OFFICE OF THE OMBUDSMAN

Out of Sight, OUT OF MIND

A Report On An Investigation Into Allegations Of Maladministration In the Mental Health Service Delivery And Injustices On The Patients With Mental Disorders By Ministry of Health In the Central Region Of Malawi.


YOUR PROTECTOR AGAINST INJUSTICE

OUT OF SIGHT, OUT OF MIND

A REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF MALADMINISTRATION IN THE MENTAL HEALTH SERVICE DELIVERY AND INJUSTICES ON THE PATIENTS WITH MENTAL DISORDERS BY MINISTRY OF HEALTH IN THE CENTRAL REGION OF MALAWI

DECEMBER 2017

Sys/Inv/2/2017

EXECUTIVE SUMMARY

"...the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped."
Hubert H. Humphrey

1. **'OUT OF SIGHT, OUT OF MIND'** is my report as the Ombudsman of the Republic of Malawi on an investigation into allegations of maladministration in the mental health service delivery and injustices on the patients with mental disorders by Ministry of Health in the Central Region of Malawi.

2. The investigation was conducted in terms of section 123 of the Constitution of the Republic of Malawi which gives me as Ombudsman the powers to investigate any and all cases of alleged injustice where it does not appear that there is any remedy reasonably available in the courts; and in terms of Section 5 of the Ombudsman Act which gives me powers to investigate 'any alleged instance or matter of abuse of power or unfair treatment of any person by official in the employ of any organ of government, or manifest injustice or conduct by such official which would properly be regarded as oppressive or unfair in an open and democratic society'.

3. The investigation was carried out in response to a newspaper investigatory article by Rabecca Chimjeka titled ***'Bwaila Mental Ward goes insane'*** published in the Nation on Sunday of 9th April, 2017. The article raised a number of human rights violations and acts of maladministration by Ministry of Health in the administration of mental health service delivery at Bwaila Psychiatric Unit.

4. Accordingly, despite not receiving a formal complaint on this I decided to conduct an investigation into this matter as the violations reported were against one of the most vulnerable groups in society and also because I believed that the investigation would ultimately effect improvements in the mental health services in Central Region.

5. I interviewed the Principal Secretary for Health, the Director of Mental Health Services, 5 of the 9 District Health Offices in central region, other relevant members of staff from the Ministry of Health, Medical Council of Malawi and the Director of Services of St John of God Hospitaller Services

(Lilongwe).

6. I visited Mwavele Village T/A Manthalu in Mchinji District, Kamuzu Central Hospital and Bwaila Psychiatric Unit.

7. I held meetings with representatives of the Federation of Disability Organisations in Malawi, officials from Central Medical Stores Trust and Office of the Director of Public Procurement.

8. The investigation reveals maladministration and injustices as follows:

   i. Failure by the Ministry of Health to provide comprehensive information to the general public regarding the closure of Bwaila Psychiatric Unit and the new systems put in place for accessing mental health services was unreasonable and unfair omission of duty.

   ii. Failure to enhance the capacity of the Districts to handle their own patients before effecting the strict referral system amounted to unreasonable exercise or performance of duties.

   iii. Failure to provide space specifically for treating patients with mental disorders within the district hospitals resulting in them being treated together with other patients amounts to unfair treatment of patients generally and patients with mental disorders in particular.

   iv. Failure by Ministry of Health to address the persistent problem of acute shortage of psychiatric staff thereby compromising quality of care for patients with mental disorders.

   v. Failure by Ministry of Health to use their Health Education Unit to conduct mass civic awareness campaigns as they do with other illnesses like HIV/AIDS is quite disturbing and amounts to unreasonable omission.

   vi. The inefficiencies regarding procurement of psychotropic drugs for patients with mental disorders amounts to negligence and unfair and unreasonable discharge of duties.

9. The following are the remedial actions ordered:

   i. The Lilongwe District Health Officer to assess its psychiatric staff needs

at Bwaila Hospital and fill the gaps from either Lilongwe district or Kamuzu Central Hospital. This should be done by 31st January, 2018.

ii. Secretary for Health to place public notification on the closure of Bwaila Psychiatric Unit through 2 radio stations that enjoy national coverage and all community radios in central region. The notification should also cover issues of mental health and mental wellbeing and should be aired for a period of 5 days not later than 22nd December, 2017.

iii. Kamuzu Central Hospital to start sending supervisory teams on a monthly basis to all District hospitals in the Central Region. To allow for proper planning of these activities I direct that such monthly visits begin in January 2018.

