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Kate Karban

Kate Karban is senior lecturer in Social Work at the School of Social and International Studies, University of Bradford, United Kingdom.

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Scaling Up Mental Health Services in Zambia

Challenges and Opportunities Reported in an Education Project

Abstract: The need to increase the capacity of developing countries to meet the mental health needs of the population is widely acknowledged (1). This paper examines some of the challenges associated with a British Council DelpHE project that had the aim of strengthening the capacity of mental health educators to prepare the mental health workforce for a shift from institutional to community-based model of care in Zambia.

The discussion will draw on the analysis of data from two focus groups in which the participants were drawn from college educators who had taken part in a number of workshops intended to enhance curriculum alignment to ensure that the education and training provided for Clinical Officers (psychiatry) and Mental Health Nurses was ‘fit for purpose’. In particular, their perspectives on some of the tensions in focusing on mental health as opposed to broader health care and in ensuring appropriate opportunities for practice or field placements will be highlighted. The continuing impact of stigma and limited resources available for mental ill-health will be acknowledged within the wider context of inequities in mental health care.

The findings of this evaluation may be applicable to other sub-Saharan contexts however the discussion should be understood within the Zambian context. It is therefore reflective of the limitations of current research in Zambia on workforce and educational development in mental health. Given this, local, front line ‘know how’ and expert opinion is significant in making sense of local and national challenges and opportunities. Finally, recommendations for further work in this area, to address some of the issues that have been identified, will be offered.

There is increasing attention to the impact of mental health difficulties and the need for appropriate responses, within sub-Saharan Africa. Whilst the Millennium Development Goals (2) have been understood as focusing more explicitly on communicable diseases, the inter-relationship between physical and mental well-being is increasingly recognised. It is estimated that 14% of the Global Burden of Disease (3) is attributed to psychiatric and other related disorders, pointing to the personal and financial costs of mental ill health and the importance of addressing mental health issues as a priority.

The aim of this study is to identify some of the challenges that exist when working to scale up the response to mental health issues, drawing on the experience of one small scale project intended to support the development of the mental health workforce in Zambia. In

particular the 'chicken and egg' nature of the challenge will be demonstrated, in that the lack of a developed infrastructure of community-based mental health services, alongside a level of stigma and the low priority accorded to mental health, in relation to other health care priorities, results in few opportunities for learning in the field and a continuing ambivalence regarding the value of a career in mental health for nurses, clinical officers and other professionals. This in turn affects the recruitment, retention and capacity-building of the mental health workforce.

The views of the educators involved in this project, many of whom have also worked as mental health practitioners, provide the basis for a discussion of the range of interacting features that characterise this environment. The implications arising from the themes from this discussion will also be examined to identify learning from this project and recommendations for further work.

Context and Background

Zambia has a population of over 13 million, with more than 60% estimated to be living in poverty (4). The economy is heavily dependent on the fortunes of the copper market and subject to international market forces as well as international monetary policies. Within this picture, in common with other low and middle-income countries, there are limited resources for healthcare in general and mental health remains a low priority with serious underfunding (5). It is estimated that 38% of health care expenditure is from external sources and mental health accounts for only 0.4% of the overall health care budget (6).

Health care resources in Zambia are also significantly affected by the prevalence of HIV infection within the adult population, estimated at 15% (adults 15 – 49 years), and the high rate of death from AIDs in adults aged 20 – 34 years (7). Life expectancy is 47 and 49 years for men and women respectively with high rates of morbidity and mortality associated with malaria. Additionally WHO (8) data indicates that one in six children die before their fifth birthday.

The loss of economically active adults is further affected by the impact of the 'brain drain', with the loss of trained staff leaving for better opportunities outside the country. Also practitioners and educators describe a draw away from mental health when they are posted to clinics by the Ministry of Health in order to respond to physical health and public health issues such as HIV, malaria, and maternal health, even though good mental health is key to having sound physical wellbeing .

Currently there is no comprehensive national base line data regarding the incidence and prevalence of mental illness although schizophrenia is recognised as a priority. In addition to the main psychiatric hospital which includes a forensic unit, seven provincial general hospitals have allocated psychiatric beds. Mental health however remains a low priority and there is 'a critical shortage of mental health providers' (9). Data from the World Health Organisation (10) also indicates that the numbers of trained personnel within the mental health workforce are low with figures of 0.03 psychiatrists, 1.36 nurses, 0.02 psychologists, 0.15 social workers and 0.04 occupational therapists / 100,000 population. Other health workers are estimated as numbering 1.13 / 100,000 population, including the cadre of Clinical Officers (psychiatry), trained over two years, who act as the professional mainstay of mental health services.

