Human Rights Gaps in Zambia's Mental Health Legal Framework: A Doctrinal Analysis of the Mental Health Act No. 6 of 2019

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ABSTRACT

This study critically examines human rights gaps in Zambia's mental health legislation and policy framework, with particular focus on the Mental Health Act No. 6 of 2019. The overall objective of the study was to analyze the extent to which Zambia's mental health legislation and policies align with international human rights standards and to identify gaps affecting the protection of the rights of persons with mental health conditions. Specifically, the study sought to examine alignment with international frameworks such as the Convention on the Rights of Persons with Disabilities (CRPD), identify key human rights provisions, analyze gaps and inconsistencies, assess governance and accountability mechanisms, evaluate the protection of specific rights such as legal capacity and freedom from coercion, and propose evidence-based reforms.

A qualitative doctrinal research design was employed, relying on document analysis of legal instruments, policy documents, and international frameworks. The findings reveal that the Mental Health Act No. 6 of 2019 represents a significant shift from a custodial to a rights-based framework, incorporating principles such as dignity, non-discrimination, and access to mental health services. However, substantial gaps remain, including the persistence of substituted decision-making, broad provisions for involuntary admission and treatment, weak accountability mechanisms, and limited prioritization of community-based care.

The study concludes that while Zambia has made notable progress in reforming its mental health legislation, the current framework remains only partially aligned with international human rights standards. It recommends comprehensive legal and policy reforms, including strengthening autonomy, reducing coercive practices, enhancing accountability, and promoting community-based mental health care to ensure full protection of human rights.

Keywords: Mental health legislation, human rights, Mental Health Act No. 6 of 2019, Zambia, CRPD, legal capacity, involuntary treatment, community-based care, mental health policy, governance and accountability

INTRODUCTION

Mental health is increasingly recognized as a fundamental component of overall health and well-being, as well as a critical human rights issue. Globally, there has been a paradigm shift from institutional and custodial models of mental health care toward rights-based, person-centered approaches that prioritize dignity, autonomy, and social inclusion. This transformation is strongly reflected in international human rights instruments such as the Convention on the Rights of Persons with Disabilities, which establishes a comprehensive framework for protecting the rights of persons with psychosocial disabilities, including equal recognition before the law, freedom from coercion, and the right to live independently within the community (United Nations, 2006). Complementing this, the World Health Organization has advanced global mental health reforms through guidelines that emphasize community-based care, integration of mental health into primary healthcare systems, and the promotion of human rights–based approaches (World Health Organization, 2021).

In many low- and middle-income countries, including Zambia, mental health systems have historically been shaped by colonial-era legislation that prioritized institutionalization, social control, and public safety over the rights and autonomy of individuals. In response to both international obligations and domestic constitutional demands, Zambia enacted the Mental Health Act No. 6 of 2019, replacing the outdated Mental Disorders Act of 1949 with a more progressive and rights-oriented legal framework. The Act seeks to promote access to mental health services, safeguard the dignity of individuals, and align national legislation with international human rights standards (Republic of Zambia, 2019).

Despite these significant legal reforms, emerging evidence indicates that substantial gaps persist between legislative intent and practical implementation. While the Act incorporates key human rights principles, challenges remain in critical areas such as legal capacity, informed consent, protection from coercion, access to community-based care, and the effectiveness of accountability mechanisms. These challenges reflect broader systemic constraints, including limited financial resources, inadequate institutional capacity, and persistent stigma and discrimination associated with mental health conditions (Kapungwe et al., 2010; World Health Organization, 2021). Consequently, the mere existence of progressive legal provisions does not necessarily translate into the effective realization of rights in practice.

Background of the Study

Mental health has gained increasing recognition as both a public health priority and a human rights concern. International frameworks such as the Convention on the Rights of Persons with Disabilities emphasize the principles of dignity, autonomy, non-discrimination, and equal recognition before the law, thereby obligating States Parties to align their domestic legal and policy frameworks with these standards (United Nations, 2006). Similarly, the World Health Organization underscores the need for mental health systems to be grounded in human rights principles, ensuring access to quality care, participation in decision-making, and protection from abuse and coercion (World Health Organization, 2021).

Historically, Zambia's mental health system was governed by the Mental Disorders Act of 1949, a colonial-era law characterized by a custodial approach that emphasized detention and control rather than treatment, rehabilitation, and rights protection. This framework also contained derogatory and discriminatory terminology, which was challenged in the landmark case of *Mwewa and Others v Attorney General*, where the High Court declared such provisions unconstitutional for violating principles of dignity and equality (High Court of Zambia, 2017). This judicial intervention highlighted the urgent need for comprehensive legislative reform.

The enactment of the Mental Health Act No. 6 of 2019 marked a significant milestone in addressing these historical deficiencies. The Act introduces provisions aimed at promoting and protecting the rights of persons with mental health conditions, including safeguards relating to informed consent, confidentiality, and access to services. It also establishes institutional mechanisms such as the National Mental Health Council to enhance oversight and accountability (Republic of Zambia, 2019). These developments signal Zambia's commitment to aligning its mental health framework with international human rights obligations.

However, despite these advancements, evidence suggests that critical human rights gaps persist within the legal and policy framework. For instance, key areas such as community-based care, social inclusion, and support systems remain insufficiently addressed, limiting the full realisation of rights for persons with mental health conditions (Sikazwe et al., 2022). Furthermore, the continued reliance on substituted decision-making frameworks raises concerns regarding compliance with Article 12 of the CRPD, which advocates for supported decision-making and equal legal capacity (United Nations, 2006). This indicates an ongoing misalignment between national legislation and international human rights standards.

Problem Statement

Despite the enactment of the Mental Health Act No. 6 of 2019, which represents a progressive shift toward a rights-based approach, significant challenges remain in ensuring the effective protection and promotion of the rights of persons with mental health conditions in Zambia. While the Act seeks to align with international

standards such as the Convention on the Rights of Persons with Disabilities, existing evidence suggests that notable gaps persist both within the legislation itself and in its implementation (Republic of Zambia, 2019; United Nations, 2006).

Current scholarship highlights persistent structural barriers, including limited access to services, stigma and discrimination, and inadequate resource allocation (Kapungwe et al., 2010; World Health Organization, 2021). However, there remains a lack of comprehensive doctrinal analysis examining the extent to which Zambia's legal and policy framework fully complies with international human rights standards. Critical issues such as restrictions on legal capacity, the use of involuntary treatment, weak accountability mechanisms, and insufficient emphasis on community-based care remain underexplored (Sikazwe et al., 2022).

Moreover, the gap between legislative provisions and their practical implementation raises concerns regarding the effectiveness of the current framework in safeguarding human rights. Weak institutional capacity, limited funding, and inadequate policy coordination further undermine enforcement and accountability mechanisms, thereby limiting the realization of rights in practice (Kapungwe et al., 2010; World Health Organization, 2021).

Accordingly, this study addresses this gap by undertaking a comprehensive human rights–based analysis of Zambia's mental health legislation and policy framework. It critically examines the extent of alignment with international standards and identifies key gaps that hinder the effective protection of the rights and dignity of persons with mental health conditions.

General Objective

To critically analyze the human rights gaps in Zambia's mental health legislation and policy framework, with particular focus on the Mental Health Act No. 6 of 2019, in order to assess its alignment with international human rights standards.

Specific Objectives

1. To examine the extent to which Zambia's mental health legislation and policies align with international human rights standards, particularly the *Convention on the Rights of Persons with Disabilities (CRPD)* and WHO guidelines.

2. To identify and critically analyze human rights provisions within the Mental Health Act No. 6 of 2019 and related policy documents, focusing on key principles such as dignity, autonomy, non-discrimination, and informed consent.