iv. Secretary for Health should facilitate a review of existing physical structures of its District hospitals to assess the possibility of establishing mental units by refurbishing the existing structures or constructing new ones. This should be done by March 2018.

v. Secretary for Health should put in motion all the processes or steps required for the final adoption and implementation of the National Mental Health Policy by 30th June, 2018.

vi. Starting from 2018/19 Financial Year the budget allocation to mental health from the national health budget should be increased from 1.1% to not less than 5%.

vii. Secretary for Health should include in their 2018/19 budget estimates funds for the construction of a proper referral mental hospital at Kamuzu Central Hospital premises in Lilongwe.

viii. The Secretary for Health should within the next 3 financial years starting from 2018/19 include in their budget estimates funds to construct at least 10 beds' wards (5 beds for each of the sexes) and an office in each of the district hospitals in central region for mental health services.

ix. The Secretary for Health in liaison with the Law Commission should put in place processes for the review of the Mental Treatment Act.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CMST	Central Medical Stores Trust
DHO	District Health Office
FEDOMA	Federation of Disability Organizations in Malawi
FY	Financial Year
HIV	Human Immunodeficiency Virus
KCH	Kamuzu Central Hospital
MoH	Ministry of Health
ODPP	Office of the Director of Public Procurement
St John of God	St John of God Hospitaller Services
TB	Tuberculosis
The Unit	Bwaila Psychiatric Unit

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A. BACKGROUND OF MENTAL HEALTH SERVICES DELIVERY IN MALAWI

1. Provision of mental health services started at Zomba Central Prison in 1910 when the first psychiatric patient was reported among the prisoners who were then under the King African Rifles in Zomba.

2. From then till 1916 mentally ill patients were under the administration of the army then referred to as the Nyasaland Volunteer Reserve. The services were provided in the Mental Asylum.

3. In 1917, Zomba Central Prison and the Mental Asylum took over the responsibility for the care of the mentally ill patients and the prison warders staffed the asylum. During this period no medical treatment was given to the patients even for their physical ailments, although the Government was concerned in providing a humane environment for the inmates.

4. In the 1930s, some medical treatment was offered but the authorities paid more attention to the diet and provided suitable activities under the supervision of the prison warders.

5. In 1952, with the advent of the phenothiazines antipsychotics, (basic medication for mental disorders) the Mental Asylum was handed over to the Director of Medical Services until 1953 when the present Zomba Mental Hospital was built.

6. The responsibility for the provision of mental health services was handed over to the then Ministry of Health and Population. A medical officer, working with one nurse and the prison warders who were already in the system, was appointed to take charge of the hospital. The hospital developed and became an important treatment center for persons with mental disorders from all parts of Malawi. The Ministry recruited psychiatrists, nurses, medical orderlies and later medical assistants and clinical officers to work in the center.

B. THE BASIS OF THE INVESTIGATION (COMPLAINT)

1. On 9th April, 2017 the Nation on Sunday carried an investigatory article written by a journalist Rabecca Chimjeka on Bwaila Psychiatric Unit (the Unit) titled ***'Bwaila Mental Ward goes insane'.***

2. The article which was as a result of an undercover tour of the facility that the journalist undertook revealed the deplorable conditions that patients are forced to live in and staff forced to work under at the clinic.

3. The article mentioned that patients were sleeping on the floor due to a shortage of beds in the ward forcing the facility to discharge them prematurely; some patients were seen eating from a burst sewer which had been left unattended to for months leaving human excreta all over the place.

4. Additionally, it revealed that in all seclusion rooms, violent patients can defecate and stay for days with faecal matter that developed maggots and patients were also seen fetching water spilling out of a blocked sewer pipe.

5. The article further revealed Government plans that had been there to close the Unit, transfer the patients and build another facility.

6. In short, the article raised a number of human rights violations and acts of maladministration by Ministry of Health (MoH) in the administration of mental health services in the Central Region. Accordingly, despite not receiving a formal complaint on this I decided to conduct an investigation into this matter as the violations reported were against one of the most vulnerable groups in society and also because I believed that the investigation would ultimately effect improvements in the mental health services in Central Region.

7. In the course of investigating this matter, the Government through MoH closed the Unit on 4th October, 2017. Following this closure, I decided to wind up this investigation but then there were two intervening factors that made me think otherwise;

   a. The exit interviews for the investigations showed that the closure of

the Unit had created more problems and revealed some deep systemic issues in mental health service delivery in Central Region.

b. The issue which was all over the social media about the woman who had allegedly killed her three children in Mchinji whilst under an epileptic psychosis attack. According to her medical report, this is one of the serious mental health disorders which can cause an individual to lose contact with reality. The intervention of the office in this matter fortified my views that there was need to thoroughly investigate the mental health services delivery system in the Central Region.

