

**Refugee Review Tribunal  
AUSTRALIA**

**RRT RESEARCH RESPONSE**

**Research Response Number:** ZWE34835  
**Country:** Zimbabwe  
**Date:** 7 May 2009

Keywords: Zimbabwe – Mental illness – Social attitudes – Treatment programs – Support groups – Legal provisions

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**Questions**

- 1. Is there any reference material to indicate the manner in which Zimbabwe society generally treats or considers persons with mental illness?**
- 2. Is there any evidence that persons suffering such illness are denied basic support or treatment or discriminated against under Zimbabwe law or culture?**

**RESPONSE**

- 1. Is there any reference material to indicate the manner in which Zimbabwe society generally treats or considers persons with mental illness?**

A 2007 article indicates that religious and cultural beliefs, along with a lack of knowledge about mental illnesses, have resulted in the “uninformed ridicule,” maltreatment and abuse of mentally-ill members of Zimbabwean society, who culturally, are viewed as “social outcasts.” The article indicates that “mental health problems may be attributed to witchcraft” and that some people with mental disorders are resorting to traditional treatment methods which may be unsuitable for their condition. The article also highlights a lack of access to health care facilities, particularly in rural areas.

Accessibility of mental health care, particularly in developing countries such as Zimbabwe, is also a cause for concern.

In Zimbabwe for instance, access to mental health facilities is generally centralised and not easily accessible to the majority of the people, especially those residing in rural areas.

Generally, as experts note, there is very little psychiatric care.

People's beliefs and attitudes towards mental illnesses compound this.

Because of the centralised system that is more inclined to big hospitals and institutions such as Ngomahuru in Masvingo, Ingutsheni in Bulawayo and Annex in Harare, many people perceive mental health institutions as the product of white European culture or the middle class.

This has resulted in some of these noble centres acquiring bad institutional images because of lack of knowledge by the majority of the population.

Some of the centres and their inmates are subject to uninformed ridicule by members of the society who do not know that mental health illnesses are just as good or bad as any other illnesses. Because of lack of knowledge about mental illnesses and cultural beliefs, many people seek help from institutions that offer professional advice, therapeutic and medical treatment as a last resort.

It is unfortunate that many perceptions about mental health illnesses are based on cultural and religious beliefs that have dire consequences on people's health. Religious perceptions, for instance, may cause people to view mental illnesses as matters of spiritual concern rather than genuine illnesses that can be treated using modern socio-psychological and scientific methods.

Cultural beliefs are equally damaging.

For instance, mental health problems may be attributed to witchcraft or ngozi. In such instances, both family members and communities would not seek modern remedies.

One of the most dominant "cultural" perceptions that is damaging is to view mentally-ill people as social outcasts.

This leads to the abuse of such people, as they are chucked out of homes and left to wander in streets.

The consequence is that such people are then exposed to more abuse. They may be physically assaulted by community members, raped or sexually abused resulting in them being infected with HIV.

Mrs Elizabeth Matare, the Executive Director of the Zimbabwe National Association for Mental Health, cited five common examples of how lack of knowledge about mental illnesses and their treatment lead to the abuse of mental health patients by the community, families and care givers.

-- Because of lack of knowledge and cultural beliefs, people with mental illnesses may be targets for physical violence by family members and the community in a bid to control their behaviour engendered by their mental condition.

What is significant, she said, is that people should acknowledge that these people have no insight into their condition, "They don't understand that they are sick," she said.

"Physically assaulting them in an attempt to control their conditions is tantamount to abuse," she added.

...-- Where a patient's condition is chronic, family members must ensure that s/he has a constant supply of medication.

"The family have the onus to ensure that medication is in constant supply and that it is taken regularly otherwise the patient might relapse and hospitalisation may be required again," Mrs Matare said.

Due to ignorance and beliefs, family members might not take the patient's medication seriously and this, as Mrs Matare said, is serious abuse of the patient.

-- "Because of inflation and poverty among families, the person who bears the brunt is the mental patient because it is easy for them to ignore meeting the needs of the mentally-ill person when they are overwhelmed by other problems," said Mrs Matare. The treatment of patients in such cultural environments according to mental health experts needs two types of competencies (Mudzingwa, K. 2007, 'Zimbabwe: The Mentally-Ill Not Outcasts' *AllAfrica Global Media*, source: The Herald, 1 February <http://allafrica.com/stories/200702010467.html> - Accessed 1 May 2009 - Attachment 1).

A 2002 article also highlights the cultural belief in Zimbabwe that mental illness is caused by witchcraft and evil spirits. Professor Gordon Chavunduka, president of the Zimbabwe National Traditional Healers, outlines his views on traditional treatments and preventative methods for mental illness, for example, "charging more cattle to be given to the aggrieved family in the form of compensation where somebody might have died during a fight. This should pacify the avenging spirits not to visit the house of the murderer and cause mental illnesses in that household."

The number of people suffering from mental illness in Zimbabwe has been increasing due to the tough economic and social environment.

Experts say one in every four people in Zimbabwe suffers from a mental disorder.

There is, however, a difference of opinion on what causes mental illnesses, depending on whether one looks at the problem from the cultural perspective or from a scientific perspective.

Zimbabwe National Traditional Healers president Professor Gordon Chavunduka holds strong views on the subject.

He beleives [sic] there are natural causes attributed to mental illness such as traffic accidents and other injuries but his association dealt mostly with social causes such as witchcraft and evil spirits.

"It is not proper for society to dismiss the cultural perspective on witchcraft as the other cause of mental illness," said Prof Chavunduka.

"People are not aware of the African culture because of colonialism. Our local people still have a colonial mentality blocking them."

He dismissed traditional healers who prescribe rape or forced marriage as a way of appeasing avenging spirits that might be the cause of mental illnesses.

Professor Chavunduka said his organisation did not accept such kind of treatment. He said the old system they used when issuing certificates of practice had not been tight enough to flush out quacks.

"We are working on a new system which is very tight to avoid bogus healers. We have specialists who are experts in the treatment of mental illnesses."

The old practice of sacrificing innocent girls by forcing them into marriage in a bid to appease the avenging spirits is no longer acceptable at law.

This problem can be circumvented by charging more cattle to be given to the aggrieved family in the form of compensation where somebody might have died during a fight.