The provision of psychiatric services rests primarily on a Western-influenced model although the role of traditional healers remains significant in local communities. A new mental health policy, introduced in 2008, set out the intention to move towards community based services. The current model of care relies heavily on the provision of in-patient

treatment, where deemed necessary, and the prescribing of medication. The discharge of patients back to the community is frequently problematic in the absence of community based support for individuals and their families. The potential for long term incarceration and 'revolving door' admission is of concern.

There are also plans to review the legislative framework which is the 1951 Mental Disorder Act as, in common with a number of other countries. The 1951 Act is outdated and fails to sufficiently protect human rights. A report from the Mental Health and Poverty Project (11) comments that in the African region 64% of countries are either without legislation or have legislation that is outdated and in respect of Zambia it is noted that the current law 'criminalises' being mentally ill. It is important to note that the challenges faced in Zambia, in many respects, reflect those recorded elsewhere in low and middle income countries where shortcomings in mental health care in terms of scarcity, inequity and inefficiency are present. These challenges have led to a call for governments to develop a comprehensive approach including clear allocation of budgets, investment in the mental health workforce and efforts to reduce stigma (12,13). In particular, Saxena et al (14) commenting in relation to low and middle income countries in general, suggest that mental health policy has 'probably been unfairly disadvantaged by the endemic stigma attached to mental illness.'

The influence of Western psychiatry also brings its own challenges, not least of which is a temptation to conflate Euro-American models with Zambian aspirations arriving at the conclusion that the terms of reference for service provision and responses to local challenges ought to be found in models developed within wealthier countries. Therefore, the figures above on workforce size/composition, and diagnostic prevalence should be read as a cautious indication rather than a definitive position, as local design and provision may innovate in directions away from Western style provision, reflecting different frames of reference, the limited resources available and variations in human geography e.g. patterns of rural and urban living.

Project Aims and Objectives

The three year project that forms the basis for this discussion was funded by the British Council as part of the DelpHE programme and involved a partnership between Chainama College of Health Sciences in Lusaka, Zambia and the Faculty of Health and Social Sciences, Leeds Metropolitan University, UK. The aim of the project was to support the development of the workforce to meet the demands of the new mental health policy.

An important feature of this project was to build strong reciprocal and respectful relationships between the staff from both institutions, avoiding the quasi colonial re-inscribing of inequality and the message, implicit or otherwise, that the objective of the project is to impose the thinking and practices of the historically dominant country, in this case, Britain. The emphasis was on the sharing of ideas and experiences and the benefits of learning from each other, recognising both the commonalities and the differences between the two countries in terms of a number of features including the demography, economy and culture.

A series of workshops were held in Zambia throughout the life of the 3 year project. These included workshops for practitioners and educators on psychosocial perspectives for practice as well as sessions dedicated to the educators. These latter sessions focused on best educational practice including curriculum design and alignment, and student centred learning. Additionally practice workshops were delivered for home-based volunteers

working with a non-governmental organisation in the south of the country and a workshop was held for families and carers of people with mental health difficulties.

The curriculum workshops comprised a total of 8 days. This included a three day workshop that was delivered twice with a two day follow-up session for participants who had attended either of the earlier sessions. A total of 62 workshop places were taken, with college educators attending two workshops over 5 days each. Reciprocal visits were also made and Chainama Hills College educators visited the UK to look at both educational and clinical practice.

Methodology

Focus groups were utilised for data collection from college based educators who had attended the workshops as these were recognised as being effective in generating interactive discussion between participants with shared experiences (15, 16). Ethical approval for the evaluation was obtained from the University of Zambia Bio-Medical Ethics committee. A total of 13 participants attended either one of two groups with the first group containing 4 men and 1 woman and the second group comprised of seven women and one man. Distribution between the groups had been planned to involve equal numbers of men and women but this was not possible due to other commitments of those who were invited to take part. The majority of the participants [10] were aged between 36 and 45 years and their experiences as lecturers ranged from less than one year [2] to one to five years [3] with 8 participants having over 5 years experience. All were involved in teaching on mental health programmes for Mental Health Nurses or Clinical Officers. Four participants had a background in nursing practice with others coming from a range of professional backgrounds including clinical officer, nutritionist, psychologist and environmental health. A total of ten participants had over 10 years practice experience in their professional area before entering the college as educators.