8. In so deciding, I took cognisance of the considerable amount of studies and reports that have been undertaken as regards mental health in the country. One such report was done by our sister institution the Malawi Human Rights Commission in March 2012, whose main focus was on the human rights violations in the mental health institutions which they visited across the country.

9. This investigation however has a completely different focus by looking at the systemic problems plaguing the mental health services generally in Central Region. Unlike the Southern Region and Northern Region which despite their own challenges has at least well-structured systems for mental health, the Central Region has none. Moreover, it is my considered view that the findings and recommendations herein can be easily replicated in the whole country if need be.

C. THE LEGAL MANDATE OF THE OFFICE OF THE OMBUDSMAN

1. The Office of the Ombudsman is an independent institution established by the 1994 Constitution and is complimented by the Ombudsman Act of 1996.

2. The Office of the Ombudsman has powers under section 123 (1) of the Constitution to investigate any and all cases where it is alleged that a person has suffered an injustice and there is no remedy available by way of court proceedings or there is no practicable remedy available to that person.

3. In addition, under section 5 (1) of the Ombudsman Act, the Ombudsman has the mandate to inquire and investigate any complaint laid before the Ombudsman concerning any alleged instance of abuse of power; unfair treatment; manifest injustice or conduct qualifying as oppressive or unfair in an open and democratic society; the exercise or performance of powers duties and functions in an unreasonable, unjust or unfair way. As per section 5 (2) this further includes decision or recommendation made by or under the authority of any organ of Government or any act or omission of such organ that is unreasonable, unjust or unfair or based on any practice deemed as such and also that the powers, duties and functions which vest in any organ of Government are exercised in a manner which is unreasonable, unjust or unfair.

D. ISSUES FOR INVESTIGATION

1. Whether there was maladministration by MoH in the manner in which the Unit was closed.

2. What are the existing systemic problems affecting mental health service delivery in the Central Region.

E. INVESTIGATION APPROACH

My approach to the investigation was as follows:

1. Physical visits to the Unit;

2. Interviews with the Principal Secretary of Health, the Director of Mental Health Services, 5 of the 9 District Health Offices (DHO) in Central Region, other members of staff in the MoH, the Acting Registrar of Medical Council of Malawi, the Director of Services for St John of God Hospitaller (St John of God);

3. Physical visit to Mwavele Village T/A Manthalu in Mchinji District, home of one of the patient with a mental disorder;

4. Visit with the Minister and Secretary for Health made to Kamuzu Central

Hospital (KCH) to appreciate the arrangements that had been put in place for patients with mental disorders following the closure of the Unit; and

5. Meetings with representatives of the Federation of Disability Organisations in Malawi (FEDOMA), officials from Central Medical Stores Trust (CMST) and Office of the Director of Public Procurement (ODPP).

F. EVIDENCE GATHERED

i. Observations of the Physical Structure of the Unit

1. The facility has only two wards; one for males and another for females. These wards have no separate rooms to isolate patients based on their mental conditions and age. All patients were put in one seclusion room and this caused chaos as patients who were violent tended to abuse the others. Usually, the under- age patients were the ones who suffered most as they were beaten and got injured.

2. The sewer system at the female ward constantly broke down and human excreta could visibly be seen in water drains. The bathrooms and toilets especially at the female ward have no doors. The wards did not have electricity and patients slept in darkness.

3. Furthermore, in the male ward there is a very big wall that was built to prevent patients from sneaking out of the ward. However due to the aging of the building this wall is on the verge of collapsing and this is a death trap to the patients because it is very close to their bathing area and most of the times these patients rest beside it.

4. The facility lacks enough beds to cater for all patients at the ward especially in the male seclusion rooms. This situation has resulted in patients fighting over beds at times resulting into injuries.

5. The Unit however has three rooms which are relatively new and adjacent to the Unit. They are used as offices for the psychiatric staff.

ii. Administrative Issues at Bwaila Psychiatric Unit

1. The facility was under the management of KCH and unfortunately it was by-passed in most of the top management decisions affecting it. This resulted in less support coming towards it and forcing the Unit to depend more on well-wishers.