This should pacify the avenging spirits not to visit the house of the murderer and cause mental illnesses in that household.

"The Government should do away with the Witchcraft Suppression Act, which uses the European perspective," Professor Chavunduka suggested.

The issue of the causes of mental illnesses is close to the heart of the Zimbabwe National Association for Mental Health.

Advocacy officer, Mr Misheck Kweshe, said women were more prone to be affected by mental illnesses than men.

"Our society expects women to look after their husbands if they are sick, while men are expected to marry another woman should the wife become a mental case.

"Society should discard cultural values which look upon women as slaves. Society should treat people suffering from mental illnesses with dignity," said Mr Kweshe. "No one can account for mental illness. It is a disease like any other from which one can successfully be rehabilitated," he added.

The association, in conjunction with stakeholders, is working on a draft national mental health policy, which will be presented to Parliament as soon as it is ready. Zimbabwe has a shortage of experts to deal with the many cases of mental illnesses that are plaguing the country as a whole (Masvikeni, A. 2002, 'Zimbabwe: Mental Illness On the Increase', *The Herald*, 23 June - Attachment 2).

The social treatment of mentally-ill people in Zimbabwe is also described in a 2000 report from the Immigration and Refugee Board of Canada (IRBC). The report suggests that mentally ill people in Southern Africa have traditionally been well tolerated by society, as the traditional view of mental illness being caused by "external phenomena" such as spirits indicates an "external locus of control," resulting in "little stigma associated with being mentally disturbed." However, the report also cites an interview with an Assistant Professor of History at Barnard College, Columbia University, who is of the view that "there is some stigma associated with mental illness in Zimbabwe, but it is dependent upon the nature of the illness."

Historically in Southern Africa, prior to the advent of Western influences, mentally ill people were well tolerated by their societies and cared for by family members. The

traditional view of all illness, including psychiatric disturbance, was that it was caused by external phenomena such as displeased ancestral spirits. As a consequence, this external locus of control meant there was little stigma associated with being mentally [sic] disturbed. Indeed, sometimes there was (and in more traditional sections of Southern African society [sic] still is) overlap between being mentally ill and being 'called' upon by ancestral spirits to become a sangoma, or traditional healer, although by no means would all traditional healers be regarded in Western terms as mentally ill.

... The following information was obtained during a 2 May 2000 telephone interview with an Assistant Professor of History at Barnard College, Columbia University. She stated that her information is based upon her knowledge as a historian, as well as her recent trips to Zimbabwe.

... In the assistant professor's opinion there is some stigma associated with mental illness in Zimbabwe, but it is dependent upon the nature of the illness. For example, she stated that persons who are born with a mental disability "may not be treated in the most enlightened way" by some communities and that these persons might be avoided. However, in her opinion, this treatment would not be any worse than that received by similar persons in the United States or Canada. Other persons in Zimbabwe with mental illnesses, such as those who wander around in strange ways, are tolerated by the community. In some cases no stigma is attached to the individual. For example, an individual with a problem may be diagnosed by a traditional healer as suffering as a result of a spirit's anger with a failing of the family. The assistant professor also stated that she is aware of instances where violent persons were chained. She concluded by stating that the potential stigma is dependent upon the type of illness as well as how it is diagnosed. However, she added that in her opinion, in many instances Zimbabwean communities attempt to co-exist with persons suffering from mental illness (Immigration and Refugee Board of Canada 2000, ZWE34298.E - *Zimbabwe: Treatment of persons suffering from mental disabilities; resources and services available to such persons*, 3 May – Attachment 3).

However, an article from *The Herald* dated 17 October 2006 indicates that discrimination against people with mental illnesses is widespread in Zimbabwe. The article also highlights a concern expressed by the director of the Zimbabwe National Association for Mental Health (ZIMNAMH), Mrs Elizabeth Matare, that the stigma surrounding mental illnesses prevents sufferers from seeking help.

The past president of the WFMH and director of the Zimbabwe National Association for Mental Health (Zimnamh), Mrs Elizabeth Matare says the main challenge facing Zimbabwe and other African countries is the lack of awareness and education targeting the public on the devastation suicides brings to relatives, loved ones and their families.

"We need to do more to raise awareness about mental health problems as well as the immense personal suffering the victims endure," she says. "There is too much focus on human rights, the HIV/Aids, gender and other issues and very little on people living with mental challenges."

The WFMH estimates that 450 million people worldwide are affected by mental, neurological or behavioural problems at any given time every year and that mental disorders are associated with more than 90 percent of all cases of suicide.

Mrs Matare says the stigma associated with mental illness and suicidal behaviour in Zimbabwe and in most African countries works against early intervention and prevention by keeping persons at risk of committing suicide from seeking life-saving help.

"We need to mobilise more resources to raise awareness on mental health issues as well as suicides which are fast becoming a big problem in Zimbabwe," she says. "The message about the importance of mental health is not filtering to the public."

She says raising awareness among the African populations about mental health issues will serve as a powerful strategy to mitigate the growing problem of suicides.

...Zimnamh vice chairperson Mr Alec Ndhlukula says discrimination against people living with mental illnesses is still rampant in the country despite efforts to raise awareness on this issue.

"People with mental health problems are not receiving better treatment, relatives are not caring for them," he says. "In both urban and rural areas, they are being despised by their own relatives, they are not being regarded as human. They are still being discriminated against."

Although there are good signs that African countries are working to formulate mental health policies to address the mental health issues, the massive loss of skilled psychiatric specialists, dwindling donor funding, lack of drugs, poor investment in health care facilities for mental patients and sidelining of mental health programmes is weakening efforts to reduce stigma and discrimination of mental health patients (Tsiko, S. 2006, 'Mental Health Care Promotion Vital', *The Herald*, 17 October - Attachment 4).

In addition, a 2007 report on people with disabilities in Zimbabwe describes discriminatory practices against physically and mentally ill people carried out by members of society, including parents of disabled people not allowing their children to choose their own marriage partners, families of disabled women denying them rehabilitation treatment, and mentally ill children not attending school as their families "considered them incapable of learning."

In the focus group discussion in Mashonaland Central, it was noted that marriage may occur between two people with disabilities as long as the disabling condition does not affect the reproductive ability of the individuals.