The focus groups were facilitated by a one member of the project team who had not been directly involved in the curriculum workshops. Participants were provided with an information sheet and gave written consent to their involvement and to the audio-recording of the discussions. It was emphasised that the decision to participate or not would not have any impact on the individual's employment. A topic guide for the focus groups was prepared in advance and provided a flexible structure for the discussion (17). Following the focus groups, the audio recordings were transcribed and subjected to thematic analysis (18). Themes and codes were identified and cross-checked by two members of the project team.

Findings

A number of themes related to the application of learning from the workshops and these are discussed in a further paper (in preparation). The discussion here will focus on a number of themes which together can be seen as reflecting wider tensions and challenges in developing the mental health workforce. These include the priority and resources allocated to mental health which in turn is associated with public perceptions of mental health and accompanying stigma. Related to this are student's potential career trajectories and opportunities as well as the availability of appropriate practice or field learning opportunities whilst in training.

Several participants referred to the challenges of developing community-based mental health services and the impact of stigma on those affected by mental health difficulties as well as those working to deliver services.

'Once one develops a mental illness they are no longer accepted. Trust is no longer there and there is so much stigma.' (FG2)

The lack of community-based resources was also highlighted, including the limited availability of medication. This led to continuing dependence on the main psychiatric hospital and a cycle of admission, discharge and relapse leading to re-admission.

...you find there is no register of the patients. They will tell you, you know, when they come we just send them to [hospital] because here we don't have any drugs. (FG2)

...the referral system where mental health is concerned, it is almost non-existent. (FG2)

These challenges also had the effect of limiting the opportunities for students to learn about mental health practice in the community. On the positive side there was a sense that mental health students did begin to make a difference in identifying 'patients' and visiting them at home, however this activity tended to cease when the students completed their placement.

The moment we withdraw them from the clinics, that's the end of community mental health...the only time it becomes a bit revamped is when the students are there.

In some situations those clinical instructors who were meant to be supervising mental health students, were in fact involved in general health and medical care and this then became the focus of the students' work:

And one of their [students'] concerns was that most of the times they were left on their own. The clinical instructor who is meant for psychiatry is basically involved in just doing general work. As a result even the studentsthey were saying we are just doing general medicine.. (FG1)

There was a sense that there was an urgent priority to motivate and educate field-based staff so that they were clear about the role and expectations of the college curriculum and what the students needed to learn and practice.

Concerns about the learning opportunities available in placements also reflected wider concerns about the pressures for staff trained in mental health to move into other areas of health care, especially where funding was more plentiful. In respect of one group of staff trained in psychiatric rather than general nursing:

If you go right now you won't find them practising psychiatry, they have all gone to general medicine and some of them do not want to be associated because they are getting money through these activities....if they just remain in psychiatry way they will die of hunger because there are no activities there, they are not even funded...its because of funding coupled with stigma. (FG2)

Another participant commented that:

When they graduate and go there they find there is no pulling force towards whatever they learnt. In the end the pulling force is more on the general. (FG2)

In respect of Clinical Officers (psychiatry), it was acknowledged that in some situations:

Maybe he is posted at a rural health centre and is alone, and in that place he is required to see general cases. (FG1)

Compared to other areas of healthcare including general nursing or work associated with HIV and AIDS, the lack of career opportunities was noted.

You see all you are going to be is a mental health nurse, maybe a ward manager. (FG2)

A concern about the future prospects for anyone trained in mental health was also seen to permeate attitudes at the college in terms of recruitment. It was felt that careers in mental health were not widely understood or recognised. One participant referred to the questions of prospective applicants or their parents:

The first they will say is, are you sure it is a progressive career? Are you sure you are going to make some money out of it? Because we don't know it so well. (FG2)

In turn some academic staff would comment that:

...if psychiatry does not work out, you can still be a registered nurse. (FG2)

Similarly for those trained as Clinical Officers (psychiatry) it was acknowledged that: *This course could be stigmatised, after going for work as a Clinical Officer psychiatry, they would come back to the college and do general clinical officer [training]. (FG1)*

A key part of the discussion in both groups concerned how this ambivalence regarding the prospects for careers in mental health could also be seen to pervade the curriculum. In respect of Clinical Officers it was felt that in respect of the training for either general or psychiatric work

The period is the same three years, you uplift from the other 3 years almost everything and you add on psychiatry (FG1)

