history and current incidences of human rights violations in mental health care across national has been variously described as a "global emergency" and an "unresolved global crisis", evidenced by reports of physical and sexual abuse; discrimination and stigma; arbitrary detention; inability to access health care' vocation and residential resources; and denial of self-determination in financial and marital matters, among other rights deprivations.

Mental illness affects nearly one in three individuals globally during their lifetime and nearly one in five in the past 12 months. Mental and substance abuse disorders were leading causes of disability and were responsible for 8.6 million years lost to premature deaths worldwide in 2010.

In recent years, the number of countries that have adopted or are considering adopting legislation on mental health has increased rapidly. This is the result of multiple factors, including the increasing awareness of the importance of mental health to achieve sustainable development, the expansion of universal health coverage, the substantial impact on mental health of humanitarian crises and emergencies such as Covid-19 pandemic, and the enhanced attention to human rights challenges in mental health care. Most of these reforms have been passed through stand-alone mental health laws, which have been viewed as a progressive feature to advance universal health coverage and service provision. However, the primary function of these laws is still to authorise and regulate coercive practices.

The Convention on the Rights of Persons with Disabilities (CRPD) (2006) calls for a significant paradigm shift within the mental health field. The CRPD reinforces existing international human rights law protections, such as those provided by the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Right (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). It further reaffirms all persons with disabilities, including persons with psychosocial disabilities as right holders and equal participants in society. The CRPD fundamentally challenges long-standing practices in mental health systems, such as the denial of legal capacity and the use of coercive practices, and provides instead for a "supportive paradigm" that underscores the duty and crucial importance of rethink the objective and role of legislation on mental health to promote personhood, autonomy, full participation and community inclusion.

The relationship between mental health and human rights has at least three areas. First, human rights violations such as torture and displacement negatively affect mental health. Second, mental health practices, programmes and laws such as coercive treatment practices, can impact human rights. Finally, the advancement of human rights benefits mental health synergistically. These benefits extend beyond mental health to the

close connection between physical and mental health. There are thus clinical and economic reasons, as well as moral and legal obligations, to advance human rights in mental health care.

A human rights-rights based approach (HRBA) to mental health care therefore capitalizes on these interconnections. An HRB approach is "a conceptual framework that is normative based on international rights standards and operationally directed to promote and protect human rights." This provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes. In pursuing HRBA, health policy, strategies and programmes should be designed explicitly to improve the enjoyment of all to the right to health, with a focus on the furthest behind first. In the context of mental health care, an HRBA means placing emphasis not only on avoiding human rights violations but making sure human rights principles are at the centre of a service-providing organisation.

National Legal and Policy Framework on Mental Health

Malawi has legal and policy frameworks on mental health. Mental health disorder is recognized as a disability in Malawi and therefore falls under the legal framework of the Disability Act (No. 8 of 2012).

However, the treatment of patients with mental disorders is primarily governed by the Mental Treatment Act (Cap 34:02 of the Laws of Malawi) (1948). The Act provides for the protection of persons with mental disorders. Section 17 of the Act provides that an Officer in Charge, administrative officer or Chief may take into his safe-keeping any person whom he has reason to believe to be suffering from mental disorder or mental defect and who is found, within the limits of his jurisdiction, wandering at large. Where the officers mentioned above have reason to believe that any person within the limits of his jurisdiction is suffering from mental disorder or mental defect and is not under care and control, or is being having the charge of him, shall immediately report the fact to the nearest magistrate who may order such person to be brought before him.

With regard to certification of a person's soundness of mind, section 20 of the Mental Treatment Act, provides that Where any person is brought before a magistrate under section 17 or section 19, the magistrate may, by order

3 WHO/OHCHR – Draft Guidance on Mental Health, Huan Rights, and Legislation 2022

in writing, authorize the detention of such person in a mental hospital, or in any place which the magistrate deems suitable for the purpose, for such time not exceeding thirty days as may, in his opinion, be necessary to enable a medical practitioner to determine whether or not such person is a person in respect of whom a medical certificate of unsound mind may properly be given. However, no person shall be detained in any police station or prison if any other suitable accommodation is available.

Malawi has also a National Mental Health Policy which was developed in 2000 and has no impact at all on mental health service delivery. The policy has been going through a revision since 2014 and remains in draft form to date.

On the other hand, the Penal Code recognizes mental health in the form suicide. Section 228 of the Penal Code prohibits aiding another to commit suicide by killing himself or procuring or counselling another to kill himself and thereby induces him to do so. Such a person will be liable to imprisonment for life. Further, section 229 of the Penal Code provides against attempted suicide.

3.0 Objectives and methodology of the monitoring mission

3.1 Overall objective

The overall objective of human rights monitoring and the investigation was to understand the magnitude of mental health issues and mechanisms that have been put in place to deal with the situation. This was achieved through the following specific objectives:

a) To establish challenges that a person with mental health issues experiences in their homes and communities.
b) To ascertain interventions put in place by the government through District Councils to fight mental health-related issues.
c) To establish if persons with mental health issues have access to social services
d) To assess if services provided to persons with mental health issues meet the required human rights standards.
e) To identify services available for persons with mental health issues.