People with mental health problems or learning disabilities are less likely to marry or be married due to the belief that they will genetically pass on the disability to the offspring.

Giving birth to a disabled child is blamed on the woman, and can be grounds for divorce. Generally women with disabilities face the burden of being disabled single mothers to disabled children, and as such attain a low status in society. In extreme cases, when women give birth to disabled children, it is associated with evil, sin or witchcraft.

It is common practice that parents do not allow their sons or daughters with disabilities to choose their own partners, instead insisting on them getting married to someone who is judged able to take care of them as a person with a disability. This lack of choice over marriage partners can create a pressure for people with disabilities

to have premarital sex, exposing them further to HIV and AIDS. However, even when they do marry, there is a high likelihood that they may be abandoned later on. Psychologically impaired men are often feared because of the view that they cannot control their sexual drive.

In the area of mental health, Elizabeth Matare, Executive Director of the Zimbabwe National Association for Mental Health, commented:

Both men and women should be afforded the opportunity to access services without discrimination. In the area of mental health, more men are getting help than women. Families would not bring a woman for rehabilitation. If a woman suffers from a mental illness she is likely to be divorced while the man is taken care of. As such women carry a greater burden of the role of taking care of the mentally ill. Programmes need to address gender aspects related to access and provision of services.

...Although the Education Act (1987) talks of 'Education for ALL,' education has not really been for all children with disabilities. A SINTEF study conducted in 2003 (SINTEF, 2003a and 2003b) indicated that 32 per cent of people with disabilities in Zimbabwe have had no schooling (36 per cent had some primary schooling, and 32 per cent had some education beyond primary level). A third of the interviewees reported that they did not go to school because family members considered them incapable of learning. This was particularly the case for females with disabilities and those affected by mental illness and/or learning disabilities (Choruma, T. 2007 'The Forgotten Tribe: People with Disabilities in Zimbabwe', January, Chapter 2 Attachment 5).

## **2. Is there any evidence that persons suffering such illness are denied basic support or treatment or discriminated against under Zimbabwe law or culture?**

The US Department of State 2008 Human Rights report on Zimbabwe provides information on the treatment of disabled people, including evidence of societal discrimination against those who are viewed by society as "bewitched."

### **Persons with Disabilities**

The constitution and law prohibit discrimination against persons with disabilities in employment, access to public places, and the provision of services; however, the lack of resources devoted to training and education severely hampered the ability of persons with disabilities to compete for scarce jobs. The law stipulates that government buildings be accessible to persons with disabilities, but implementation has been slow. NGOs continued to lobby to include persons with albinism in the definition of "disabled" under the law. Persons with disabilities faced harsh societal discrimination. Traditional belief viewed persons with disabilities as bewitched, and children with disabilities often were hidden when visitors arrived. In September the government announced it was reviewing the Disabled Persons Act, the Mental Health Act, and the constitution to align them with the Convention on the Rights of People with Disabilities; no further action was taken by year's end.

According to the National Association of Societies for the Care of the Handicapped (NASCOH), persons with disabilities continued to be a forgotten and invisible group in society. For example, although an estimated 10 percent of citizens had disabilities,

the sector has largely been marginalized from HIV/AIDS intervention programs. Except for a short period in the 1990s, instructions on the use of condoms have never been distributed in Braille for the visually impaired, and no efforts were made to advertise condoms in sign language for the deaf. There was no HIV/AIDS information in Braille. The organization also reported that only 33 percent of children with disabilities had access to education.

Voter turnout by persons with disabilities in the March 29 election was low; only 245 of approximately 30,000 persons with disabilities in Harare voted. NASCOH reported that 48 persons with disabilities served as election observers in Harare in the March elections.

The amendments to electoral laws changed voting procedures for the disabled. On February 29, ZEC issued a notice explaining that "only the Presiding Officer and two other Electoral Officers or employees of the Commission will assist any voter who requests to be assisted." Some groups complained that this violated persons with disabilities' right to cast their votes in secret. Ahead of the June 27 run-off, there were widespread reports that ZANU-PF militias and war veterans instructed voters to claim blindness at the polling place in order to be assisted to vote for Mugabe.

In May NASCOH denounced the ongoing political violence, particularly because the violence was resulting in permanently disabling injuries. NASCOH stated that organizations providing support and rehabilitation for persons with disabilities were already overstretched and could not afford to also provide for persons who were newly disabled.

Operation Murambatsvina in 2005 severely affected persons with disabilities and, according to the UN special envoy's report on the operation, the government held approximately 50 persons with physical and mental disabilities without care at a transit camp separated from the rest of the camp population. The government broadcast a regular, prime-time program on state radio to promote awareness of the rights of persons with disabilities (US Department of State 2009, *Country Reports on Human Rights Practices for 2008: Zimbabwe*, February, Section 5 – Attachment 6).

Information from the government of Zimbabwe's Ministry of Health and Child Welfare website outlines the mission and responsibilities of the department, indicating a commitment to "the provision of quality mental health and psychiatric care services" to Zimbabwean communities, families and individuals.

The mission of the department of mental health is to ensure the provision of quality mental health and psychiatric care services thereby improving the quality of life for individuals, families and communities in Zimbabwe.

To achieve this mission the department's responsibilities are:-

- Coordinating the development of comprehensive and integrated national mental health and psychiatric care policies, strategies including budgets and their implementations.
- Periodically review the relevance and adequacy of available mental health and psychiatric care policies.

- Co-ordinating the development of Mental Health Training programme for Health workers and the general public including providing advice on long term Human Resources Development strategies.
- Provide professionals/technical leaderships, advice, support and supervision on mental health and psychiatric care areas.
- Co-ordinate the development, implementation and maintenance of national mental health and psychiatric care programmes, standards and regulations affecting the programme.
- Ensure the provision of quality mental health and psychiatry care through effective and efficient use of appropriate technology.
- Develop and maintain an integral system through which effective direction, co-ordination and control of units providing mental health psychiatric care are provided.
- Liaise [sic] with Ministry of Justice, Legal and Parliamentary Affairs in matters concerning forensic psychiatry.
- Co-ordinate the implementation of Mental Health Act.
- Advocate for high political commitment to department activities.
- Represent the Ministry of Health and Child Welfare on Mental Health issues in intersectional, inter-ministerial, inter-regional and international fora.