2. The diet was very poor such that at one time patients demonstrated violently over food conditions at the unit.
3. Unavailability of essential drugs was also one of the big challenges affecting service delivery at the Unit. The Unit was getting drugs from CMST. However the drugs were not supplied on time and some drugs were not available. The most difficult drug to get is the Depot injection which is given to violent patients and those who resist taking oral medication.

4. The Unit also faced transport logistics problem to transfer patients to KCH for treatment whenever the patients were suffering from other diseases such as malaria and Tuberculosis (TB) because the Unit had no vehicle. Consequently, some patients died due to delay in accessing treatment.

5. The Unit was understaffed, populated with demotivated and under-qualified staff. At the time I visited the Unit in April 2017, there were 13 staff members against the required 33. It had only 2 psychiatric clinical officers to treat and handle up to 60 admitted patients and out patients.

6. The staff did not have materials in place to protect themselves against violent patients. As a result some of the staff had been hurt and lost teeth during the violent incidents. Despite working in such an environment, the risks of working with patients with mental disorders are undermined and the staff is not given any incentives to motivate them to work.

iii. Events Leading to Closure of Bwaila Psychiatric Unit

1. The management of the Unit has since 2012 been writing to the Hospital Director of KCH to update him on the pathetic situation at the Unit.

2. The Unit was declared uninhabitable by Government in 2013 after an undercover journalist visited the Unit and revealed its pathetic conditions.

3. Despite this, there is no evidence to suggest that any action was done by the MoH towards rectifying the situation until 2017 when the Ministry took some concrete actions towards correcting the situation.

4. The MoH set up a committee to look into the matter which resulted in the drafting of guidelines on the management of psychiatric patients when the Unit is undergoing rehabilitation or construction works.

5. More discussion within the Ministry culminated into a memo issued by the Principal Secretary of Heath on 14th August, 2017 which for its importance in as far as this investigation is concerned is reproduced below;

Ref. No. CD/21 14th August, 2017

FROM : SECRETARY FOR HEALTH, MINISTRY OF HEALTH, P.O. BOX 30377, LILONGWE 3.

TO : ALL CENTRAL HOSPITAL DIRECTORS

ALL DISTRICT HEALTH OFFICERS

CC : CHIEF OF HEALTH SERVICES

DIRECTOR CLINICAL SERVICES

DIRECTOR MENTAL HEALTH SERVICES

DIRECTOR NURSING AND MIDWIFERY SERVICES

DIRECTOR PLANNING AND POLICY

HEAD OF QUALITY MANAGEMENT DEPARTMENT

CLOSURE OF BWAILA PSYCHIATRIC UNIT FOR MAJOR REHABILITATION WORKS

Kamuzu Central Hospital provides tertiary psychiatric services at Bwaila Psychiatric Unit. The unit is housed in an old building which was constructed in 1939 and currently it is in dilapidated state that poses a safety and hygienic risk to both patients and staff.

It is against this background that the Ministry has recommended that the facility be closed to pave way for major rehabilitation works. The facility will officially close for inpatient services from **4th September 2017.**

The Ministry has laid out the following guidelines to be adhered to once the unit is closed. The guidelines are intended to support the continuous provision of mental health services to patients who access mental health services at Bwaila Psychiatric Unit.

- Bwaila Psychiatric Unit will be providing outpatient services and short stay services for management and monitoring of acute patients 48 hours before referral.
- Patients from the Central Region District Hospitals requiring further management shall be referred to Zomba Mental Hospital
- The patients will be referred to Zomba Mental Hospital via Bwaila Psychiatric Unit after undergoing a review by the Psychiatrist based at Kamuzu Central Hospital
- The Ministry will establish a service level agreement with St John of God Hospitaller Services-Lilongwe Services for admission of patients who may need emergency and further management.
- Mental health services in all district hospitals to be strengthened in order to prevent unnecessary referrals through having dedicated mental health professionals providing the services and beds for patients with mental and behaviour disorders
- Lilongwe DHO to strengthen Mental Health services for patients from within the district through OPD services.
- Bwaila Psychiatric unit and Lilongwe DHO staff to work together during this period in order to have adequate and strong team.
- The Psychiatrist based at Kamuzu Central Hospital will intensify district supervisions to support district mental health services

Looking forward to your usual cooperation.

Dr. Dan Namarika.
SECRETARY FOR HEALTH

6. Further follow ups at the Unit showed that the operations were still continuing even after 7th September, 2017. However, I observed that as time progressed, the operations had scaled down to attending to outpatients only with those requiring longer treatment being referred to Zomba Mental Hospital or St John of God.