3.2 Methodology

The monitoring and investigation mission took a multifaceted approached as follows:

a) Monitored the human rights situation through administration of interviews (key informant interviews and Focus Group Discussions) focussing on key institutions that handle mental health cases vis-a-via National Referral Hospital, District Hospitals, Malawi Police Services, District Social Welfare Offices, District Labour Offices, Private mental health institutions, NGOs and CSOs dealing in mental health matters such as Mental Health Users and Careers Association (MEHUCA), YONECO, Americare, Salvation Army, International Office of Migration, Global AIDS Alliance, Medicines San Frontier and Baylor just to mention a few.

b) Sensitized communities on issues of mental health and the importance of respecting rights of those with mental health challenges.

The scope of the monitoring and investigation mission, as reported above covered key institutions that deal with issues of mental health in districts that recorded rising cases of mental breakdown, suicide and number of individual loitering around the streets. In this regard, the following districts were sampled for this specific mission:

Northern Region	Southern Region	Central Region	Eastern Region
Karonga	Blantyre	Lilongwe	Ntcheu
Rumphi	Chiradzulu	Mchinji	Balaka
Nkhatabay	Phalombe	Salima	Machinga
Mzuzu City	Mulanje	Nkhatakota	Mangochi
Mzimba	Mwanza	Kasungu	Zomba

The Commission conducted 42 random interviews with community members to understand their perceptions and experiences concerning mental health issues. In addition, the Commission conducted Key Informant Interviews (KIIs) with key institutions as follows:

20 Districts monitored, 5 in each region
20 Police Stations/Stations
20 District Hospitals plus 1 National Mental Hospital
2 Private Mental Health Care Service Institutions
20 District Social Welfare Offices
7 Mental Health-focused Non-Governmental Organizations

4.0 Limitations

Although the study was designed to cover 20 districts, resources could not permit for the data collection teams to cover all the targeted institutions and individuals. In this regard, the teams sampled what they felt could provide the most required information. In addition, those that were targeted from the rural settings (especially those who have a relation with a mental health challenge) were not very much willing to speak on the subject matter considering the sensitivity of the matter. However, despite these limitations the Commission is of the opinion that the information that was collected should provide for the needed analysis.

In addition, the Commission noted that there were no interventions on mental health run by NGOs in most districts. The Commission hence relied on information provided by the District Health and Social Services (DHSS), District Social Welfare Office (DSWO), and individuals.

5.0 Findings of the mission

5.1 The General understanding of Mental Health

The Commission assessed the knowledge and understanding of mental health among service providers. During this assessment, it transpired that service providers from the medical profession were more conversant with various aspects of mental health unlike other providers outside the mental health realm. In all the districts visited, respondents in the medical field agreed that mental health looks at an individual's well-being socially, physically, psychologically and mentally. In other words, medical professionals view mental health as the functionality of an individual towards

society (bio-social model) from the psychological, social, biological and spiritual perspectives.
The Commission also noted that the respondents' knowledge and understanding of mental health is in line with the definition as provided by the World Health Organization. The health sector documents some of the mental health issues and include Hysteria, epilepsy, depression, schizophrenia, bipolar disorders, anxiety, drug and substance abuse, suicide attempts, psychosis, post-traumatic stress disorder, for example, Covid 19 stress, mania violent, mania talkative, eating disorder, paranoia. The Social Welfare officers understood mental health in the context of post-traumatic stress disorder in relation to experience of Gender Based Violence (GBV). Sometimes survivors of GBV experience depression, nightmares, disturbed sleeping patterns, appetite loss, and eating disorders.

The non-health professionals like the Social Welfare confused mental health with mental health problems. For instance, professional medical staff defined mental health as "the health and well-being of the mind" while non-professional medical staff like DSWOs, Police and local Malawians defined mental health as "people with mental problems". This, therefore, depicts the knowledge gap that exists in the area of mental health which requires concerted efforts to address. Apart from the knowledge gap that exists, the definition by non-medical people is a glaring testimony of the negativity and stigma that surrounds issues of mental health. As such, the mental health sector is mostly associated with or perceived as psychiatric problems.