In addition, the website outlines Zimbabwe's Mental Health Act of 1996, National Mental Health Policy, Mental Health Regulations of 1999, and the availability of government mental health institutions:

#### • **MENTAL HEALTH ACT**

The government of Zimbabwe in its desire to provide human treatment and quality of mental health care to its people enacted the Mental Health Act 1996 No. 15. This Act consolidate and amend the law relating to the care, detention and after-care of persons who are mentally disordered or intellectually handicapped, whether for the purposes of treatment or otherwise; to provide for the establishment of various boards and the functions of such boards; to repeal the Mental Health Act, 1976; and to provide for matters incidental to or connected with the foregoing.

#### **1.2. NATIONAL MENTAL HEALTH POLICY**

The Zimbabwe National Mental Health Policy's major aim is to harmonise Mental Health activities and improve quality of care of those living with mental disorders. It provides a frame work within which mental health programmes, projects and activities are designed, implemented, monitored and evaluated using the multidisciplinary, multisectoral approaches, community involvement and participation within the context of primary health care to provide all Zimbabweans with the highest achievable mental health care services.

#### **1.3. MENTAL HEALTH REGULATION**

The above is Mental Health Regulation Statutory Instrument 62 of 1999.

The regulations are prescribed for carrying out or giving effect to the Mental Health Act.

## 2. MENTAL HEALTH PROGRAMME

The main objective of the Mental Health Programme is to reduce morbidity and mortality through promotion of mental health and prevention of mental illnesses.

### 2.1. Government Mental Health Institutions in Zimbabwe.

Nationally there are nine civilian Mental Health Institutions in Zimbabwe. These being four referral centres which are Ingutsheni Central Hospital, Harare Psychiatric Unit, Parirenyatwa Hospital Annexe and Ngomahuru Hospital. The other provinces [sic] have units like Mutoko and Marondera mental health units in Mashonaland East province, Sakubva Psychiatric Ward in Manicaland Province, Gweru Psychiatric Ward in the Midlands Province, Chinhoyi Psychiatric Unit in Mashonaland West Province.

#### • Mental Health Programme Focus areas are:-

- Promotion of mental health and prevention of mental illness
- Human Resource
- Programmes and activities strengthening
- Advocacy for Mental Health
- Human Resource Development
- Increasing Mental Health awareness
- Integration of Mental Health Services into the General Health system.
- Co-ordination, Collaboration and Co-operation (Ministry of Health and Child Welfare (undated), 'Mental Health', Ministry of Health and Child Welfare website <http://www.mohcw.gov.zw/mental%20health/mental%20health.htm> – Accessed 4 May 2009 – Attachment 7).

An article from *The Herald* in 2007 outlines the appointment of members to the Mental Health Review Tribunal, whose role is to hear appeals made by incarcerated mentally ill people, determine the release of recovered detained patients, and “take necessary steps to ensure detained mental health patients are accorded their rights.”

THE Minister of Health and Child Welfare, Dr David Parirenyatwa, yesterday announced the appointment of members of the Mental Health Review Tribunal and special boards for Chikurubi and Mlondolozzi prisons.

The National Mental Health Review Tribunal, acting on the recommendations of the special boards, will hear applications and appeals by incarcerated mental health patients, direct the release of detained patients and take necessary steps to ensure detained mental health patients are accorded their rights.

The appointments are in terms of the Mental Health Act and members will be in office for three years.

...Dr Parirenyatwa said the appointment of the boards was a major milestone, which would help decongest prisons.

"The speedy action of these boards will determine the continued incarceration of the detained patients who have recovered and are ready for release.

"Let me inform you that you will be dealing with cases of persons who need special attention hence there is need for commitment, sensitivity and dedication on your part individually as members of the boards to accomplish its tasks especially under these challenging times," Dr Parirenyatwa said.

An estimated 10 percent of Zimbabwe's population suffer from mental health problems. Dr Parirenyatwa said there were at present 237 psychiatric patients detained at various prison institutions countrywide ('Zimbabwe: Minister Appoints Mental Health Review Tribunals for Two Prisons' 2007, *AllAfrica Global Media*, source: The Herald, 14 June <http://allafrica.com/stories/200706140608.html> - Accessed 6 May 2009 – Attachment 8).

However, an article published on the IRIN website dated 5 January 2004 highlights the views of the Zimbabwe National Association for Mental Health (ZIMNAMH), stating in particular that "ZIMNAMH says Zimbabwe's Mental Health Act of 1996 has never been fully implemented, resulting in the shoddy treatment and exclusion of the mentally ill," particularly in AIDS awareness programs and support systems. In addition, it is emphasised that Zimbabwe's mental health facilities suffer from a lack of supplies and specialised health professionals.

[T]he mentally ill are usually the vulnerable ones.

Apart from abandonment by their families and neglect as a result of shrinking spending on health, they also risk sexual exploitation and the increased risk of HIV infection as AIDS awareness programmes have bypassed them.

According to the World Health Organisation, most middle- and low-income countries devote less than one percent of their health expenditure to mental health, which means that policies, legislation, community care and treatment facilities are dismally short of resources.

The public's less than sensitive attitude towards the mentally ill is a cause for concern. But Elizabeth Matare, national director of the Zimbabwe National Association for Mental Health (ZIMNAMH), believes the government can do far more to enforce the rights of those stricken with mental, neurological or behavioural problems and has shirked its responsibility.

"Mentally ill or retarded people are always left out of national budgets, disease prevention and mitigation policies. The lack of laws and the reluctance of the government in playing its part in the implementation of the national mental health policy exposes the ill or retarded to disease, deliberate neglect, and various forms of abuse, including sexual, which gives rise to the issue of HIV/AIDS," said Matatre.

"The mentally ill people of Zimbabwe are not recognised in term of social care and support systems, so there has never been a budget for them. The National AIDS Policy, which forms the guidelines for the operation of the National AIDS Council [NAC] has no provision for the mentally ill, yet they are a group that suffers from AIDS just as everybody does," she recently told a workshop in Zimbabwe's second city, Bulawayo.

According to ZIMNAMH's estimates, more than half of the country's 300,000 mentally ill are living with HIV/AIDS.