7. The Unit was completely closed on 4th October, 2017. All the patients that were under short stay then were referred to Zomba Mental Hospital.

8. At that time, it was not clear as to what arrangements had been put in place for patients who were initially getting help from the Unit. All I was told was that there would be special arrangements made at KCH. Nothing specific was said.

9. During the same time, social media was awash with a video clip of a woman with a mental disorder at Maula prison who was being interviewed for a Mother's Day special programme and presented serious psychiatric signs. Her story and the fact that she was incarcerated whilst obviously suffering from an acute type of mental disorder made me wonder how such patients will fair with the closing down of the Unit. I, therefore, resorted to widening my investigation to all the DHOs in the Central Region.

iv. District Health Officers' Experiences Following Bwaila Psychiatric Unit's Closure

1. I managed to speak to the District Health Officers and the Psychiatric staff from the following district hospitals; Lilongwe, Mchinji, Ntchisi, Nkhotakota and Dedza. My efforts to speak with the other District Health Officers proved futile. I, however believe that the issues raised by the District Health Officers I spoke with would be similar to the others as well.

2. One major problem that the Unit's closure has caused is the lack of space within the DHOs to handle psychiatric patients. Initially, the DHOs could easily refer patients to the Unit without necessarily having to admit them. With the closure, the referral system has been tightened and they have had to admit those patients in the district

which has brought to fore the problem of space. Due of the nature of mental disease it is never advised to treat patients with mental disorders especially the violent ones in general wards which is what is happening now.

3. Related to this, is the issue of unavailability and insufficiency of drugs to treat the patients with mental disorders now that they have to handle them on their own.

4. The situation is made worse by the fact that mental health services is only allocated 1.1% of the national health budget and it does not enjoy much financial support from donors as compared to other diseases like HIV/AIDS, cancer etc. Without resources there is nothing much that can be done to improve mental health services both at national and district level and yet this is a real problem.

5. Another problem is the dire shortage of psychiatric staff in the District Hospitals. Apart from Dedza and Mchinji DHO which claimed to have quite sufficient number of psychiatric staff the situation is quite pathetic in the other districts with Dowa, Nkhotakota and Lilongwe only having one psychiatric staff to handle all the psychiatric patients in their respective districts.

6. It also became apparent that currently after graduation, the interns are only attached to four departments: Paediatrics; Obstetrics; Surgery; and the Medical department leaving out the psychiatry department. This is in spite of the fact that whilst as undergraduate students, they are attached to the psychiatry department.

7. Generally, all the DHOs interviewed made mention of difficulties experienced due to the new system put in place as a result of the Unit's closure. Lilongwe DHO specifically made reference to those patients coming from other regional districts who used to come straight to the Unit to get medication but are now being sent back to their respective district hospitals. Neither the patients nor the guardians were informed of the changes.

8. Another issue is the lack of capacity to handle violent patients. It is clear the District hospitals are struggling when it comes to this and have had to resort to using the police to administer medication to some of these patients.

v. Alternative Arrangements for Psychiatric Patients at Kamuzu Central Hospital

1. Together with the Minister and Secretary for Health I visited KCH to appreciate the arrangements that have been put in place as a result of the Unit's closure.

2. We were shown a room set aside next to the short stay section with three beds. Patients will be held for a period of not more than 48 hours for observance and stabilisation before being referred to St John of God or Zomba Mental Hospital for further treatment if necessary.

3. The Head of Department of Psychiatry at KCH gave a brief which highlighted the present status of mental health service delivery in Central Region as follows:

   a. 80% of the patients referred to the Unit were from Lilongwe DHO;

   b. Zomba Mental Hospital capacity to absorb patients from the Unit and Central Region referrals is very limited as the Hospital is operating at 100% capacity at most times. Even when space is available, when the number of patients exceed the facility's actual functional capacity, the patient care and staff safety is compromised;

   c. The mental health carer to population ratio is poor across the region ranging from 1: 80,840 in Nkhotakota to 1: 558,470 in Dowa; and

   d. Availability of the basic psychotropic medications which are supposed to be available at primary and secondary levels remains erratic. This forces patients to circumvent local health structures and this puts pressure on tertiary facilities like the Unit.

G. THE LEGAL AND POLICY FRAMEWORK FOR MENTAL TREATMENT

1. Mental disorder is recognised as a disability in Malawi and therefore falls under the legal framework of the Disability Act (No. 8 of 2012) which is a relatively new piece of legislation. However the treatment of Patients with mental disorders is primarily governed by the Mental Treatment Act (Cap 34:02 of the Laws of Malawi). This law was promulgated in 1948 and therefore out of touch with the current trends in mental health service delivery.