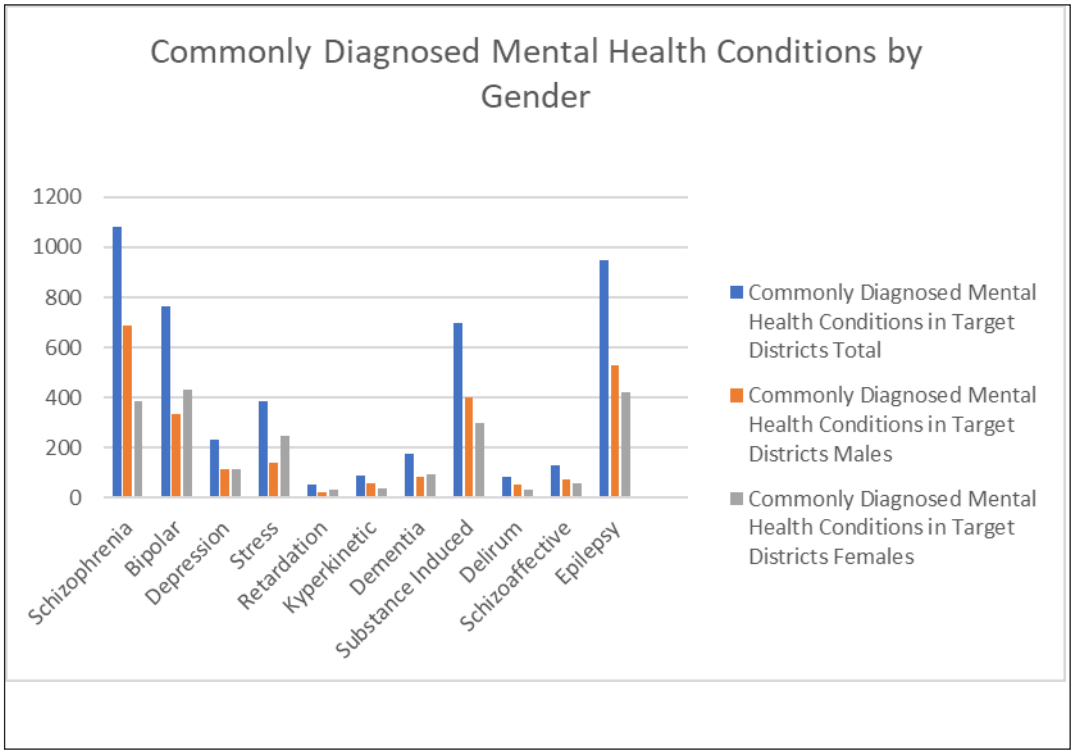
As Knowledge base from the Police was limited to the occurrence of suicide cases emanating from either long-term or short-term depression resulting from prolonged development of loneliness, helplessness and worthlessness, drug and substance abuse. Similarly, school authorities understood mental health as a good state of mind and were able to highlight some examples that include Hysteria, Stress disorder (getting sick while going closer to examinations), school fees stress especially, for children from poor families), mania due to over reading.

5.2 Most Diagnosed Mental Health Conditions in the target Districts

While most community respondents to the mission lumped all mental health cases in one group as "misala" and" wakhunyu", those from the health professional sector were able to categorize most of the diagnosed

conditions. This could be due to lack of awareness by most members of the community on how the mental health conditions manifest. The mission revealed the existence by schizophrenia, Bipolar, Depression, Retardation, hyperkinetic, Dementia, Stress, Substance induced, Delirium, Schizoaffective and epilepsy. **Graph 1 below shows** the commonly diagnosed mental health conditions by gender:

Graph 1: Commonly Diagnosed Mental Health Conditions by Gender



Graph 1 shows that the most commonly diagnosed mental health conditions in the target districts are Schizophrenia, Epilepsy, Bipolar and Substance Induced mental cases. Within the same conditions, data available suggests that the conditions are more on males than on their female counterparts except in the case of Bipolar where females are more.

5.3 Common causes of mental health challenges

The existence of mental health challenges in people are visible in the way they behave and respond to situations. There are times when mental health challenges are not visible especially those of psychological related

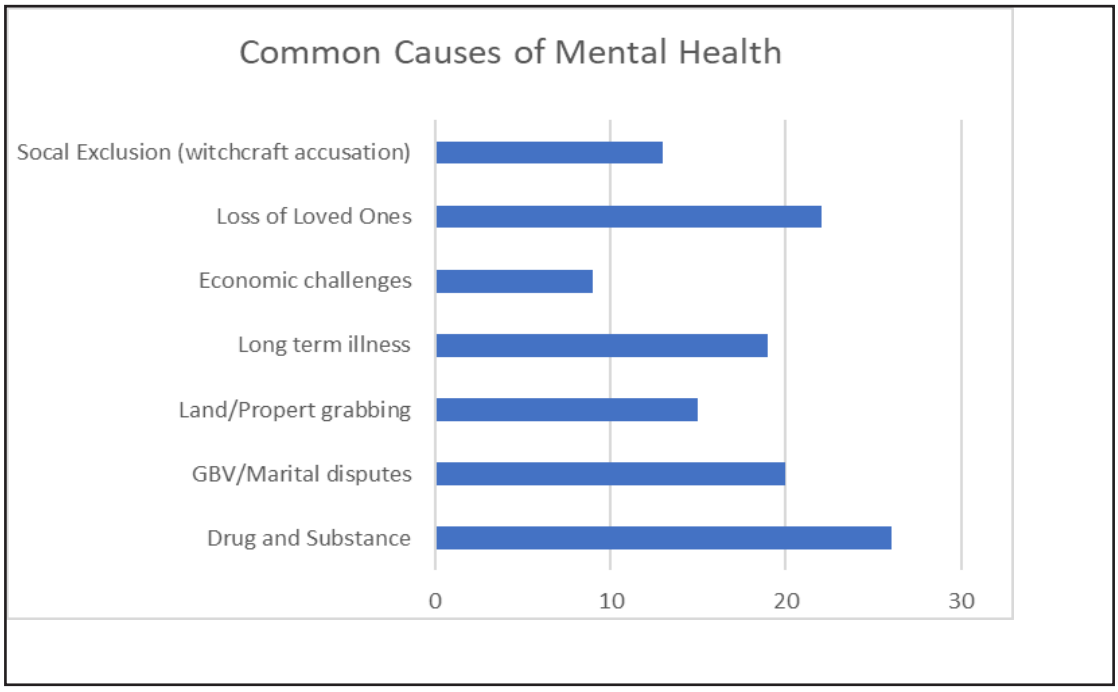
as victims try to contain themselves until such times when containment no longer holds. Psychiatric mental health problems are easily identified as victims' resort to talkativeness, abnormal silence and violence.