"What is alarming, however, is that despite this majority, the National AIDS Council, which has been in existence for three years, has never [accepted] ZIMNAMH's [argument] for their inclusion in the national anti-AIDS strategies. There is no AIDS education for the mentally ill, no distribution of condoms, contraceptives or other preventives, yet these people engage in sexual activities just like everybody," said Matare.

A spokesperson for NAC said the organisation was aware of the plight of the mentally ill and was still considering the use of ZIMNAMH proposals as guidelines for the formulation of a special programme in anti-AIDS campaigns.

He noted that NAC "now recognises this important segment of society we had left out. They might soon be considered in our quarterly budgets".

NAC distributes funds to local anti-AIDS campaigns through provincial committees, which supervise district committees all the way down to the ward level.

At the national level, ZIMNAMH's advocacy campaign has targeted parliamentary portfolio committees on public health, labour and social welfare. Home affairs and justice committees have also been approached in relation to the treatment of the mentally ill while in police custody and inside the country's prisons.

ZIMNAMH says Zimbabwe's Mental Health Act of 1996 has never been fully implemented, resulting in the shoddy treatment and exclusion of the mentally ill. The act has also been criticised as being too vague - or outright insensitive - on gender issues relating to mental illness.

The organisation argues that despite the government being a signatory to a host of conventions on the rights of the mentally ill, mental health still does not feature as a priority in national public health policy formulation, and community-based health programmes remain on the drawing board.

Zimbabwe has two major referral hospitals with psychiatric sections in the capital, Harare, and one hospital specialising in mental disorders in Bulawayo.

However, the institutions have been hit by shortages ranging from food and fuel to drugs and the lack of specialised personnel due to a brain drain that has attracted some of Zimbabwe's best health professionals abroad.

Matare has called for consensus among all the role players and the creation of a Mental Health Policy Advisory Council to formulate an alternative policy ('Zimbabwe: Action needed to aid mentally ill' 2004, IRIN website, 5 January <http://www.irinnews.org/report.aspx?reportid=47895> – Accessed 4 May 2009 – Attachment 9).

Another article from the IRIN website dated 20 December 2004 identifies the launch of Zimbabwe's Mental Health Policy, citing ZIMNAMH's director, Mrs Elizabeth Matare, who commends the new policy guidelines, particularly for the inclusion of mental health issues as part of the national HIV/AIDS strategy. However, Mrs Matare also expresses concern over the implementation of the policy, which "should be followed by action plans aimed at improving the welfare of the mentally ill" in order to be effective. In addition, she highlights the lack of specific attention given to women in the policy.

Activists have welcomed the launch of the Zimbabwe's first national mental health policy, but warned that delays in implementation could make it irrelevant.

Elizabeth Matare, director of the Zimbabwe National Association for Mental Health (ZIMNAMH), told PlusNews that her organisation welcomed the new policy, as well as the increased budgetary allocations for the mental health sector.

"The inclusion of mental health issues in the national HIV/AIDS programme is highly commendable - we have always complained that mental health patients have been sidelined. But the policy is only a statement of intention on the part of the ministry of health. We would like to see the policy put into action - Zimbabwe has a long history of coming up with acts and working documents that are never implemented," she remarked.

Under the new policy guidelines, mental health issues form part of the national HIV/AIDS mitigation and information strategy, thereby giving the mentally ill greater access to information, treatment and counselling. Matare said the policy should be followed by action plans aimed at improving the welfare of the mentally ill.

"We would like to see action that improves the lot of those affected [by mental illness]; that deals with such components as treatment, rehabilitation and forensic psychiatry for the mentally ill who are held in prisons, among other things. We are happy to note that the policy recognises the link between HIV/AIDS and mental health," she said.

"It is a known fact that people suffer from varying stages of depression once they get to know their positive status - some fail to cope with it and suffer from serious forms of mental illness. So, recognising this link puts us in a position to deal with the problems once they arise," Matare added.

However, she said ZIMNAMH was still concerned that the new policy lacked a specific clause dealing with women and mental health. She called for a specific agenda, as women were affected by mental health problems in a number of ways.

"We have to recognise that women are usually the caregivers for people suffering from such serious illnesses as HIV/AIDS. This exposes them to high stress factors, which in turn affects them mentally. They end up suffering from many conditions, like continuous headaches, sleeping disorders, depression and other psychosomatic disorders," Matare explained. This sets them apart as a sector begging for special attention, and we would be pleased if that could be incorporated into the mental health policy."

A total of Zim \$5 billion (US \$877,346), up from Zim \$120 million (about \$22,000) in 2004, has been set aside for programmes and improvements in the country's three psychiatric hospitals during 2005. ZIMNAMH estimates that about 300,000 Zimbabweans suffer from various types of mental illness ('ZIMBABWE: Mental health policy launched' 2004, IRIN website, source: Plus News, 20 December <http://www.irinnews.org/Report.aspx?ReportId=38045> – Accessed 6 May 2009 – Attachment 10).

The World Health Organisation's (WHO) Mental Health Atlas for 2005 also describes Zimbabwe's mental health facilities and identifies training provided to mental health care workers, indicating that a shortage of staff and materials has limited the sustainability of mental health care programs.

**Mental Health Facilities** Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary health care workers have the capacity to handle patients with severe psychosis and refer only those that they feel require specialized services. Most of the rural and district hospitals do not have facilities for inpatient care and only 17 district, provincial and central hospitals have primary care teams.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 2000 personnel were provided training. There are training facilities for nurses, occupational therapists, rehabilitation workers and social workers. All student nurses are supposed to go through a period of training in mental health (4 weeks of theory and 8 weeks of practical experience). Training workshops for mental health are also organized from time to time at the district and provincial level. However, the programme has significant limitations. A system of supervision, referral and back referral has been established in some regions. There are community care facilities for patients with mental disorders. There is a shortage of material and staff to sustain community care programme (World Health Organisation 2005, 'Mental Health Atlas: 2005', WHO website, Section II, p. 513

<http://apps.who.int/globalatlas/default.asp> - Accessed 4 May 2009 – Attachment 11).

In addition, the 2000 IRBC report cited earlier outlines the effectiveness of Zimbabwe's mental health services and facilities, similarly indicating that the mental health care system is inadequate and suffers from staff shortages, limited available medication and lack of coordination, particularly following "the collapse of Zimbabwe's National Mental Health Plan" and the emigration of many trained psychiatrists to places that offer higher salaries. The report also highlights the abuse of patients at psychiatric hospitals and the shame associated with mental illness.