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

H. ANALYSIS

1. As clearly observed above, Mental Health in Malawi has a fractured and poor history. This history unfortunately set a very bad and negative tone to the manner in which mental health services are handled. To date Mental Health remains undeveloped, heavily underfunded and effectively ignored area of health service delivery in the country.

2. This is clearly evidenced in this case by physical condition of the Unit itself as described in paragraph (F) (i) above. No human being let alone patients with mental disorders deserved to be kept in that kind of environment. Despite the building being declared uninhabitable about 5 years ago, neither decisive action was taken towards rectifying this nor were alternative measures put in place.

3. The closure itself has revealed other systemic problems and has created further challenges with mental health systems in Central Region in particular and the country in general requiring correction.

4. One major issue that has arisen from the closure of the Unit is the acute lack of space in the District Hospitals and even KCH to accommodate patients with mental disorders. This has resulted in a situation where patients with mental disorders including violent ones are accommodated

in the general wards thereby compromising the quality of care towards them and exposing other patients to danger.

5. The situation is worse at Lilongwe DHO which fully relied on the Unit. With the closure, Lilongwe DHO is struggling to create space to treat its psychiatric patients. This is clearly a breach of section 6(2)(c)of the Disability Act which obliges Government to provide persons with disabilities with the same range, quality and standard of free or affordable health care services as provided to other persons.

6. Another anomaly that is also clear is the non-availability of information to the general public especially the patients about the closure of the Unit and the referral systems put in place for people to access mental health services. I am aware that one of the newspapers carried an article on the closure of the Unit although without detailed information on the referral system. However, very few people especially in rural areas have access to the national newspapers. The MoH had a duty to inform the general public of the new arrangements. The general public deserves to know all of this.

7. Following the Unit's closure, the District Hospitals are now expected to handle most of the issues or ailments of their patients with mental disorders within their respective Districts. Referral to KCH will only be approved by KCH after the District Hospitals has failed to treat the patient, or requires further assessment by KCH, Zomba Mental Hospital or St John of God.

8. My interviews with the District Health Officers showed that there is some levels of panic on the closure of the Unit as the strict referral systems had to be implemented immediately after the closure. Almost all the Districts bemoaned lack of capacity in terms of shortage of staff, funding and medication to handle the patients. KCH and all DHOs interviewed except for Mchinji and Dedza lamented about the shortage of psychiatric staff.

9. The situation is so bad such that DHO at the moment is operating with 13 psychiatric staff against a population of about 2.7 million residents in the district (according to the National Statistics Office 2017 projections). With

such disproportionate figures, it is impossible to attain quality mental health care.

10. This problem of staff however starts from how the training for Doctors is designed. Whilst the undergraduates are exposed to the different aspects of the medical profession including Psychiatry, during the internship, psychiatry is completely shunned thereby further depriving additional and potential psychiatric staff. To think that Medical Council has overlooked this issue for years is beyond my comprehension.

11. The issues of privacy are also apparent with the new arrangement that has been made at KCH following the Unit's closure. There is no proper demarcation for male and female patients in the room. The right to privacy is being heavily compromised contrary to section 21 of the Constitution.

12. My investigation further revealed that other District Hospitals simply use offices when conducting consultations with mental patients and there is no sense of privacy during such times.

13. Despite the MoH having a unit for Health Education almost all DHOs and the Mental Health Director acknowledged that not much is being done to sensitise the public on mental health as has been done with other diseases like Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS), cancer etc. It is general knowledge that during the early years HIV/AIDS, there was so much stigma attached to it. However with massive and intensive civic awareness, the disease has been demystified and shame removed from it such that it is easy for people to come out, declare their status and get the necessary help.

14. The Nation newspaper of 27th November, 2017 carried an article titled ***'Mental Illnesses remain Neglected- Study'*** done by St John of God assessing the number of mental patients who are assessing mental health services in hospitals. It was their finding that the patients they see in hospitals are fewer than those in communities. Such patients keep the illness in the home due to lack of knowledge and widespread cultural beliefs. The evidence gathered showed that over 50% of mental patients that the research has come across have never visited a hospital.

15. The recent case of the patient with mental disorder mentioned in paragraph (B)(7)(b) above is on point. My visit to her home revealed to me how mental health services are so detached from majority of Malawians. Despite showing signs of mental problems when she had her first child 23 years ago, nobody in the village thought of taking her to the hospital instead they continued to give her medication from traditional healers. So many lives could be lost in this country especially in such kind of remote communities due to mental health problems.