It is important to note that there are three common perceived causes of mental health. ***These are***

a) Biological causes: these are mostly understood as medical and inheritable traits
b) Psychological causes: this category covers such issues as worries, intense anger, stress
c) Sociocultural causes: this is understood in a number of ways such as ancestral spirit attacks, vimbuza, witchcraft and satanism.

In trying to understand this further, Graph 2 below shows what the Commission established common causes of mental health in the target districts:

Graph 2: Common Causes of Mental Health Disorders



As observed, from graph 2, most causes of mental health mentioned by respondents fall under sociocultural perceived causes with drug and substance abuse featuring the most. Loss of loved ones also featured highly may because of the time the monitoring mission took place. At this time,

societies were just healing from losses of their loved ones due to Covid-19 and the nation was just experiencing the effects of Cyclone Ana and other floods effects.

5.4 Impact of mental health problems on the welfare and development of the society

The monitoring exercise has established that mental health problems are detrimental to the welfare and development of the society. Effects of mental health are cross cutting and affects all aspects of life even among key stakeholders who provide the service. For example, persons with psychiatric mental health problems mostly become inactive or destructive to the society's development. The following are some of the registered impact of mental health issues:

a) Pressure on the health service provision caused by an increase in the economic cost burden to provide more drugs, services and facilities to support people with mental health.

b) Lack of parental support for children whose parents develop maniac conditions.

c) Disruption of socio-economic status when people withdraw for their businesses and careers.

d) Divorce and separation of families.

e) Increased cases of violence and property destruction.

f) Impedes the individual's capacity to work productively and realize their potential and make a contribution to their community.

g) Creation of orphanhood in case of deaths and lack of proper support to children ending up in pushing the to the streets and engagement in other deviant behaviour.

h) Relatives or guardians of people with mental health problems spend time providing care to their relations suffering from mental health thereby denying them time to concentrate on their productive personal and national development issues.

i) People with mental health problems such as schizophrenia are generally aggressive and therefore are a potential danger to people and property.

j) For children with mental health problems, it becomes a challenge

for them to perform well in class thereby creating social problems of poverty.

5.5 Community attitudes towards mental health issues and persons

Persons who mostly suffer from mental health challenges face social neglect, social exclusion and stigmatization by friends, relatives and members of the general community. Their social value and contribution to the community development is usually not recognized. For example, some epileptic patients are locked in a house when relatives leave homes for other engagements on the pretext of protecting them injuring themselves in the absence of any immediate helper.

The Commission, further noted that health professionals who support persons with mental disorders also face stigma and discrimination from fellow professionals and clients accessing the service. This includes name calling which was noted in Kasungu where a mental health clinical officer expressed that they experience high levels of stigma and discrimination in day-to-day life. For example, the officer stated that they are called "a dokotala a misala" (a doctor with mental illness) or "a nurse a misala" (a nurse with mental illness). At Kamuzu Central Hospital, a female clinician recalled her experiences when some of her fellow professionals could laugh at her for working in the psychiatric section of the hospital instead of the "Normal" Sections. The stigma and discrimination experienced by these service providers negatively impacted service delivery in mental health delivery cycles.

It has also been stated above that the communities in the targeted districts mostly relate mental health disorders to witchcraft or curses. In this regard, it was noted that at times, relatives of such persons only go to the hospital later after visiting witch doctors or religious intervention sometimes and by the time they visit the hospital, the mental illness has already deteriorated. In other situations, persons with mental health disorders are regarded as bewitched or a result of the wrongful execution of charms. In such times, people are taken for demon cleansing and exorcism by traditional healers.