3. To identify and analyze gaps and inconsistencies within Zambia's mental health legislation and policy framework in relation to international human rights standards.

4. To analyze the legal and policy provisions relating to governance, oversight, and accountability mechanisms in the protection of mental health rights in Zambia.

5. To examine the extent to which Zambia's mental health legislation and policies provide for the protection of key human rights, including legal capacity, freedom from coercion, and access to community-based care.

6. To propose evidence-based recommendations for strengthening mental health legislation and policy frameworks in Zambia in line with international human rights standards.

Research Questions

Main Research Question

To what extent does Zambia's mental health legislation and policy framework align with international human rights standards in protecting the rights of persons with mental health conditions?

Specific Research Questions

1. How does Zambia's mental health legislation and policy framework align with international human rights standards, particularly the *Convention on the Rights of Persons with Disabilities (CRPD)* and WHO guidelines?
2. What human rights provisions are contained within the Mental Health Act No. 6 of 2019 and related policy documents, particularly regarding dignity, autonomy, non-discrimination, and informed consent?
3. What are the key human rights gaps and inconsistencies within Zambia's mental health legislation and policy framework in relation to international standards?
4. What legal and policy provisions exist for governance, oversight, and accountability mechanisms in the protection of mental health rights in Zambia?
5. To what extent do Zambia's mental health legislation and policies provide for the protection of key human rights, including legal capacity, freedom from coercion, and access to community-based care?
6. What reforms are necessary to strengthen Zambia's mental health legislation and policy framework in line with international human rights standards?

Significance of the Study

This study is significant in several ways, particularly within the context of strengthening a human rights–based approach to mental health in Zambia.

Firstly, the study will contribute to the existing body of knowledge by providing a comprehensive human rights–based analysis of Zambia's mental health legislation and policy framework. While previous studies have largely focused on stigma, service delivery, and health system challenges, this research specifically interrogates the extent to which legal and policy instruments uphold internationally recognized human rights standards. In doing so, it fills a critical gap in literature by integrating legal, policy, and implementation perspectives.

Secondly, the study will be valuable to policymakers and government institutions, particularly the Ministry of Health and regulatory bodies responsible for mental health governance. By identifying specific human rights gaps within the Mental Health Act No. 6 of 2019 and related policies, the findings will provide evidence-based insights that can inform legislative review, policy reform, and improved regulatory frameworks. This is essential for ensuring alignment with international obligations such as the *Convention on the Rights of Persons with Disabilities (CRPD)*.

Thirdly, the study will benefit mental health practitioners and service providers by highlighting the extent to which human rights principles—such as dignity, autonomy, informed consent, and non-discrimination—are integrated into service delivery. The findings may guide the development of more rights-based practices, improve patient care, and promote ethical standards within mental health institutions.

Fourthly, the research will be important for advocacy groups, civil society organizations, and human rights bodies working in the field of mental health and disability rights. By providing empirical evidence on gaps and challenges, the study can support advocacy efforts aimed at protecting the rights of persons with mental health conditions and promoting inclusive, community-based care.

Fifthly, the study will contribute to academic development, particularly for students and researchers in public health, law, social work, and policy studies. It will serve as a reference point for future research on mental health governance, human rights, and health systems in Zambia and similar contexts.

Finally, the study has broader societal significance, as it seeks to promote the protection of the rights and dignity of persons with mental health conditions. By identifying gaps and proposing reforms, the research aims to

contribute to a more inclusive and equitable mental health system in Zambia, where individuals are not subjected to discrimination, neglect, or rights violations.

Scope and Delimitations of the Study

Scope of the Study

This study focuses on the analysis of human rights gaps within Zambia's mental health legislative and policy framework, with particular emphasis on the Mental Health Act No. 6 of 2019. It examines the extent to which national legislation aligns with international human rights standards, especially those articulated in the Convention on the Rights of Persons with Disabilities (United Nations, 2006).

The study addresses key thematic areas, including legal provisions on dignity, autonomy, non-discrimination, and informed consent; issues of legal capacity and decision-making; involuntary admission and treatment practices; governance and accountability mechanisms; and access to mental health services, particularly community-based care. Geographically, the study is confined to Zambia, while methodologically, it adopts a qualitative doctrinal approach based on systematic document analysis of legislation, policies, and international standards.

Delimitations of the Study

The study is subject to several delimitations. First, it focuses primarily on legal and policy frameworks and does not provide an in-depth clinical or epidemiological analysis of mental health conditions. Second, it adopts a human rights–based approach and does not extensively engage with alternative perspectives, such as biomedical or purely psychological models. Third, the study is limited in empirical scope, as it does not involve large-scale quantitative data collection due to time and resource constraints.

Additionally, the findings are context-specific and may not be fully generalizable beyond Zambia without appropriate contextual adaptation. Finally, the study focuses primarily on the period following the enactment of the Mental Health Act of 2019, with historical analysis included only to provide necessary context.

Conceptual Framework: Human Rights–Based Legal Analysis Model

This study is grounded in a Human Rights–Based Approach (HRBA), which conceptualizes mental health legislation as a normative framework through which states fulfil their obligations to respect, protect, and realize human rights. Central to this framework is the recognition that laws and policies must uphold dignity, equality, and autonomy, as articulated in international instruments such as the Convention on the Rights of Persons with Disabilities (United Nations, 2006).

Given the study's doctrinal research design, the framework focuses on analyzing the normative content, structure, and coherence of legal and policy provisions rather than their practical implementation. It provides a structured analytical lens for evaluating the alignment between national legislation and international human rights standards.

Core Assumption of the Framework

The framework is premised on the assumption that the degree of alignment between national mental health legislation and international human rights standards determines the level of protection afforded to persons with mental health conditions. Strong alignment is indicative of robust legal protection, whereas weak or inconsistent alignment reflects gaps requiring reform.

Key Components of the Framework

Independent Variable: Mental Health Legislation and Policy Framework

The independent variable comprises the primary unit of analysis, including the Mental Health Act No. 6 of 2019, national policies, and legal provisions relating to dignity, autonomy, legal capacity, non-discrimination,

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informed consent, freedom from coercion, and community-based care. These elements constitute the legal foundation for assessing human rights protection.

Analytical Lens: International Human Rights Standards

The framework employs international human rights standards as the benchmark for evaluation. These include the Convention on the Rights of Persons with Disabilities and guidelines developed by the World Health Organization (WHO, 2021). These instruments provide authoritative criteria for assessing compliance and identifying deficiencies.

Dependent Variable: Level of Human Rights Compliance

The dependent variable refers to the degree of alignment between national legislation and international standards, categorised as full compliance, partial compliance, or non-compliance. This is assessed across key dimensions such as legal capacity, autonomy, non-discrimination, informed consent, freedom from coercion, and community inclusion.

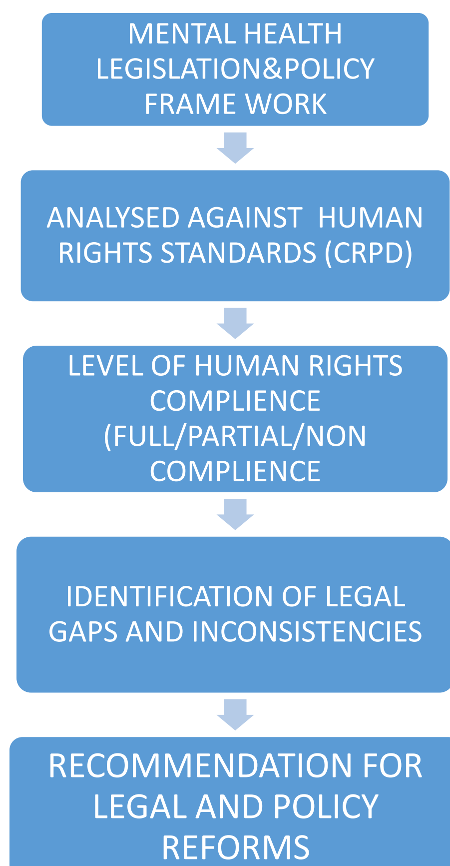
Output: Identification of Legal Gaps and Inconsistencies

The analytical process generates findings related to missing or underdeveloped provisions, weak or qualified protections, inconsistencies with international standards, and ambiguities affecting enforceability. These findings provide the basis for evidence-based recommendations for legal and policy reform.