Zimbabwe started off well after independence, initially adopting a plan of decentralised community-based medical care not unlike that in Botswana, but this has faltered under pressure from world financial institutions to 'restructure' the economy (often a euphemism for reducing public spending).

Hence, where medical services were free initially, there are now charges for people earning over about 400 Zimbabwe dollars monthly (about AUS\$50).

A National Mental Health Plan was adopted in 1984 but later was abandoned. Under the original plan each province was to have a psychiatric unit within the provincial hospital. Five out of eight provinces now have a provincial hospital, a sixth is being constructed with Chinese aid funding. ...

Community clinics were built. It is claimed there is a clinic within 8-10 km of anyone's home. Mental health care is provided by psychiatric nurses and generalist nurses with psychiatric skills. A Community Health Worker programme was commenced but has not been successful, in contrast to that in Botswana. The reasons for this are obscure, but may relate to the manner in which they are appointed and trained.

In Botswana VHWs [village health worker] are elected by a village meeting and are representative of the local people. In Zimbabwe this was not always so and reportedly many local health workers abandoned their posts for the more attractive lifestyle of the cities, using the position of village health worker as a stepping stone out of rural poverty.

With the collapse of Zimbabwe's National Mental Health Plan, each province is now responsible for its own services, with resulting inequities and inadequate coordination. A national mental health coordinator has lately been appointed, but there is no National Directorate of Mental Health. Deinstitutionalisation of the chronically mentally ill has not occurred to the same extent as in Botswana.

A recent report commissioned by the Ministry of Health suggested there are inadequate after-care facilities in the community which makes discharge impossible in many cases. Non-government organisations such as the Zimbabwe National Association for Mental Health (ZIMNAMH) are developing an important role, especially in mental health education and rehabilitation programmes.

The University of Zimbabwe trains psychiatrists in a four year Master of Medicine course. There is also a one-year post-graduate diploma in psychiatry for doctors wishing to improve their psychiatric skills. Unfortunately few Zimbabwean medical graduates are specialising in psychiatry. Many emigrate to South Africa, attracted by the promise of greater affluence. A system was recently introduced compelling recent graduates working in hospitals to do either psychiatry or anaesthetics (another shortage area) for four months in their second post-graduate year. ...

In Zimbabwe and Botswana medications are limited to the basic tricyclic antidepressants, for instance amitriptyline and imipramine, and neuroleptics such as chlorpromazine, thioridazine and fluphenazine decanoate. Lithium is available but used rarely in rural areas owing to lack of pathology facilities. Most anticonvulsants are available, also often used in unmonitored doses (De Saxe n.d.).

It is estimated that 20 per cent of Zimbabwe's population have mental health problems (Xinhua 3 Apr. 1995; IPS 9 Jan. 1996), while a 29 March 1995 Xinhua report referred to "a recent survey done by local psychiatrists" that 35 per cent of Zimbabwean women living in "high density suburbs" had "mental health problems." According to the chairman of the Department of Psychiatry at the University of Zimbabwe: "women are more vulnerable as they are subjected to more stress than men. ... However, very little is being done for mental health as compared to other health care area" (ibid.). A 9 January 1996 IPS report corroborated these reported results of the survey. A 2 November 1995 IPS article reported the government's chief psychiatrist as saying there were 1,500 patients at 10 psychiatric hospitals.

The following information was obtained during a 2 May 2000 telephone interview with an Assistant Professor of History at Barnard College, Columbia University.

...The National Referral Center for Psychiatric Disorders, or Ingutsheni Hospital is the country's largest for psychiatric patients (IPS 9 Jan. 1996; *Chicago Tribune* 24 Aug. 1996). IPS stated that the hospital "carries the burden of having to provide relief for the increasing numbers of Zimbabweans suffering maladies of the mind" and said that Zimbabwe's economic difficulties "have fuelled the mounting cases of mental disturbance. ... But because government continues to axe health and social welfare budgets there has been no corresponding increase in mental health care services" (9 Jan. 1996). In 1968 the hospital cared for about 1,000 patients, in contrast to the approximately 560 people who were under care in January 1996 (ibid.). Another 1996 report stated the hospital had 600 patients (*Chicago Tribune* 24 Aug. 1996).

The assistant professor described the director of Ingutsheni hospital as "very good" and said that despite the hospital being chronically poor and understaffed, it has won awards. She said that the staff listen to their patients and "indulge" them where

possible. She said that the patients appear to wander around with some freedom and that the "general culture seems to be relatively humane."

The assistant professor said the next largest institution for psychiatric care in Zimbabwe is Ward 12 at Harare's main hospital, Parirenyatwa. Both establishments handle out-patients and resident patients. She said there is also a facility outside of Masvingo, and a hospital for the criminally insane attached to the prison in Bulawayo. In addition, there are a variety of smaller more traditional places of treatment. She explained that in Zimbabwe many persons who experience mental health problems would first visit a traditional healer for treatment.

...As a historian the assistant professor said that she could not provide detailed information about the admittance and treatment procedures at either Ingutsheni or Ward 12. However, she said that many patients are treated with drugs and that shock therapy is also used. However, she emphasized that these treatments are also used in "western" countries.

The assistant professor also stated that Zimbabwe's poor economic performance, and its continuing deterioration, has had a negative effect on the level of services available to persons suffering from mental illness.

In other information, at a 1995 "five-day international conference on mental health in Africa" President Mugabe:

expressed concern about the lack of dialogue between traditional healers and the modern health community in dealing with mental health problems. Mugabe said most mentally ill people would consult traditional healers first before approaching other health practitioners. Little research has been done to find out methods used by traditional healers, the outcome of their treatments and ways of integrating traditional medicine with modern mental health care services. ... In Zimbabwe, according to 1990 statistics, there is one traditional healer per 250 mental health people, one psychiatrist per one million and one psychiatric nurse per 8,000. ...The conference ...is aimed at devising better ways of dealing with mental health. Mugabe said that violence, civil wars and drastic political and economic changes in the region would have a devastating effect on the mental health of many children and their families. Other factors causing the increase in mental health problems include overpopulation, family breakdowns, drug and alcohol abuse and AIDS, he added (Xinhua 3 Apr. 1995).