Communities' preference for the institutionalization of persons with psychiatric mental disorders promotes social exclusion.

5.6 Awareness on the available legislation, policies and programmes on mental health

The monitoring also established huge knowledge gaps among other health service providers operating outside the health facility. All the health professionals interviewed cited the Mental Treatment act as the guiding legislation. However, respondents were quick to point out that Malawi is currently using an out-dated law of 1949 and there is a need for its review to make it in tandem with the current context. However, the Social Welfare Officers, the Police and the District Planning officers could not clearly cite the Mental Treatment Act. It is sufficed to argue that service providers directly working on mental health have the requisite knowledge.

On policy framework, most health service providers, demonstrated awareness of the mental health policy, but were quick to note that policy is not widely disseminated. It was however, pointed out that just like the Mental Treatment Act, the Mental Health policy needs to be reviewed to accommodate emerging mental health challenges that have also resulted from Covid-19.

For example, it is worth noting that the law forbids any mental health institution from self-determined interventions on suspected mentally ill persons or from proactively providing self-determined treatment to individuals suspected of having mental health disorders. It is also important to note that Part III provides for voluntary admission into mental health facilities as well as admission without a reception order. With this it is clear that the Mental Treatment Act focuses on the institutionalization of mental health patients while not recognizing community treatment programing. It is the over-reliance on institutionalization that exacerbates the stigmatization of persons with mental health problems.

In addition, the monitoring noted that the law over-criminalizes sex with persons with intellectual disabilities in that it fails to recognize their ability to enjoy a healthy sexual life. This way, the law completely takes away their enjoyment of the Sexual and Reproductive Health and Rights.
In terms of existing mental health programmes, the mission established that district health offices conduct various mental health clinics within

the health facilities and in the community. It was noted that while Health facilities run community outreach programmes sometimes in collaboration with the Malawi Police Service, collaboration with other key stakeholders in mental health such as, District Social Welfare Office and Private Institutions does not exist. This siloed approach to handling issues of mental health at the district level promotes duplication of efforts and lack of value for money interventions. Another prime finding in this area is that much as the Ministry of Health established mental health structures at district level, these structures do not exist at health centre level. Coupled with under staffing levels, this contributes to overburdening of the district hospitals where they have to make sure all patients who visit on a particular day are attended to.

Observations were made where mental health patients are prescribed a particular drug and hospitals run short of that drug. This has forced mental drug administrators to change the prescriptions but this often-caused relapses where the patients were getting better and other complications
It is also important to note that mental health issues are not taken as a priority when drawing District Development Plan and their execution. Evidence has shown that where a health problem is prioritized in development plans, efforts to address the matter brings in strategic results. This is evidenced with cases of Cholera, Covid-19 and emergency issues such as floods.

5.7 Existence of Structures and institutions for handling mental health issues

The monitoring mission also established that despite having a law that provides for management of mental health provision, the situation does not meet the required standards as stipulated by WHO. The country is operated with one state owned mental hospital in Zomba after the closure of Bwaila Mental Unit in 2017. St John of God House of Hospitality stands as the only fully operational private mental hospital. The mental health facilities, in the districts usually provide service for out-patients where admissions are not entertained unless on special occasions. In situations, that require admissions, persons with mental challenges are mixed with other patients in the normal ward and this was reported at Mchinji District Hospital, Kamuzu Central Hospital, Nkhotakota District Hospital and Salima District Hospital.

The Commission also ascertained that most mental health sections are understaffed in most of the district hospitals. For example, at Kasungu and Karonga District Hospitals, only one staff member is assigned to the mental health clinic. However, these staff are not solely attached to mental health

Institution	Mental Health Clinician(s)	Psychiatry Nurse(s)	Assigned Other General Duties
Ntcheu District Hospital	3	2	Yes
Kasungu District Hospital	0	1	Yes
Karonga District Hospital		1	Yes
Machinga District Hospital	2	4	Yes
Mangochi District Hospital	2	1	Yes
Balaka District Hospital	0	6	Yes

Furthermore, capacitation of officers handling mental health in the districts was found to be wanting as many of them cited lack of exposure to respond to most of the psychological mental health issues that mostly do not require medication.

Government efforts in the provision of mental health is complimented by various Non-Governmental Organizations (NGOs) and that include:

a) The Salvation Army, International Office for Migration, and Theatre for a Change in Mchinji.

b) Global AIDS Interfaith Alliance in Mulanje works on mobile clinics to deal with epilepsy and other mental health problems induced by general medical conditions.

c) Save the Children International in Mwanza and Neno work on awareness on GBV and suicide issues.

d) Red Cross in Mwanza works on awareness on GBV and other mental health issues.

e) Medicines Sans Frontiers (SMF) in Chiradzulu works on HIV and AIDS induced mental health issues.

f) Baylor in Phalombe provides outreach clinics for mental health patients and epileptic people.

g) Blantyre Synod in Mwanza works on Securing Children's Rights through Education on Positive Parenting.

h) Community mental health forum in Mulanje comprising the DSWO, Police, Judiciary and the Education Department to ensure proper coordination of mental health issues.

i) Mental Health Users and Cares Association in Rumphi work on helping the reintegration of persons with mental health into their communities.