Conceptual Relationships

The framework establishes a linear analytical relationship in which the mental health legislation and policy framework is evaluated against international human rights standards. This comparison determines the level of compliance, which in turn reveals legal gaps and inconsistencies. These gaps subsequently inform targeted recommendations for reform aimed at strengthening the protection of human rights.

Diagrammatic Representation



Application of the Framework to the Study

This framework guides the study by:

- Assessing alignment with international standards (Objective 1)
- Identifying human rights provisions (Objective 2)
- Detecting legal gaps and inconsistencies (Objective 3)
- Analysing governance and accountability (Objective 4)
- Evaluating protection of specific rights (Objective 5)
- Informing evidence-based recommendations (Objective 6)

Theoretical Foundation

This study is grounded in three complementary theoretical perspectives: The Human Rights–Based Approach (HRBA), Doctrinal Legal Theory, and Social Justice Theory.

The HRBA provides the central normative foundation, emphasizing that mental health is both a health and human rights issue. It requires legislation to uphold dignity, autonomy, non-discrimination, participation, and accountability, as articulated in the CRPD.

Doctrinal Legal Theory underpins the methodological approach by enabling systematic analysis of legal texts, including statutes and policies. It ensures that the legal framework is assessed for coherence, consistency, and compliance with international standards.

Social Justice Theory provides the ethical justification for reform by emphasizing equity, inclusion, and fairness, particularly for marginalized populations such as persons with mental health conditions. It reinforces the need for legal frameworks that promote both rights protection and social inclusion.

Together, these perspectives ensure that the study is legally rigorous, normatively grounded, and socially responsive.

Definition of Terms

- Mental Health: A state of well-being in which individuals realise their abilities, cope with normal stresses, and contribute to society (WHO, 2021).
- Mental Health Legislation: Legal frameworks governing mental health services and rights protection (Republic of Zambia, 2019).
- Human Rights: Fundamental rights inherent to all individuals (United Nations, 2006).
- Human Rights–Based Approach (HRBA): Integration of human rights principles into laws and policies (WHO, 2021).
- Legal Capacity: The right to make decisions on an equal basis with others (United Nations, 2006).
- Substituted Decision-Making: Decisions made on behalf of a person deemed incapable (WHO, 2021).
- Supported Decision-Making: Systems enabling individuals to make their own decisions (United Nations, 2006).
- Informed Consent: Voluntary agreement to treatment based on adequate information (WHO, 2021).

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- Involuntary Admission: Admission without consent under legal provisions (Republic of Zambia, 2019).
- Coercion: Use of force or pressure to compel treatment (WHO, 2021).
- Community-Based Mental Health Care: Services provided within community settings (WHO, 2021).
- Deinstitutionalisation: Transition from institutional to community care (WHO, 2021).
- Non-Discrimination: Equal treatment regardless of mental health status (United Nations, 2006).
- Dignity: Inherent worth requiring respect (United Nations, 2006).
- Autonomy: Right to make personal decisions (WHO, 2021).
- Accountability: Obligation to answer for actions and provide remedies (United Nations, 2006).
- Governance (Mental Health): Structures regulating mental health services (WHO, 2021).
- Mental Health Council: Statutory body overseeing mental health services in Zambia (Republic of Zambia, 2019).
- CRPD: International treaty protecting rights of persons with disabilities (United Nations, 2006).
- WHO Guidelines: International standards for rights-based mental health systems (WHO, 2021).

RESEARCH METHODOLOGY

Research Design

This study adopted a qualitative doctrinal research design, focusing on the systematic examination and interpretation of legal and policy documents relating to mental health in Zambia. A qualitative approach was deemed appropriate because the study seeks to explore and critically analyze the content, meaning, and implications of legal provisions, rather than quantify variables or measure outcomes. This approach allows for an in-depth understanding of how human rights principles are embedded within legislation and policy frameworks.

The doctrinal legal method specifically involves the analysis of statutory provisions, legal principles, and policy texts, with the aim of evaluating their consistency, coherence, and alignment with established international standards. In this study, the design enabled a critical assessment of the Mental Health Act No. 6 of 2019 and related policy documents against international human rights instruments such as the *Convention on the Rights of Persons with Disabilities (CRPD)* and World Health Organization (WHO) guidelines. By focusing on legal texts, the study provides a structured and rigorous evaluation of human rights compliance without reliance on empirical field data.

Study Area

The study was conducted within the legal and policy context of Zambia, with particular focus on national legislation and policy frameworks governing mental health. The selection of Zambia as the study area is justified by ongoing reforms in the mental health sector, particularly the enactment of the Mental Health Act No. 6 of 2019, which represents a shift toward a rights-based approach.

Although the study primarily focuses on national-level frameworks, it situates the analysis within a broader international context by comparing Zambian legislation with global human rights standards. This allows for a comprehensive understanding of how national laws align with international obligations. The study does not involve geographical fieldwork but instead examines the legal jurisdiction of Zambia as a unit of analysis, making it suitable for doctrinal research.

Target Population

The target population for this study consisted primarily of legal and policy documents relevant to mental health governance in Zambia. These documents form the core data source, as the study is based on document analysis. Key documents included legislation, national policies, strategic frameworks, and international instruments.

The methodological approach focuses exclusively on documentary sources, as these provide authoritative and verifiable evidence of legal provisions and policy intentions. This ensures consistency with the doctrinal research design and enhances the reliability of the findings by relying on official and published sources.

Sampling Techniques

The study employed purposive sampling to select relevant documents for analysis. This sampling technique is appropriate in qualitative and doctrinal research because it allows the researcher to deliberately select documents that are most relevant to the research objectives.

The selected documents included:

- The Mental Health Act No. 6 of 2019
- National health and mental health policies
- Strategic plans and guidelines
- International frameworks such as the CRPD and WHO guidelines

The use of purposive sampling ensured that the analysis focused on authoritative, relevant, and information-rich sources, thereby enhancing the depth and quality of the study. Unlike probabilistic sampling, which seeks representativeness, purposive sampling prioritizes relevance and analytical value.

Data Collection Methods and Tools

The study relied exclusively on document analysis as the primary method of data collection. Document analysis involves the systematic review and interpretation of written materials to extract meaningful information relevant to the research objectives.

Document Analysis

Document analysis was conducted on selected legal and policy documents to identify:

- Human rights provisions
- Legal principles and safeguards
- Gaps and inconsistencies
- Alignment with international standards

This method enabled the researcher to critically evaluate the normative content of the law, rather than its practical implementation.

To ensure rigour and consistency, the following data collection tools were used:

Document Analysis Guide

A structured Document Analysis Guide was used to systematically extract relevant information from each document. This tool ensured that all documents were analysed using a uniform framework, enhancing comparability and consistency.

The guide included:

- Document identification details (title, year, type, issuing authority)
- Key legal provisions related to human rights
- Governance and accountability structures
- References to international standards

This tool helped to organise data and ensured that no critical aspects of the documents were overlooked.