A 30 June 1998 report from *The East African* stated that Zimbabwe was attempting to recruit Tanzanian medical personnel, including 13 psychiatrists, because of "an acute shortage" in government facilities. The article stated that "a large number of Zimbabwean medics have left the public service to either work in the lucrative home-care centres or in Botswana and South Africa where salaries are higher" (ibid.).

A Senior Nursing Officer at Ingutsheni claimed that mental health patients must deal with "stigmas" and that there is a "shame attached to mental illness" (ibid.). He went on to say:

"My personal feeling and experience is that we need to develop psychiatry services more than they are now. We are behind. The psychiatry field is also divided into groups itself - psychiatric, alcoholic, epileptic. What is happening here is that all of these patients are lumped into one group which is treated as expendable. There are no specifications."

He says that an ordinary depressed person who is reacting to a death in the family, or who has been rejected by a lover, will often react badly to such a situation and become depressed. In advanced countries they look at this as a reaction to the situation and the patient receives suitable medical help.

"In our situation you are quickly whisked into Ingutsheni, your documents are signed, your rights are taken away. It does not help. They leave you for years. We need money to develop these services and facilities, or have Ingutsheni demarcated into sections and specialized areas," suggests the Chief Nursing Officer.

Sadly, Zimbabwe's mental health delivery system is handicapped by a chronic shortage of trained psychiatrists and psychiatric staff. Stories of patients being sexually abused by staff, or starved, punished and locked up for not doing chores have come out of Ngomahuru Psychiatric Unit in Masvingo, southern Zimbabwe (ibid.)

A 2 November 1995 IPS article reported allegations of the abuse of patients, including sexual and beatings, at the country's psychiatric hospitals, including Ngomahuru Psychiatric Hospital in Masvingo, that were dismissed by the country's chief psychiatrist as exaggerations (Immigration and Refugee Board of Canada 2000, ZWE34298.E - *Zimbabwe: Treatment of persons suffering from mental disabilities; resources and services available to such persons*, 3 May – Attachment 3).

The loss of medical staff to neighbouring countries offering higher salaries is also highlighted in the following article dated 18 December 2008, which describes the deaths of more than fifty mentally-ill patients in the Ingutsheni hospital from hunger and malnutrition. The article outlines the severe shortage of food supplies, stocks of medication and medical staff in Zimbabwe's hospitals, reflecting the overall impact of hyperinflation and the economic crisis in Zimbabwe.

Over fifty mental patients at Zimbabwe's Ingutsheni hospital in Bulawayo have died of hunger as the institution has run out of food and depleted drugs stocks. A senior official at the hospital, Naboth Chaibva said the deaths were caused by an acute shortage of food. He noted that as a result of the unbalanced diet, the hospital continued to record a number of deaths because of malnutrition.

...Under normal circumstances Ingutsheni hospital patients get three meals a day and snacks but all that is a thing of the past. Chaibva added that the number of inmates have been slashed to 450 from 600, citing serious shortage of food. The 400 inmates at the institution are not getting a high protein diet although their medication requires a lot of food.

Zimbabwe is reeling under one of the worst economic crisis worldwide, with an inflation figure hitting 5 quintillion, according to independent statisticians. The economic meltdown is blamed on President Robert Mugabe's 28-year rule.

To worsen the shortage of food, the hospital is operating with a skeleton staff since doctors, nurses and other medical staff are leaving the ravaged country to neighbouring states for greener pastures. Chaibva said experienced staff was resigning due to pathetic salaries ('Mental patients perish from starvation, as Zimbabwe's humanitarian crisis deepens' 2008, *The Zimbabwean*, 18 December [http://www.thezimbabwean.co.uk/index.php?option=com\\_content&task=view&id=17413&Itemid=103](http://www.thezimbabwean.co.uk/index.php?option=com_content&task=view&id=17413&Itemid=103) – Accessed 7 May 2009 – Attachment 12).

However, although not specifically related to mental health care workers, an recent article dated 27 April 2009 indicates that a significant number of public health care employees have resumed work in the sector following the implementation of a retention incentive offered by Zimbabwe's newly-formed government.

About 95 per cent of employees in the public health sector have returned to work following the introduction of the health sector support fund which is paying out allowances to health workers, the Minister of Health and Child Welfare, Dr Henry Madzorera has said.

The resumption of duty by government health workers will go a long way in resuscitating the country's health sector, which had totally collapsed due to mismanagement by the then Zanu (PF) government.

Madzorera said the resuscitation of Zimbabwe's health care system was one of the major challenges facing the country's inclusive government since its formation in February.

"It's a work in progress. We are working with international partners to first make sure that rural facilities have the personnel, drugs and equipment and then move on to other issues, such as upgrading facilities. We are taking over a collapsed system," said Madzorera.

He added that: "We now have the health sector support fund, which is paying out allowances to health workers of \$100 a month as a retention incentive."

Madzorera was appointed the Minister of Health in February ('Health employees return to work' 2009, *The Zimbabwean*, 27 April [http://www.thezimbabwean.co.uk/index.php?option=com\\_content&task=view&id=20800&Itemid=103](http://www.thezimbabwean.co.uk/index.php?option=com_content&task=view&id=20800&Itemid=103) – Accessed 7 May 2009 – Attachment 13).

A 2005 article from the IRIN website emphasises an increase in patients consulting traditional healers, who are unrepresented by a proper council and not formally recognised by the government, and attributes this trend to the rising costs of medical care which limits public access to medical facilities and treatments.

An increasing number of Zimbabweans are turning to traditional healers for inexpensive medical care as health costs continue their upward trajectory.

Under-resourced state hospitals and clinics charge around Zim \$20,000 (US 8 cents) per consultation, but the cost at better-equipped private hospitals is around Zim \$500,000 (US \$20) and patients can quite easily run up a bill of Zim \$15 million (US \$615) in a week.

Gordon Chavhunduka, the director of the Zimbabwe National Traditional Healers' Association (ZINATHA), said prohibitive medical costs had made it difficult for the poor to access healthcare and most government and private hospitals demanded cash upfront.

"We have, for a long time, been telling the government that they cannot go it alone in the delivery of health. There has been a lot of tension between the government and us over our usefulness, and it is encouraging that they are seeing the light now,"

Chavhunduka told IRIN.