16. The availability of mental drugs is critical across the country. As I got to learn during this investigation, when there is low drug supply, the relapse levels increase and pressure on the hospitals increases.

17. During my interviews with officials from CMST and ODPP on this issue of non-availability of drugs, I was reliably informed that there is a positive turn around in the situation in that CMST is now using Framework Agreements in procuring psychotropic drugs. These agreements have enabled CMST to order drugs as and when required from a pool of selected suppliers. However for this system to actually work effectively there is need for money to buy the medication and also most importantly there is need for improved monitoring of the medical stocks as these are protected drugs whose procurement meets with a lot of restrictions and therefore takes long.

18. The general legal framework of mental health in Malawi leaves a lot to be desired. That to date we are still relying on a piece of legislation dating back to 1948 simply shows how much as a country we disregard this aspect of health. The same goes for the policy framework which has been in draft form since 2014 without any good reasons at all.

I. FINDINGS

1. The failure by the MoH to provide comprehensive information to the general public regarding the closure of the Unit and the systems put in place for people in the Central Region to access mental health services was unreasonable and unfair omission of duty and therefore maladministration.

2. By closing the Unit and effecting the new referral system before putting measures to strengthen the capacity of the Districts to handle their own patients amounted to unreasonable exercise or performance of duties. It was maladministration.

3. The general lack of space within the District Hospitals forcing the staff to confine patients with mental disorders to small spaces as well as treating them together with other patients amounts to unfair treatment of patients generally and patients with mental disorders in particular. Same treatment does not result in equality, as their respective conditions and needs are different necessitating different interventions.

4. The acute shortage of psychiatric staff across the country is another area of concern that compromises quality of care for patients with mental disorders. Whilst I appreciate that this is also common in other areas of health service delivery, the situation in mental health is quite dire and has been the case since mental health was acknowledged in this country. The failure by MoH to intervene amounts to unreasonable and unfair omission. It is maladministration.

5. The failure by MoH to use their Health Education Unit to conduct mass civic awareness campaigns as they do with other illnesses like HIV/AIDS is quite disturbing and reveals how much inattention this issue is granted and amounts to unreasonable omission of duty.

6. The unavailability of psychotropic drugs across the hospitals in the country more so where the same is as a result of inefficiencies within the system is another worrisome matter. Where patients' conditions worsen simply because an institution did not timely make the necessary orders with CMST is negligence, unfair and unreasonable discharge of duties. It is maladministration.

J. INJUSTICE OCCASSIONED

1. The stigmatisation of patients with mental disorders started way back in the 1930s when as a country we decided to treat the patients as prisoners requiring incarceration and monitoring by prison warders. With this the stigmatisation was complete and despite legal and policy interventions

in the area, no improvement worth mentioning has happened. To date, mental health remains a heavily ignored section of health service delivery.

2. The problems that have plagued mental health care ever since remain nicely laid out in various papers and reports that have been produced with no comprehensive action taken. They are simply ignored. The sad part is that we are doing this to a most vulnerable group of health seekers who cannot speak for themselves. Instead of creating a system that helps such patients, we continue regarding them as a group of people that we would rather keep out of sight and as demonstrated in this investigation, out of mind. It is a very shameful thing for Malawi as a country to do. It is a far cry from justice.

K. REMEDIAL ACTIONS

1. Under Section 126 of the Constitution and also section 8 of the Ombudsman Act, I am empowered to direct an appropriate administrative action to be taken to redress the grievance and also cause an appropriate authority to ensure that there are in the future reasonably practicable remedies to redress the grievance.

2. In short the law gives me powers to remedy the injustice occasioned as explained above. From the foregoing, it is my view that the injustice occasioned can only be remedied by way of immediate and long term interventions. I have therefore categorised my directives as such.

a. Immediate Interventions

1. The DHO Lilongwe should assess its psychiatric staff needs at Bwaila Hospital and try to fill the gaps from the Lilongwe district. If the same cannot be satisfied with staff from within Lilongwe District, she should submit a formal request to the Secretary for Health so that staff that previously worked at the Unit and had been deployed to various sections at KCH can be re-posted to Bwaila Hospital by 31st January, 2018.