Human Rights Compliance Checklist

The Human Rights Compliance Checklist was used to assess the extent to which legal and policy provisions align with key human rights principles. Each principle was evaluated based on evidence from the documents.

The checklist covered:

- Dignity and respect
- Non-discrimination
- Legal capacity
- Informed consent
- Freedom from coercion
- Access to services
- Community-based care
- Accountability mechanisms

Each item was rated as Yes, No, or Partial, supported by textual evidence. This tool provided a structured and objective basis for evaluating compliance.

Human Rights Gap Analysis Matrix

The Gap Analysis Matrix was used as a core analytical tool to compare Zambian legal provisions with international human rights standards. It enabled the identification of:

- Areas of compliance
- Missing provisions
- Inconsistencies
- Required reforms

By systematically linking legal provisions to CRPD articles and WHO standards, this tool facilitated a clear and evidence-based gap analysis.

Data Analysis

Data were analysed using thematic analysis, guided by the Human Rights-Based Approach (HRBA). The analysis involved identifying patterns and themes within the legal and policy documents.

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The process included:

1. Familiarisation with documents
2. Coding of key human rights themes
3. Categorisation into thematic areas aligned with objectives
4. Comparison with international standards
5. Identification of gaps and inconsistencies

The Compliance Checklist and Gap Analysis Matrix were central to this process, ensuring that analysis was systematic, transparent, and aligned with the conceptual framework.

Trustworthiness of the Study

To ensure the quality and rigour of the study, the following criteria were applied:

- Credibility: Use of authoritative legal documents ensured accuracy
- Dependability: Structured tools provided consistency in analysis
- Confirmability: Findings were based on verifiable legal texts
- Transferability: Detailed descriptions allow application to similar contexts

These measures enhanced the validity and reliability of the study.

Ethical Considerations

The study adhered to ethical standards despite relying solely on documentary data. Ethical considerations included:

- Proper citation and acknowledgement of all sources
- Accurate representation of legal and policy content
- Avoidance of plagiarism

Since no human participants were involved, issues such as consent and confidentiality were not applicable. However, the study maintained academic integrity and transparency throughout.

Limitations of the Study

The study is limited by its reliance on document analysis, which does not capture practical implementation or lived experiences. As a result:

- Findings reflect legal provisions rather than real-world practice
- Some documents may be outdated or incomplete
- The study does not assess institutional performance

Despite these limitations, the approach provides a strong foundation for legal and policy analysis.

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Data Presentation And Analysis

Examining Alignment Switch International Human Rights Standards and the Mental Health Act No. 6 of 2019 (Zambia)

"As evidenced in Section 4 of the Mental Health Act No. 6 of 2019, the law explicitly recognizes dignity and human rights, stating that services must respect the dignity and fundamental freedoms of individuals."

Human Rights Compliance Checklist from the Mental Health Act No. 6 of 2019 (Zambia)

Human Rights Principle	Key Questions	Compliance	Evidence from the Act (Sections & Direct Quotes)	Critical Gap Analysis
Dignity & Respect	Does the law promote dignity and humane treatment?	Yes	Section 4 provides that mental health services shall be delivered in a manner that *"respects the dignity, human rights and fundamental freedoms of a person."*	Although dignity is explicitly recognized, the Act does not operationalizes this principle through enforceable standards. There are no detailed regulations governing conditions in mental health facilities or penalties for violations, making the provision largely aspirational rather than actionable.
Non-discrimination	Are there protections against discrimination?	Yes	Section 4 requires that services be provided in a manner consistent with human rights and equality, implicitly prohibiting discrimination.	The Act does not define discrimination in the mental health context, nor does it establish remedies, sanctions, or complaint procedures. This weakens enforcement and leaves individuals without clear legal recourse in cases of discriminatory treatment.
Legal Capacity	Does the law recognize equal legal capacity?	Partial	Under Part V (Treatment and Care), the Act allows consent to be provided by a guardian or authorized person where a patient is deemed incapable of making decisions.	This reflects a substituted decision-making model, which is inconsistent with CRPD Article 12. The absence of supported decision-making mechanisms (e.g., advance directives, assisted decision-making frameworks) limits autonomy and fails to recognize equal legal capacity.
Informed Consent	Are provisions for consent to treatment clearly stated?	Partial	The Act provides that treatment shall not be administered without consent, except under specified circumstances such as emergencies or involuntary admission.	Broad exceptions permitting treatment without consent undermine the principle of autonomy. The lack of stringent safeguards—such as independent review, strict criteria, and time limitations—creates potential for abuse and weakens compliance with CRPD standards.

Freedom from Coercion	Are involuntary admissions regulated and safeguarded?	Partial	Part IV (Admission of Patients) allows involuntary admission where a person poses a risk to themselves or others or lacks capacity.	The criteria for involuntary admission are vague and overly broad. Safeguards such as judicial oversight, legal representation, and periodic independent review are insufficiently detailed, increasing the risk of arbitrary detention contrary to CRPD Article 14.
Access to Services	Does the policy ensure equitable access to care?	Partial	Section 5 promotes the provision and integration of mental health services within the general healthcare system.	The Act lacks enforceable obligations on the State to ensure equitable access, particularly for rural and marginalized populations. It does not address funding, infrastructure, or human resource allocation, resulting in implementation gaps.
Community-Based Care	Are community services prioritized over institutional care?	Partial	The Act recognizes treatment in the least restrictive environment and includes provisions encouraging community-based care.	There is no explicit legal requirement prioritizing community-based services or deinstitutionalization. Institutional care remains dominant, indicating partial alignment with CRPD Article 19 on independent living and community inclusion.
Accountability Mechanisms	Are oversight and complaint systems provided?	Partial	The Act establishes the Mental Health Council under Part II to regulate and oversee mental health services.	The Council's enforcement powers are limited, and complaint mechanisms are not clearly accessible or independent. The absence of strong accountability and redress systems undermines effective protection of rights.

The analysis of the Mental Health Act No. 6 of 2019 demonstrates that Zambia has made significant progress toward aligning its mental health legislation with international human rights standards, particularly the *Convention on the Rights of Persons with Disabilities (CRPD)*. The Act reflects a deliberate shift toward a rights-based approach by explicitly incorporating key principles such as dignity and respect, as articulated in *Section 4*, which requires that mental health services be provided in a manner that respects the dignity, human rights, and fundamental freedoms of individuals. In addition, the legislation promotes non-discrimination and equality, affirms access to mental health services, and establishes regulated care and oversight structures, including institutional mechanisms such as the Mental Health Council.

Despite these advancements, the findings indicate that alignment with international human rights standards remains partial rather than full, with notable gaps in several critical areas. In particular, the Act continues to rely on substituted decision-making, which limits full recognition of legal capacity as required under *CRPD Article 12*. Similarly, provisions on involuntary admission and treatment are broadly framed, raising concerns regarding compliance with *CRPD Article 14* on freedom from coercion and arbitrary detention. The Act also demonstrates limited commitment to community-based care, with insufficient prioritisation of deinstitutionalisation, contrary to *CRPD Article 19*. Furthermore, although oversight structures exist, accountability mechanisms remain weak, with limited enforcement powers and unclear accessibility for affected individuals.

Overall, the Mental Health Act No. 6 of 2019 represents a progressive departure from earlier custodial legislation and signals an important move toward a human rights–based framework. However, it remains a transitional legal instrument, in which human rights are recognized in principle but not fully realized in practice. Achieving full compliance with international human rights standards will require targeted reforms, including strengthening

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provisions on autonomy and legal capacity, enhancing safeguards against coercion, clearly prioritizing community-based care, and reinforcing accountability and enforcement mechanisms.