5.8 Referral Mechanisms

The mental health exercise revealed that there is a gap in referral pathways in the country on delivery of mental health services. As such, due to poor referral mechanisms in the country, mental health patients are still having difficulties to access proper treatment and medication. The police having had an order made by a magistrate, ought to refer suspects or persons suspected of having mental health issues to hospital(s) or health facilities for certification of their mental capacity. However, police officers dump suspects in police cells assuming they are mad and sometimes, due to lack of transport to take such persons to a mental hospital for certification, such persons are kept for unnecessarily long periods of time in police cells, contrary to the law.

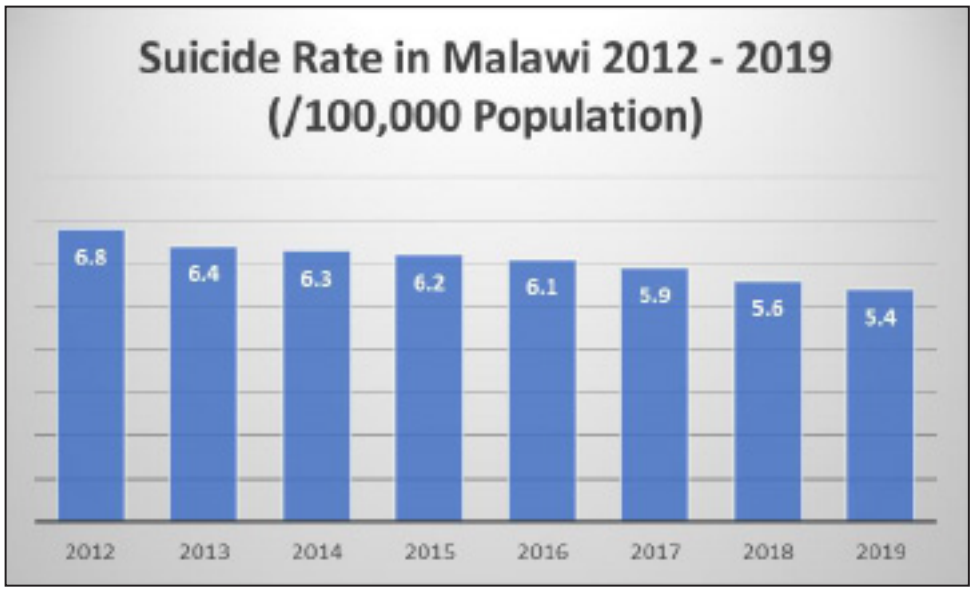
The problem of transportation is one of the contributing factors to poor mental health service delivery in the country, for instance, transport challenges, in particular, fuel and vehicles, for the hospitals to refer patients to Zomba Mental Hospital where patients spend days on end waiting to be repatriated to Zomba. Most of the times relatives are requested to contribute fuel to facilitate transportation of the patient to Zomba Mental Hospital.

However, there were complaints that in some instances, the Courts were slow in issuing Reception Orders for patients without relatives to be attached to their referral documents. Further, it was established that there js a lack of special wards for patients with mental health problems at all

districts hospitals. This results into mental health patients being mixed with patients suffering from other illnesses which is a potential risk to them as some mental health patients are aggressive, violent and hostile.

5.9 Prevalence of suicide cases in the targeted districts

It was noted through the monitoring exercise that suicide is one of the common mental problems that has been on the rise in the country in the recent years. Since 2012, Malawi has witnessed a steady decline of suicide cases from 6.80/100,000 population to 5.40/100,000 population (refer graph below). However, it is important to note that between 2019 and 2020, there has been a sharp increase in the suicide case at over fifty percent (50%).