Similar concerns about the nursing curriculum were also expressed, *The curriculum for Mental Health Nurses, they captured the entire registered nurse curriculum and only added the component of mental health to that curriculum (FG2)* *Maybe it is also the way the curriculum is arranged in that it gives people more room to do things other than deepening themselves deep in mental health. (FG2)* *People are saying the curriculum is overloaded...what we've noticed, these students who specialise ...they are spending too much time doing general learning, general medicine, rather than their specialism...this is something that has confused them. (FG1)*

One person commented that:

The problem is that we haven't tailored the courses towards the cadre that we want to train...some of the topics have no bearing and even the students ask where we are going... (FG1)

At the same time there was an acknowledgement that mental health should not be seen in isolation from physical health

Mental health is not independent of medical conditions it can only be seen well when it is integrated and most of the people who are mentally challenged they don't go to mental units they go to general units and sometimes the general clinicians will maybe overprescribe drugs without realising that this person has some sort of mental disorder which needs counselling. (FG1)

These issues interrelate as a network of factors that together hamper the continuing development of the mental health workforce. To some extent this can be seen as a negative cycle where the lack of high quality mental health facilities and motivated staff limits the potential learning opportunities available for students who in turn become uncertain about their future career prospects and are less likely to provide the positive role models for future generations of students. This analysis also needs to be located within the wider political and economic context of a country such as Zambia where other health care priorities may inevitably be seen as of greater importance.

It is also important to identify the positive suggestions that the focus group participants themselves proposed as strategies to improve the situation. These included the value of offering mental health training to primary health care workers based in the community, such as those working to combat malaria or birth attendants. One participant referred back to her experience when the college had bicycles for students to undertake field visits and follow up patients discharged from hospital. There was a clear need identified for clear career development opportunities for mental health practitioners as well

as a great level of training and support for field instructors working with mental health students.

We need to strengthen and bring the [field] instructors on board at the college so they understand their role and the expectations of the college when the students go there, what are the students expected to learn and practice. (FG2)

This was seen to include refresher courses and opportunities to update their own knowledge, understand how and what students are being taught currently, and for internet access.

Discussion

The experience of this project and the insights of the educators involved in this workshop will be discussed in relation to four broad and interconnecting areas.

Health care priorities and resources for mental health

There is a clear sense from this project that mental health is only one of a number of competing health care challenges including HIV/AIDS and malaria. Within an international context and at face value this can also be seen as reflecting the priorities of the Millennium Development Goals (2). These were agreed in 2000 by the member countries of the United Nations and refer to the need to combat poverty, hunger and disease, specifically HIV/AIDS and malaria, reduce child mortality and improve maternal health, to reduce discrimination against women and to support environmental sustainability and global partnerships. However, despite the lack of an explicit reference to mental health, there is considerable evidence of the links between mental health and HIV/AIDS and of the relationship between maternal mental health and child wellbeing (19,20).

Notwithstanding this, there would appear to be a targeting of resources and aid in countries such as Zambia, towards HIV/AIDS programmes that, by default, detracts from mental health. This in turn influences national policy and priorities, resulting in the limited attention being accorded to mental health, such as the omission of mental health from the 2011 Ministry of Health Action Plan. This 'treatment gap' in low and middle income countries has also been noted, with Bruckner et al (12) citing treatment rates of between 35 and 50%, leaving many without access to appropriate care and treatment.

It is also important to acknowledge the continuing effects of stigma towards those with mental health difficulties, on those with political power, mirroring wider public perceptions. Challenging stigma at governmental level and prioritising the integration of mental health alongside other health priorities remains an important goal. This does however need to be set within wider economic inequalities and the impact of food, fuel and financial crises (21).

In a review of mental health systems in South Africa, Ghana, Uganda and Zambia, Omar et al (6) highlight some of the obstacles to increasing the profile of mental health in national health care policy and planning. These include the priorities of donors, the lack of grassroots demands and political interest as well as the limited information and the prevalence of stigma. This stigma is perceived to affect primary health care providers as well as the wider population (22).

Public Perceptions

Although stigma towards those affected by mental health remains an international concern, until recently the incidence of stigma and discrimination in sub Saharan Africa was estimated to be of lesser significance. However this has been challenged (22,23) and is now recognised as a widespread issue. In particular it is noted that this is fuelled by limited public information and a systemic failure to address issues of discrimination, including the continuing use of policies and legislation that restrict participation in civic life and limit possibilities for employment. As in other parts of the world, stigma appeared to be perpetuated by a potent mix of fear and lack of knowledge, leading to anxieties about violence, family shame and fears of transmission.