Human Rights Provisions with Legal Evidence

Human Rights Principle	Legal Provision & Direct Citation from the Act	Alignment with International Standards	Detailed Findings	Critical Gap Analysis
Dignity and Respect	Section 4 states that mental health services shall be provided in a manner that *"respects the dignity, human rights and fundamental freedoms of a person."*	Aligns with CRPD Articles 1 & 17 (respect for dignity and integrity)	The Act establishes dignity as a foundational principle of care and reinforces humane treatment, confidentiality, and respect for individuals. This reflects a strong normative commitment to rights-based mental health care.	Despite this recognition, the Act lacks operational guidelines, monitoring systems, and sanctions for violations. Dignity is therefore not enforceable in practice, remaining largely aspirational.
Autonomy (Legal Capacity & Decision-Making)	Part V (Treatment and Care) emphasizes patient involvement in treatment decisions; however, it allows consent by a guardian or authorized person where capacity is lacking.	Partially aligns with CRPD Article 12 (equal legal capacity)	The Act promotes participation in decision-making and acknowledges patient involvement, indicating movement toward respecting autonomy.	The continued use of substituted decision-making undermines full legal capacity. The absence of supported decision-making frameworks (e.g., advance directives) reflects inconsistency with CRPD standards and limits autonomy.
Non-Discrimination and Equality	Section 4 requires services to be delivered in a manner consistent with *human rights and fundamental freedoms*.	Aligns with CRPD Article 5 (equality and non-discrimination)	The Act promotes equality in access to mental health services and supports integration into general healthcare systems, reducing stigma and exclusion.	The Act does not define discrimination or provide remedies, sanctions, or complaint procedures. This weakens enforcement and limits the effectiveness of non-discrimination protections.
Informed Consent	Part V provides that treatment shall not be administered without consent, except under specified conditions such as emergencies or involuntary admission.	Aligns with CRPD Article 25 (right to informed consent)	The Act recognises the importance of informed consent and requires provision of information regarding treatment options, supporting patient autonomy.	Broad exceptions allow treatment without consent, particularly in involuntary situations. Safeguards such as independent review and strict criteria are not sufficiently detailed, increasing risk of coercion and abuse.

The analysis of the Mental Health Act No. 6 of 2019 demonstrates that the Act incorporates key human rights principles—particularly dignity, autonomy, non-discrimination, and informed consent—thereby reflecting a clear shift toward a rights-based approach consistent with the Convention on the Rights of Persons with

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Disabilities. Notably, Section 4 affirms that mental health services must be delivered in a manner that *"respects the dignity, human rights and fundamental freedoms of a person"* , establishing a strong normative foundation for rights protection. However, the findings reveal that this alignment remains partial and largely theoretical, as many of these rights are limited in their practical application. Autonomy is constrained by the continued reliance on substituted decision-making, while informed consent is weakened by broad exceptions permitting treatment without consent in certain circumstances. Similarly, although non-discrimination is implied, the absence of clear definitions, remedies, and enforcement mechanisms undermines its effectiveness. Across all principles, a recurring gap emerges between legal recognition and enforceability, indicating that while the Act is progressive in principle, it remains transitional in implementation. Strengthening legal safeguards, enhancing accountability, and aligning more closely with CRPD standards are therefore necessary to ensure the full realization of human rights in practice.

Gap Analysis with Legal Evidence and International Standards

Identified Gap	Legal Provision & Evidence from the Act	Relevant CRPD Standard	Enhanced Analysis of the Gap	Implications for Human Rights Compliance
Incomplete Recognition of Legal Capacity	Part V (Treatment and Care) allows consent to be provided by a guardian or authorized representative where an individual is deemed incapable.	CRPD Article 12 (Equal recognition before the law)	Although the Act promotes participation in decision-making, it retains a substituted decision-making model. The absence of supported decision-making mechanisms such as advance directives or assisted decision frameworks limits recognition of individual will and preferences.	Undermines autonomy and equality before the law; reflects continued reliance on a medical model rather than a rights-based approach.
Broad Provisions for Involuntary Admission and Treatment	Part IV (Admission of Patients) permits involuntary admission where a person poses a risk or lacks decision-making capacity.	CRPD Article 14 (Liberty and security of person)	The criteria for involuntary admission are broad and discretionary, lacking strict legal thresholds. The Act does not clearly provide for independent review, mandatory legal representation, or periodic reassessment.	Creates risk of arbitrary detention and coercive treatment; weak safeguards compromise protection of liberty and security.
Weak Emphasis on Community-Based Care	The Act references community-based care but does not establish it as a mandatory or primary model of service delivery.	CRPD Article 19 (Living independently and being included in the community)	While community care is acknowledged, there are no binding obligations, implementation frameworks, or deinstitutionalization strategies. Institutional care remains dominant in practice.	Limits social inclusion and perpetuates institutionalization; fails to fully realize the right to independent living.
Limited Enforcement of Non-Discrimination	Section 4 promotes human rights and equality in service delivery but lacks detailed enforcement provisions.	CRPD Article 5 (Equality and non-discrimination)	The Act does not define discrimination in the mental health context, nor does it provide remedies, sanctions, or complaint procedures for violations.	Non-discrimination remains largely symbolic; absence of enforcement mechanisms weakens legal protection.

Qualified Nature of Informed Consent	Part V requires consent to treatment but allows exceptions in cases of involuntary admission and emergency care.	CRPD Article 25 (Right to health and informed consent)	Although informed consent is recognized, broad exceptions permit treatment without consent. Safeguards such as independent oversight and strict procedural controls are insufficiently developed.	Undermines autonomy and increases risk of coercion; results in only partial compliance with international standards.
Weak Accountability and Oversight Mechanisms	The Act establishes the Mental Health Council under Part II to oversee services.	CRPD Article 13 (Access to justice and remedies)	Oversight structures exist but have limited enforcement powers. Complaint and redress mechanisms are not clearly accessible, independent, or effective.	Weak accountability reduces transparency and limits access to justice for individuals whose rights are violated.
Lack of Explicit Resource and Implementation Guarantees	The Act promotes access to services but does not provide binding commitments on funding, service standards, or equitable distribution.	CRPD Article 25 (Right to health)	The absence of enforceable obligations on resource allocation and service delivery creates a gap between legal provisions and practical implementation, particularly in rural areas.	Results in unequal access to care and limits the realisation of the right to health; implementation depends on systemic capacity rather than legal guarantee.

The analysis of the Mental Health Act No. 6 of 2019 reveals that, despite incorporating key human rights principles, significant gaps and inconsistencies remain in its alignment with the Convention on the Rights of Persons with Disabilities. The findings indicate that the Act provides only partial compliance with international standards, particularly in critical areas such as legal capacity, involuntary admission, community-based care, accountability, and access to services. Notably, the continued reliance on substituted decision-making undermines full recognition of legal capacity, while broadly framed provisions on involuntary admission and treatment raise concerns regarding arbitrary detention and coercion. Furthermore, the Act does not establish community-based care as a binding priority, nor does it provide enforceable mechanisms for non-discrimination, accountability, or equitable resource allocation. Although oversight structures such as the Mental Health Council exist, their limited enforcement powers weaken the protection of rights in practice. Overall, the findings demonstrate that the Act reflects a transitional legal framework—progressive in its recognition of human rights but constrained by structural and legal limitations that hinder full implementation. Addressing these gaps through targeted reforms is essential for achieving full compliance with international human rights standards and ensuring the effective realization of rights for persons with mental health conditions.