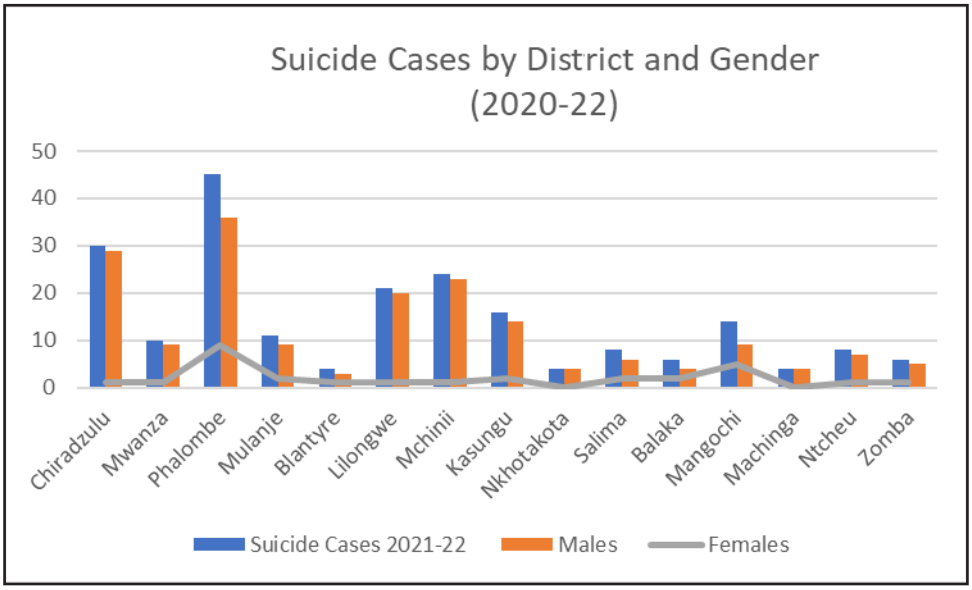


Source: http/www/theglobeeconomy.com/Malawi/Suicide

During the exercise, the Commission collected data from various police stations in the visited districts to understand the nature and extent of the problem. It is important to note from the outset that it was problematic to collect data on suicide cases due to poor record keeping in some police formations. This also is an indication of lack of prioritization on mental heal matters by Malawi Police Service.

Graph 3 below indicates incidences of suicide cases in 2020-22 in selected Districts disaggregated by Gender

Graph 3: Suicide Cases by District and Gender



The table depicts that out of the districts that were visited where data was collected, Phalombe had the highest occurrences of suicide seconded by Chiradzulu. An interesting feature in all the districts is that the occurrences are high in males than in females. The reasons suggested for this are:

a) Males as bread-winners often experience mental break down due to economic challenges and resolve to committing suicide;

b) There is an increase in Gender Based Violence and males often suffer in silence in such cases. The only solution to them becomes committing suicide;

c) Drug and alcohol abuse leading to situations where suicide is the end result; and

d) Stress and trauma due to loss of job or livelihood.

What was worth noting was the fact that even children are also victims of suicide. Through the activity, the Commission identified lack of parental care or parental neglect as the main underlying cause of suicide among children. The Commission noted that where children observe that they are not being cared for by their parents/guardians, they feel discriminated and isolated. So, for them, the only way out of their situation is suicide. Two examples worth citing are:

a) In Kasungu, a 10-year-old boy attempted to commit suicide. The boy was staying with his mother and step father who married his mother after his biological father divorced his mother. It was understood that the step father had his own biological children and he was favouring his biological children over him. The step child was therefore feeling discriminated against and isolated. As a result, he attempted to commit suicide; and,

b) In Salima, an eighteen (18) year old boy whose parents separated attempted to commit suicide simply because he was not provided with money to pay schools fees.

The Commission further noted that lack of mental health information is fueling suicide cases in the country. Through the activity it was observed that most people are generally not aware of what mental health is and what to do when confronted by mental health challenge. Service providers for example, pointed out that people who have prolonged illnesses tend to commit suicide simply because they see no sense in their existence. According to medical personnel, if mental health information including counselling is extended to such people, chances of committing suicide would be minimized.

Another cause of suicide identified during the activity was land/property grabbing. The activity established that some existing cultural customs fuel property/land grabbing. This was particularly highlighted in the central region districts which are matrilineal society. It was noted for example, that when a father dies, properties including land are grabbed by relatives of the deceased. In this case, children are left helpless and they end up committing suicide to escape the new reality of life.

5.10 Remedies for dealing with suicide cases

The Commission observed that a common remedy that is employed by stakeholders in dealing with rising cases of suicide is community engagement on this mental health issue. Particularly, the Commission observed that the police through the Community Policing Branch, conduct regular awareness meetings on various topical issues which includes suicide where among others, members of the community are advised not to take their lives if confronted by life challenging situations. The Commission particularly noted a positive approach in Nkhotakota

where two community radio stations accorded the police some airtime to talk about suicide issues. As noted above, some suicidal thoughts develop due to prolonged illnesses. As a remedy to get rid of these suicidal thoughts, the activity established that medical professionals take a step within their powers and capacity to treat the illness.

6.0 Recommendation from the Findings

The Commission makes the following immediate and long-term recommendations:

IMMEDIATE RECOMMEDATIONS	
Findings	**Recommendations**
Medical and Program Category	
a) Shortage of critical anti-psychotic drugs in most hospitals leading to re-lapses.	Government through the Ministry of Health should immediately address key challenges surrounding availability of critical anti-psychotic drugs. Such challenges include allocations of reasonable financial resources for the procurements of the drugs and straightening the supply chains to make sure that the drugs are available and accessible.
b) Poor Monitoring and Evaluation (M&E) frameworks on the Mental Health Policy implementation	Ministry of Health in collaboration with Department of Economic Planning and Development should develop a robust M&E framework for Mental Health Policy implementation
c) Lack of or little knowledge on mental health matters by key mental health stakeholders and community members	i. Government through Ministry of Health and Department of Civic Education should intensify civic education programmes on danger of skipping drugs such as ART and mental health drugs to avoid relapses and cases of suicide. ii. There is need for increased research on mental health issues. iii. There is need to increase partnerships.