2. I note that there is a big disconnect in terms of knowledge of information about the Unit's closure between the medical staff and

the general public especially those from remote areas. Accordingly, I direct that Secretary for Health should notify the public through 2 radio stations that enjoy national coverage and all community radios in Central Region about the closure of the Unit and also the systems that people have to follow when seeking mental health services. The programme should also cover issues of mental health and mental wellbeing. This programme should be aired for a period of 5 days and no later than 22nd December 2017.

3. Following the Unit's closure, the District Hospitals are now expected to handle most of the issues or ailments of their mental patients within their respective districts. I, therefore, direct that KCH sends supervisory teams on a monthly basis to all District hospitals in the Central Region. These visits should be aimed at mentoring the staff at district level and also monitor the staffing levels, mental health activities being carried out and also assess management commitment to mental health issues. To allow for planning of these activities, I direct that such monthly visits begin in January 2018.

4. Secretary for Health should facilitate a review of existing physical structures of its District hospitals to assess the possibility of establishing mental units by refurbishing the existing structures or constructing new ones. This should be done by March 2018.

5. Medical Council should revisit its current curriculum for internship program and ensure that the psychiatry department also highly features as is done with the other departments. I direct that this should begin with the current cohort of final year students who will be finishing their studies in May 2018.

6. In the absence of any known process for the review of the Mental Treatment Act of 1948, the National Mental Health Policy that is still in draft form provides an opportunity for revolutionalisation of mental health systems in the country. I, therefore, direct that the Secretary for Health should put in motion all the processes or steps required for the final adoption and implementation of the National Mental Health Policy. The adoption should be done by 30th June, 2018.

b. Long Term Interventions

1. One of the wicked and stubborn problems with mental health services is meagre funding that is allocated to mental health. To this end I direct that from the 2018/19 Financial Year (FY) the allocation to mental health from the national health budget should be not less than 5%.

2. Central Region needs a proper referral mental hospital. The adhoc arrangement currently at KCH should be deemed as such. I thus direct that an allocation be made from the 2018/19 FY national budget for the construction of a proper referral mental hospital at KCH Premises in Lilongwe.

3. Related to number 2 above and based on the report to be produced after the review visits referred to in Paragraph (K) (a) (5) I further direct that Government through the MoH should within the next 3 financial years starting from the 2018/19 FY, construct at least 10 beds ward (5 beds for each of the sexes) and an office in each of the district hospitals in the Central Region.

L. RECOMMENDATIONS

1. I have observed that the present establishment of the MoH makes it easy for mental health to be overlooked. To this end, I strongly recommend that MoH reviews its establishment to ensure that mental health enjoys the prominence that it deserves.

2. MoH should put measures that ensure monitoring of drug stocks by its health facilities so that they make timey requests to CMST. In turn ODPP and CMST should continue exploring means and ways of improving procurement systems of psychotropic drugs.

Dated this 5th Day of December, 2017

Martha Chizuma
OMBUDSMAN

ANNEX 1: LIST OF PEOPLE INTERVIEWED

Name	Designation
1. Dr. Dan Namarika	Secretary for Health
2. Mrs. I. Chamangwana	Director of Mental Services
3. Dr. Bakali	DHO Mchinji
4. Dr. Solomoni Jere	DHO Dedza
5. Dr. Zondwayo Ng'oma	DHO Ntchisi
6. Dr. Alinafe Mbewe	DHO Lilongwe
7. Dr. Soften Sankhulani	DHO Nkhotakota
8. Dr. Jonathan Ngoma	Hospital Director- KCH
9. Mrs. Lucy Magola	Matron- Bwaila Psychiatric Unit
10. Mr. Stanley Tepeka	Psychiatric Clinical Officer
11. Mr. Nyasulu	Chief Hospital Administrator - KCH
12. Mr. Charles Mwale	Director of Services- St John Of God
13. Mr. Micheal Uledi	Ass. Director of Clinical Services- MoH
14. Mr. Luciano Kumisale	Patient Attendant- Bwaila Psychiatric Unit
15. Ms. Rebecca Chimjeka	Journalist
16. Ms. Violet Mwale	Psychiatric Patient
17. Mr. Richard Ndovi	Acting Registrar for Medical Council
18. Mr. Symon Munde	Deputy Director of FEDOMA
19. Mr. Joe Khalani	CMST
20. Mr. Charles Khombeni	CMST
21. Mr. Leonard Kumwenda	ODPP
22. Mr. Feston Kaupa	CEO CMST
23. Dr. Moses Chisale	CMST


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Grace Building
Opp Reserve Bank
P/Bag 12
MZUZU
TEL: 0111 643 778

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P/Bag 171
BLANTYRE
TEL: 01 833 317

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