Governance, Oversight, and Accountability

Key Area	Legal Provision & Evidence from the Act	Strengths Identified	Gaps and Limitations
Governance Framework	Part II establishes the Mental Health Council as the main regulatory and advisory body responsible for monitoring and promoting standards of care.	Establishes a formal governance structure and aligns with WHO recommendations on institutional oversight in mental health systems.	Limited enforcement powers; primarily advisory role; lacks authority to compel compliance; potential institutional overlap reduces effectiveness.
Oversight Mechanisms	The Act provides for inspection, regulation of facilities, and review of	Introduces monitoring and review processes, indicating recognition of oversight as a	Lack of independence, unclear inspection procedures, absence of

	decisions such as involuntary admission under relevant provisions.	key function in safeguarding rights.	comprehensive monitoring frameworks; weak operational effectiveness.
Accountability Mechanisms	Provisions under Part IV and Part V allow for review of decisions and complaints relating to treatment and admission.	Acknowledges the importance of accountability and provides a basis for challenging decisions affecting patients.	No clear complaint procedures, lack of legal aid, absence of sanctions and enforcement linkages; weak access to justice mechanisms.
Protection of Patients' Rights	Section 4 requires services to *"respect the dignity, human rights and fundamental freedoms of a person."*	Embeds human rights principles within governance structures and affirms protection of dignity and freedoms.	No independent monitoring bodies, lack of regular audits, limited awareness mechanisms; rights are recognized but not effectively enforced.
Coordination and Policy Integration	Mental health services are integrated into the broader health system under government coordination.	Promotes integration within national health systems, consistent with WHO recommendations.	Weak decentralization, unclear institutional roles, limited inter-sectoral coordination (e.g., justice and social services).
Resource and Capacity Framework	The Act outlines governance structures but does not provide binding provisions on funding or capacity building.	Establishes institutional structures that could support governance if adequately resourced.	No enforceable funding commitments, limited human resource provisions, weak institutional capacity; creates implementation gap.

The findings indicate that the Mental Health Act No. 6 of 2019 establishes a structured governance and accountability framework, marked by the creation of the Mental Health Council, the inclusion of oversight functions, and the integration of human rights principles such as dignity and respect. These elements demonstrate a clear effort to align with international standards, particularly the Convention on the Rights of Persons with Disabilities and WHO guidelines, by recognizing the importance of institutional regulation, monitoring, and accountability in safeguarding mental health rights. The presence of review mechanisms and regulatory provisions further reflects an emerging rights-based governance approach within Zambia's mental health system.

However, despite these structural advancements, the governance and accountability framework remains functionally limited and only partially effective. Key weaknesses include the absence of strong enforcement powers, limited independence of oversight bodies, underdeveloped complaint and redress mechanisms, and lack of binding resource commitments. These gaps significantly undermine the practical realization of human rights, as governance structures exist largely at a formal level without sufficient capacity or authority to ensure compliance. Consequently, the system reflects a transitional model, where institutional frameworks are in place but lack the operational strength required to provide effective protection, accountability, and access to justice in line with international human rights standards.

Protection of Key Human Rights

Human Rights Area	**Legal Provision & Evidence from the Act**	**Alignment with CRPD Standards**	**Enhanced Findings**	**Critical Gaps and Implications**
Legal Capacity & Autonomy	Part V (Treatment and Care) promotes patient involvement in decision-making but allows consent by a guardian or authorized	CRPD Article 12 (Equal legal capacity)	The Act reflects an emerging recognition of autonomy by encouraging participation in treatment	Continued reliance on substituted decision-making undermines equal legal capacity. Absence of supported decision-making frameworks (e.g., advance directives) limits autonomy

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	representative when an individual is deemed incapable.		decisions, signaling a shift toward a rights-based approach.	and overrides individual will and preferences.
Freedom from Coercion & Involuntary Treatment	Part IV (Admission of Patients) permits involuntary admission and treatment where an individual poses a risk or lacks decision-making capacity.	CRPD Article 14 (Liberty and security of person)	The Act seeks to balance care and safety by allowing involuntary interventions under specified conditions.	Broad and discretionary criteria, lack of independent review, limited legal representation, and weak safeguards increase risk of arbitrary detention and coercive treatment, undermining personal liberty.
Access to Community-Based Care	The Act promotes integration of mental health services into general healthcare and recognizes community-based care approaches.	CRPD Article 19 (Independent living and community inclusion)	Reflects alignment with modern public health approaches and acknowledges the importance of community-based services.	No binding obligation to prioritize community care; lack of deinstitutionalization strategies, community rehabilitation frameworks, and social inclusion mechanisms perpetuates institutional care dominance.
Cross-Cutting Human Rights Protections	Section 4 requires that services be provided in a manner that *"respects the dignity, human rights and fundamental freedoms of a person."*	Broad alignment with CRPD principles (Articles 1, 3, 5, 25)	Establishes a strong normative human rights foundation, integrating dignity, equality, and access to care across the Act.	Rights are often conditional and may be overridden under broad provisions (e.g., involuntary treatment). Lack of enforcement mechanisms, accountability structures, and comprehensive safeguards limits effective protection.

The findings indicate that the Mental Health Act No. 6 of 2019 provides a foundational framework for the protection of key human rights, incorporating principles such as autonomy, liberty, dignity, and community inclusion. The inclusion of provisions supporting patient participation, regulating treatment, and recognizing community-based care demonstrates a clear effort to align with international standards, particularly the Convention on the Rights of Persons with Disabilities. This reflects a broader transition from custodial models of care toward a rights-based mental health system.

However, despite this normative progress, the protection of rights remains partial, conditional, and unevenly implemented. Key limitations include the continued reliance on substituted decision-making, broad and insufficiently safeguarded provisions for involuntary treatment, and the absence of enforceable obligations to prioritize community-based care. Furthermore, cross-cutting weaknesses—such as limited accountability, lack of enforcement mechanisms, and insufficient procedural safeguards—undermine the practical realization of rights. Collectively, these gaps indicate that the legal framework operates as a transitional model, where rights are recognized in principle but not fully guaranteed in practice, necessitating targeted reforms to achieve full compliance with international human rights standards.

DISCUSSION OF FINDINGS

This study critically interrogated the extent to which Zambia's mental health legal and policy framework aligns with international human rights standards, with particular reference to the Convention on the Rights of Persons with Disabilities and normative guidance advanced by the World Health Organization. The findings reveal a multi-layered pattern of partial convergence, in which progressive legal recognition of rights coexists with structural, doctrinal, and institutional constraints that significantly limit their realization. This reflects a broader

phenomenon in global mental health governance, where states demonstrate formal compliance with international norms while simultaneously maintaining legal and institutional arrangements that dilute or qualify those very rights.

At the core of this analysis is the recognition that the Mental Health Act No. 6 of 2019 constitutes a paradigmatic shift in legislative intent, moving away from colonial-era custodial frameworks toward a rights-based approach grounded in dignity, equality, and access to care (Republic of Zambia, 2019). This shift aligns with the global transition toward deinstitutionalization and the reconfiguration of mental health systems as instruments of social inclusion rather than control (WHO, 2021). However, the findings demonstrate that this transformation is predominantly normative rather than substantive, as the Act does not sufficiently operationalize the rights it proclaims. This gives rise to what may be conceptualized as a "compliance gap", where legal recognition exists without corresponding institutional capacity, enforcement mechanisms, or procedural safeguards necessary to translate rights into lived realities.

A central dimension of this gap is evident in the treatment of dignity and humane care, which the Act elevates as a foundational principle. The explicit recognition that services must respect "dignity, human rights and fundamental freedoms" reflects strong alignment with CRPD principles, particularly those concerning the inherent worth and integrity of the individual (United Nations, 2006). From a normative standpoint, this positions dignity as both a guiding value and a legal obligation. However, the absence of clearly defined minimum standards of care, regulatory benchmarks, and independent oversight mechanisms significantly undermines the enforceability of this principle. In practice, this creates a situation where dignity is juridical affirmed but administratively underdetermined, leaving its realization contingent on institutional discretion rather than legal certainty.