The authorities have been sceptical about traditional herbalists, raising concerns that their medicines were not properly administered nor scientifically proven, despite the Traditional Medical Practitioners Act, which was aimed at regulating the work of 'n'angas' (Shona for traditional healer), being passed some 25 years ago.

Minister of Health David Parirenyatwa recently publicly acknowledged that Zimbabwe has been slow in incorporating traditional healers into mainstream healthcare delivery.

"This is one of the few remaining countries in the [southern African] region that does not have a proper council representing traditional healers and their operations," Parirenyatwa told a gathering of traditional healers recently.

He added that the ministry of health had appointed a director of traditional medicine, who would focus on regulating the work of traditional healers.

Traditional medicine experts said the formal recognition of healers by government was long overdue, but warned that tighter control was needed to rein in those using unorthodox methods to treat patients.

ZINATHA has already established a team of health inspectors who carry out nationwide checks on registered traditional healers to ensure that they conform to the organisation's regulations ('ZIMBABWE: Traditional healers make a killing as healthcare costs rocket' 2005, IRIN website, 26 August <http://www.irinnews.org/Report.aspx?ReportId=56052> – Accessed 6 May 2009 – Attachment 14).

Similarly, the need for increased funding to enable health care services to be more widely available to mentally ill people is emphasised by ZIMNAMH director Mrs Matare in an article dated 10 October 2006. The article highlights the Tirivanhu Therapeutic Community, a community-based rehabilitation centre which claims to offer mentally ill people the responsibility, control and participation that they are denied by the wider Zimbabwean society. The article explains that the name of the centre, Tirivanhu, "is inspired by the stigma and discrimination that people with mental disorders are subjected to from a society which views them as a curse and a burden to it."

Sprawling over 98 acres along the Harare-Mutare Road in Ruwa, Tirivanhu Therapeutic Community, a structured rehabilitation centre for people recovering from severe and persistent mental disorders and currently home to 18 members undergoing rehabilitation, is living testimony to the success of a holistic psycho-social community-based rehabilitation.

Scores of people with mental disorders who have passed through the programme in the two decades that the centre has been in existence have since been reunited with their families and integrated into the community, where they are leading respectable lives.

The name Tirivanhu, literally translated "we are also human", is inspired by the stigma and discrimination that people with mental disorders are subjected to from a society which views them as a curse and a burden to it.

Tirivanhu's secret to success lies in its ability to give to people with disorders what the rest of society denies them - a sense of responsibility, control over their lives, complete participation in the centre's diverse activities and appreciation.

... The executive director of the Zimbabwe National Association for Mental Health (ZIMNAMH), Mrs Elizabeth Matare, said that while the centre did everything in its power to empower people with mental disorders with self-reliance, equity and self-sufficiency, it is the duty of the Government to provide adequate medication because there was a danger of these people relapsing if medication was not made readily available.

The recently-launched Mental Health Policy makes provision for the supply, availability and accessibility of psychotropic drugs at all levels.

These drugs are, however, currently unavailable because of financial constraints.

... However, despite the successes that the model community has posted during the two decades that it has been in existence, the centre needs an urgent injection of funds in order to effectively introduce drip irrigation to sustain the current activities and cater for more clients.

"A lot of deserving clients with mental disorders fail to access this community and benefit from the rehabilitation due to limited accommodation.

If the organisation had funds readily available, we would increase accommodation facilities to cater for 30 persons," said Mrs Matare.

She said the administrative grant of \$30 000 from the Ministry of Public Service, Labour and Social Welfare that the organisation received this year is not enough to meet the needs of the centre especially the provision of a balanced diet, toilet requisites for the clients, veterinary requirements and maintenance costs.

... Clients are encouraged to talk about their mental problems openly as this helps them to confront the stigma and discrimination associated with mental illness. After successful rehabilitation at the centre, the onus will now be on the family to ensure that the clients continue to take their medication and maintain a stable mental state in a conducive, supportive family environment (Rambiyawo, L. 2006 'Centre Giving Hope to Mentally Challenged', *All Africa*, 10 October – Attachment 15).

Although not specific to Zimbabwe alone, the WHO launched a mental health programme in Africa in 2008, the goal of which is "to enable persons with mental illness to lead healthy lives with the help of proper care, psychological assistance and appropriate medication" by focusing on the gap between what is required to effectively treat mental illnesses and what is currently available. In launching the Mental Health Gap programme, WHO Director-General Dr Daniel Kertesz highlighted the discrimination faced by African sufferers of mental illnesses, who he says "face many obstacles such as limited access to health facilities, inadequate trained health workers and traditional beliefs that attribute mental disorders to witchcraft."

This was made known by Dr Daniel Kertesz, WHO Representative in Ghana, in Accra last Friday. Dr Kertesz explained that Mental Health Gap focuses on the gap between what is needed to treat mental illnesses and what is actually available.

"It shows that the extra costs to close this gap are not too large. We know for example that in low-income countries, the cost of treating three major mental illnesses and for treating hazardous alcohol use requires an additional cost of less than 20 pesewas per person per year," he said.

He said Africans suffering mental illnesses face many obstacles such as limited access to health facilities, inadequate trained health workers and traditional beliefs that attribute mental disorders to witchcraft.

He said many people in Africa reject friends and relatives suffering from mental, neurological and substance abuse-related disorders while the sufferers [sic] basic human rights continue to be violated.

"How should we respond? In 1999 and 2000, Member States received recommendations derived from the African Regional Strategy for Mental health 2000-2010. The strategy recommends inclusion of mental health issues in national health plans; making sure that there are enough trained health care workers to deal with mental illness providing enough treatment drugs at all levels of the health care system." (Ayuure Kapini Atafori 2008, 'Africa: World Health Organisation Launches Mental Health Programme', *AllAfrica Global Media*, source: Public Agenda, 17 October, <http://allafrica.com/stories/200810171090.html> - Accessed 5 May 2009 – Attachment 16).

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*AllAfrica Global Media* website <http://allafrica.com>

IRIN website <http://www.irinnews.org>

#### **Topic Specific Links**

World Health Organisation website <http://www.who.int>

Ministry of Health and Child Welfare website <http://www.mohcw.gov.zw>

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Copernic <http://www.copernic.com/>

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