Given the continuation of stigma, it is unsurprising that potential applicants for training as mental health nurses or Clinical Officers (psychiatry) and their families may be cautious in considering future careers in mental health services. Equally, for those who are qualified, the existence of prejudice and fear, as well as the lack of resources for mental health, may deter all but the most dedicated from remaining in mental health, when more acceptable and better resourced services beckon.

Students' Potential Career Trajectories

Given some of the difficulties that students may encounter in deciding on a career in mental health and in sustaining this commitment, it is not surprising that the potential for career development and progression in mental health may also be a concern. Certainly the message received by many students, as indicated by the participants' comments in the focus groups, is that there are only limited opportunities for developing their future careers in mental health.

At the same time it is relevant to note that trained mental health professionals are seen by many to have a significant role in supporting the development of mental health care within primary care settings, recognising that the most effective way to provide such care is likely to be through its integration with other public and general health care provision within community and primary care settings (24). This would include the provision of support and training by mental health professionals to non specialist health care workers as well as volunteers, community organisations and service user and carer groups.

The limitations of a clear career path in mental health, coupled with more attractive options elsewhere, whether within-country to alternative health care specialisms or without, in terms of migration, currently serves to perpetuate low numbers of trained staff, in turn contributing to the shortfall in service provision and limited access to mental health care for those experiencing mental health difficulties and their families.

Practice / Field Learning Opportunities

The views of the focus group participants regarding students' practice or field-based learning suggest that some of these opportunities remain limited and that the messages received by many students are that mental health issues are seen as marginal and are of lesser importance than physical health care. This would suggest that further attention is needed to the training and support of fieldwork supervisors, in line with the recommendations made by the Lancet Global Mental Health Group (1) who comment that capacity building of the workforce with the appointment of mental health specialists to train and supervise workers, including both mental health and general health professionals, in primary and general health care settings.

Overall however, it is important to note the complex and inter-related nature of these barriers to developing the workforce and to acknowledge the need for 'innovative, concerted and sustained efforts' (14:886) to move towards the goal of community-based mental health care.

Conclusion and Recommendations

The results from this qualitative evaluation of a small scale and time limited partnership project need to be located within wider international concerns about the need to scale up resources for mental health in low and middle income countries. The scarcity of resources and shortfall in resources is recognised as a global concern requiring a concerted response to ensure that people experiencing mental health difficulties have access to effective treatment and humane care. In addition to the personal costs of mental distress, there is also the financial cost of loss of employment and need for other forms of support from families and communities as well as social welfare and health services. In the absence of a rigorous programme of research and evaluation in mental health, education and the interaction between the two, it is essential to make the most of small scale evaluation and local expertise.

The discussion in this paper is based on the experiences of educators involved in the training and education of mental health workers, in particular nurses and clinical. The themes arising from this can be seen as illuminating the wider debate and as contributing to our understanding of the challenges on the ground in developing the mental health workforce in Zambia.

Furthermore, the perceptions of these barriers to developing the workforce can also be seen as pointing to a number of ways in which these barriers can be overcome. At a strategic level these include an increased prioritisation of resources for mental health services, particularly for the development of community-based provision, the training of the mental health workforce including both specialists and other primary health care workers. Such a shift in resources would also both require a shift in attitudes towards mental health whilst signalling a challenge to the stigma that is prevalent.

The following recommendations are made understanding the small scale nature of this project. In terms of the education and training for the mental health workforce, our recommendations would be; firstly, there is a need to challenge the additive model of the curriculum whereby mental health is an 'add-on' for specialist training, leading to a lack of focus on mental health and curriculum overload; secondly, curriculum development needs input from stakeholders including service user and carer groups. This could begin to redress this imbalance in content and assist in ensuring that training is fit for purpose. Finally, attention to fieldwork placements may also require a greater level of recognition and support for fieldwork supervisors in providing appropriate learning opportunities for students to develop their understanding of mental health within the community.

While it is beyond the scope of the evaluation to make wider recommendations, there are a number of points raised in this paper about the broader context, such as the juxtaposition of recent progressive policy and older law reflecting colonial values of the 1950s, that need to be considered. The paucity of dedicated mental health resources has a great impact on Zambia being able to develop health and social care infrastructure, especially given rural expanses, as does the ongoing stigma of both being a service user and employee of mental health services. Given this, the training and educational preoccupation of this paper needs re-contextualising as a small but significant component of an overall

service design, and acknowledgement given to the demands that practitioners, families and communities face in supporting people in distress.

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