The issue of autonomy and legal capacity emerges as one of the most critical areas of divergence from international human rights standards. While the Act incorporates elements of participatory decision-making, it retains provisions for substituted decision-making, particularly in contexts of involuntary admission and treatment. This approach reflects a hybrid legal model, combining elements of rights-based discourse with residual paternalistic doctrines rooted in biomedical authority. Such a model is fundamentally inconsistent with CRPD Article 12, which rejects substitute decision-making in favour of supported decision-making frameworks that preserve individual agency (United Nations, 2006). The persistence of substitute decision-making can be understood as a manifestation of legal and epistemic inertia, where entrenched professional norms and institutional practices resist the transformative implications of human rights law. Consequently, the autonomy of persons with mental health conditions remains structurally constrained, limiting their capacity to exercise meaningful control over decisions affecting their lives.

Closely related to autonomy is the regulation of informed consent, which the study identifies as both formally recognised and substantively undermined within the legal framework. While the Act acknowledges the necessity of consent, it simultaneously provides broad exceptions that permit its override, particularly in cases of perceived risk or incapacity. This creates a dual normative structure, in which consent is affirmed as a principle but weakened through expansive derogations. Such an approach is inconsistent with CRPD Article 25, which emphasises the centrality of free and informed consent in the realisation of the right to health (United Nations, 2006). The legal permissibility of non-consensual treatment reflects an enduring tension between therapeutic intervention and rights protection, raising fundamental questions about the legitimacy of coercive practices within a rights-based framework.

The principle of non-discrimination and equality similarly illustrates the gap between formal recognition and practical enforcement. Although the Act affirms equality before the law and prohibits discriminatory practices, it does not establish effective enforcement mechanisms, such as accessible complaint procedures, judicial remedies, or administrative sanctions. This renders the principle largely symbolic, limiting its capacity to address systemic inequalities experienced by persons with mental health conditions. From a human rights perspective, the absence of enforceability mechanisms constitutes a critical deficiency, as rights without remedies lack substantive meaning (WHO, 2021). The findings therefore suggest that discrimination persists not due to the absence of legal recognition, but due to the institutional fragility of enforcement structures.

Beyond individual rights, the study highlights significant deficiencies in governance and accountability frameworks, which are essential for the effective implementation of rights-based legislation. The Act does not sufficiently provide for independent monitoring bodies, regular inspections of mental health facilities, or transparent reporting mechanisms. This institutional weakness contributes to a broader implementation deficit, where the absence of oversight enables inconsistencies in the application of the law and limits avenues for redress. In this context, accountability is not merely a procedural issue but a structural determinant of rights realisation, shaping the extent to which legal protections are translated into practice.

Furthermore, the findings reveal a limited integration of community-based mental health care, which is a cornerstone of contemporary human rights–oriented mental health systems. While the Act recognises access to services, it does not articulate a comprehensive framework for the development and resourcing of community-based alternatives to institutional care. This is inconsistent with WHO (2021) recommendations, which emphasise the importance of decentralised, person-centred services that promote autonomy, recovery, and social inclusion. The continued reliance on institutional models reflects both resource constraints and policy inertia, reinforcing patterns of exclusion and dependency that are incompatible with rights-based approaches.

Importantly, the study also situates these findings within the broader socio-legal and economic context of Zambia, where systemic challenges such as limited funding, human resource shortages, and infrastructural constraints shape the implementation of mental health policies. These contextual factors highlight the interdependence between legal reform and socio-economic capacity, suggesting that the realization of rights cannot be achieved through legislative change alone. Instead, it requires a coordinated approach that integrates legal, institutional, and resource-based interventions.

From a theoretical perspective, the findings contribute to ongoing debates concerning the translation of international human rights norms into domestic legal systems, particularly in the field of mental health. The Zambian case illustrates the complexities of this process, demonstrating that alignment at the level of legal texts does not automatically result in alignment at the level of practice. This underscores the importance of distinguishing between formal compliance and substantive compliance, and highlights the need for analytical frameworks that account for both dimensions.

In synthesizing these insights, the study concludes that Zambia’s mental health legal framework embodies a transitional model, situated between traditional custodial approaches and fully realized rights-based systems. While significant progress has been made in embedding human rights principles within legislation, the persistence of legal ambiguities, qualified rights, and weak enforcement mechanisms continues to constrain their realization. Addressing these challenges requires a shift toward systemic transformation, encompassing the strengthening of legal provisions on supported decision-making, the establishment of robust accountability mechanisms, the operationalization of rights through clear standards and guidelines, and the expansion of community-based care.

Ultimately, the findings suggest that achieving full compliance with international human rights standards requires moving beyond symbolic reform toward practical, enforceable, and context-sensitive implementation strategies. Without such a shift, the gap between legal recognition and lived experience will persist, limiting the transformative potential of mental health law and undermining the protection of the rights of persons with mental health conditions.

CONCLUSION

Introduction

This chapter presents a synthesis of the study findings, key conclusions drawn from the analysis, and evidence-based recommendations for strengthening Zambia’s mental health legislation and policy framework. The study critically examined human rights gaps within the Mental Health Act No. 6 of 2019, with particular emphasis on its alignment with international standards such as the Convention on the Rights of Persons with Disabilities and guidelines of the World Health Organization.

Building on the findings discussed in Chapter Three, this chapter consolidates the key insights regarding the extent of legal alignment, the protection of human rights, and the structural and institutional gaps within the mental health system. It further provides a forward-looking framework for legal and policy reform, aimed at enhancing compliance with international human rights obligations and improving the protection of persons with mental health conditions in Zambia.

Summary of the Study

The purpose of this study was to critically analyse the extent to which Zambia's mental health legislation and policy framework protects the human rights of persons with mental health conditions. The study was guided by six interrelated objectives, which examined:

1. The alignment of legislation with international human rights standards
2. The human rights provisions within the legal and policy framework
3. Gaps and inconsistencies in the legislation
4. Governance and accountability mechanisms
5. Protection of key human rights (legal capacity, coercion, and community-based care)
6. Evidence-based recommendations for reform

A qualitative doctrinal research design was employed, relying on systematic document analysis of legal instruments, policy frameworks, and international human rights standards. This approach enabled a critical evaluation of the normative content, internal coherence, and level of compliance of Zambia's mental health framework with global human rights obligations (United Nations, 2006; World Health Organization, 2021).

The findings revealed that while the Mental Health Act No. 6 of 2019 represents a significant shift toward a rights-based approach, its implementation remains partial and constrained by legal, institutional, and resource-related limitations. Key human rights principles—such as dignity, autonomy, non-discrimination, and access to care—are recognised within the legal framework but are often qualified by exceptions, weak enforcement mechanisms, and structural gaps.

Furthermore, the study identified persistent challenges in areas such as legal capacity, the regulation of involuntary treatment, prioritisation of community-based care, accountability mechanisms, and equitable access to services. These findings are consistent with broader global evidence indicating that mental health reforms often achieve formal alignment with international standards without fully realising substantive human rights protections in practice (World Health Organization, 2021).

Overall, the study demonstrates that Zambia's mental health legal framework operates as a transitional system, reflecting important progress while highlighting the need for comprehensive reforms to ensure full compliance with international human rights standards.