	iv. There is Need for strengthened media training and awareness on mental health matters.
d) Lack of a human rights-based approach in the design of mental health care interventions	i. MHRC should guide the Government in rights-based process to develop, implement and evaluate legislation on mental health. ii. MHRC should develop a strategic awareness campaign to address stigma surrounding mental health issues and reintegration of mental health recoveries.
Policy Category	
a) Closure of Bwaila psychiatric ward has greatly impacted mental health service delivery and overwhelmed referral systems.	i. Government through the Ministry of Health should immediately facilitate addressing the challenges that led to the closure of Bwaila Psychiatric Ward in order to relieve mental health delivery pressure on Zomba Mental Hospital which is critically overwhelmed. ii. Government should review or enter into strategic service agreement with St John of God Mental Hospital Services as one way of addressing mental health service delivery challenges.
b) Lack of prioritization of Mental Health Issues in District Development Plans leading to uncoordinated programming of mental health interventions.	i. Ministry of Local Government through District Commissioners, Directors of Planning and District Health Services should make mental health a priority ii. Health Centres should be financially empowered to provide early health disorder detection, intervention and community-based support.

	Empower Health Centres to provide early health disorder detection, intervention and community-based support. iii. Empower other players (NGOs and CSOs) to collaborate with government in service delivery.
c) Almost all districts registered low levels of staffing to facilitate provision of timely and strategic mental health services. There is lack of career growth and low staff motivation as a result of the same.	i. Government should train and recruit more psychiatry specialised clinicians and nurses to address the gap that currently exists ii. The few clinicians and nurses available and working in the mental health clinics or sections should be exempted from performing general duties to allow them to dedicate their time to psychiatry nursing. iii. Government should strategically provide for career growth while maintaining the recommended staffing levels in all psychiatric departments. iv. Government should address the capacity gaps that exist among technicians in diagnosing and identifying early mental health signs.
Legislation Category	
a) Outdated legislation – Mental Treatment Act of 1948 and the Penal Code are yet to be reviewed.	i. Ministry of Health should expedite the finalization of the review process and make sure the Mental Health Act is in line with the International Human Rights standards to make the legislation person centred, recovery-oriented and rights based. ii. There is need to review the Penal Code to decriminalise attempted suicide.

	iii. Ministry of Health should facilitate the process of bringing in the Malawi Human Rights Commission as a member of the review process to address the integration of human rights-based approaches into the review processes.
b) Gaps in the criminalization of sex with a person with intellectual disabilities	i. The current proposed amendment to the Penal Code fails to address this challenge ii. The law should be reviewed to give agency to persons with mental health issues iii. This could be achieved through research on how other jurisdictions have protected the sexual rights of persons with intellectual disabilities.
c) Suicide cases continue to rise due to increased emergencies, pandemics and change in life styles.	(i) Malawi Police Service (Victim Support Unit) should collaborate with other players to conduct awareness campaigns on mental health and suicide. (ii) There is need to support the Malawi Police Services to improve their record keeping in order to provide timely data on suicide cases and other mental health cases. (iii) Government should consider decriminalising attempted suicide as the current law gives prominence to the criminal aspect of the act at the expense of the mental health challenges the person is facing.

LONG TERM RECOMMENTATIONS	
Finding(s)	**Recommendation(s)**
a) Lack of properly designed mental health interventions at primary level	i. Government should through the Ministry of Health develop a comprehensive mental health service from primary to tertial with strategic linkages from primary through district and regional facilities to national referral centre. ii. All district hospitals should be designed to have specific wards to handle mental health cases.
b) Increased number of deaths of institutionalised mental health patients	i. Malawi Human Rights Commission should in collaboration with the Office of the Ombudsman (Hospital Ombudsman) investigate these matters ii. There is need to institute comprehensive research on deaths of institutionalised persons with mental health issues. iii. There is need to introduce a digital record keeping system to make sure all institutionalised patients are properly monitored.

7.0 Conclusion

Delivery of mental health services in the country remains low as compared to the demand for the service. The problem emanates from limited availability of mental hospitals and clinics coupled with low staff levels despite having trained professionals in psychiatry. The current training curriculum for mental health has gaps in responding to psychological mental health disorders that mostly do not require medication.

This service provision gap denies a lot of people from accessing the required mental health service. As prioritization in planning and programming remains another challenge, advocacy and awareness of this is very vital in raising the status quo of mental health in the country. Of significance, is the law on mental health which requires review to align it with international human rights standards in order to provide for the rights of persons with mental health issues. The Government and other stakeholders investing enormously in mental health services.

In addition, Government should invest enormously in mental Health services in Malawi.