Summary of Key Findings

Alignment with International Human Rights Standards

The study found that Zambia's Mental Health Act No. 6 of 2019 demonstrates moderate alignment with international human rights standards, particularly the Convention on the Rights of Persons with Disabilities and World Health Organization guidelines. The Act reflects a significant shift from a custodial to a rights-based framework by incorporating principles such as dignity, equality, and access to care (Republic of Zambia, 2019).

However, this alignment is largely normative rather than substantive, as significant gaps persist in implementation and enforcement. These are particularly evident in areas such as legal capacity, coercion, and

community-based care, indicating that the legal framework has not yet achieved full compliance with international standards.

Human Rights Provisions in the Legal Framework

The findings reveal that the Act incorporates key human rights principles, including dignity and respect (Section 4), non-discrimination and equality, and autonomy and informed consent under Part V (Republic of Zambia, 2019) . These provisions demonstrate a clear effort to align with international human rights standards.

However, the study found that these rights are often qualified by statutory exceptions and lack operational clarity, limiting their effectiveness in practice. As a result, while the Act establishes a strong normative foundation, the practical realisation of these rights remains constrained.

Gaps and Inconsistencies in the Legal Framework

The analysis identified several critical gaps and inconsistencies within the legal framework. These include the continued reliance on substituted decision-making, broad provisions for involuntary admission and treatment under Part IV, weak enforcement of non-discrimination provisions, and limited prioritization of community-based care .

These gaps demonstrate inconsistencies with key provisions of the CRPD, particularly Articles 12 (legal capacity), 14 (liberty and security), and 19 (community inclusion) (United Nations, 2006). Collectively, these shortcomings highlight the transitional nature of Zambia's mental health legal framework.

Governance and Accountability Mechanisms

The study found that governance structures, such as the Mental Health Council established under Part II of the Act, are formally in place but functionally limited (Republic of Zambia, 2019) .

Key challenges include weak enforcement powers, limited institutional independence, and inadequate complaint and redress mechanisms. These limitations reduce the effectiveness of oversight and accountability systems, thereby undermining the protection of human rights within the mental health system.

Protection of Key Human Rights

The findings indicate that the protection of key human rights—legal capacity, freedom from coercion, and access to community-based care—is partial and conditional.

Legal capacity is restricted by substituted decision-making, freedom from coercion is weakened by broad criteria for involuntary treatment, and community-based care is insufficiently prioritized. These limitations hinder the full realization of a comprehensive rights-based mental health system and reflect broader systemic challenges in implementation.

CONCLUSIONS

Based on the findings, the study draws several key conclusions. First, Zambia's Mental Health Act No. 6 of 2019 represents a significant progressive reform, replacing outdated custodial legislation with a more rights-oriented framework. Second, despite this progress, the legal and policy framework demonstrates only partial compliance with international human rights standards, particularly the Convention on the Rights of Persons with Disabilities.

Third, the persistence of legal, structural, and institutional gaps limits the effective protection and realization of human rights. Fourth, governance and accountability mechanisms, although institutionally established, remain functionally weak, thereby reducing their capacity to enforce rights. Finally, Zambia's mental health system can be characterized as being in a transitional phase, moving toward a rights-based model but not yet fully aligned with international best practices.

This study concludes that while Zambia has made important strides in reforming its mental health legislation, significant challenges remain in ensuring the full protection, respect, and realization of human rights. The Mental Health Act No. 6 of 2019 provides a strong legal foundation; however, its effectiveness is limited by gaps in implementation, enforcement, and resource allocation.

Achieving a fully rights-based mental health system in Zambia requires a holistic and sustained reform process, encompassing legal amendments, institutional strengthening, resource investment, and societal transformation. Only through such comprehensive efforts can the rights, dignity, and well-being of persons with mental health conditions be fully realised in accordance with international human rights standards.

Evidence-Based Recommendations

Reform of Legal Capacity Frameworks

The Mental Health Act No. 6 of 2019 retains substituted decision-making under Part V, thereby restricting legal capacity on the basis of mental status, contrary to Article 12 of the Convention on the Rights of Persons with Disabilities. It is recommended that the Act be amended to institutionalize supported decision-making mechanisms, including advance directives and supported consent frameworks, in order to align with international standards and strengthen autonomy, dignity, and equal recognition before the law.

Strengthening Safeguards Against Coercion

The Act permits involuntary admission and treatment based on broad and discretionary criteria such as “risk” and “incapacity,” which is inconsistent with Article 14 of the CRPD. It is recommended that the law introduce narrowly defined legal thresholds, alongside mandatory judicial oversight, legal representation, and periodic independent review, to prevent arbitrary detention and enhance protection of liberty and security of the person.

Promotion of Community-Based Care

The current legal framework inadequately prioritizes community-based care, thereby perpetuating institutionalization contrary to Article 19 of the CRPD. It is recommended that community-based mental health services be legally established as the primary model of care, supported by structured deinstitutionalization strategies, in order to promote independent living, social inclusion, and participation.

Enhancing Governance and Accountability

Existing governance and oversight mechanisms lack effective enforcement powers, limiting accountability and access to justice as required under Article 13 of the CRPD. It is recommended that oversight bodies be granted expanded investigative, quasi-judicial, and sanctioning authority, alongside the establishment of independent monitoring institutions, to strengthen enforcement of rights and institutional accountability.

Strengthening Protection Against Discrimination

Although the Act recognises equality, it lacks enforceable anti-discrimination provisions, undermining compliance with Article 5 of the CRPD. It is recommended that the law incorporate clear definitions of discrimination, together with enforceable remedies and monitoring systems, to ensure substantive equality and effective protection against discrimination.

Improving Access to Mental Health Services

The absence of binding guarantees for equitable access to mental health services is inconsistent with Article 25 of the CRPD and the AAAQ framework. It is recommended that the law establish minimum service standards, mandate equitable distribution, and integrate mental health into primary healthcare systems, thereby improving accessibility and realisation of the right to health.

Resource Allocation and Capacity Development

The legal framework does not provide binding provisions for resource allocation, resulting in weak implementation capacity. It is recommended that the State adopt ring-fenced funding mechanisms, invest in workforce development, and strengthen infrastructure, to ensure sustainability and effective delivery of mental health services.

Awareness, Advocacy, and Human Rights Education

Low levels of human rights awareness among stakeholders undermine the practical realisation of rights, contrary to the principles of the CRPD. It is recommended that the government institutionalise continuous human rights training and public awareness programmes, in order to reduce stigma, enhance rights literacy, and improve service delivery.

Strengthening Policy Coordination

Weak inter-sectoral coordination limits policy coherence and system efficiency within the mental health framework. It is recommended that formal multi-sectoral coordination mechanisms be established, with clearly defined institutional roles, to strengthen governance and ensure integrated mental health support systems.

Monitoring and Evaluation Systems

The absence of robust monitoring and evaluation mechanisms limits accountability and compliance with CRPD implementation obligations. It is recommended that the State develop human rights–based indicators, conduct periodic audits, and institutionalise regular legislative and policy reviews, to enhance transparency, support evidence-based reform, and ensure continuous improvement in mental health governance.

Future Research Implications

The findings of this study highlight several important implications for future research on mental health law, policy, and human rights in Zambia and comparable contexts. While this study adopted a doctrinal approach focusing on legal and policy analysis, there remains a critical need for empirical and interdisciplinary research to complement and deepen understanding of how the Mental Health Act No. 6 of 2019 operates in practice.

First, future research should focus on implementation studies that examine how the provisions of the Act are applied within mental health institutions and community settings. Such studies could assess the extent to which legal protections—particularly those relating to dignity, autonomy, and informed consent—are realized in everyday clinical practice. This would help bridge the gap between law in theory and law in action, which remains a key limitation identified in this study.

Second, there is a need for patient-centered and rights-based empirical research, including qualitative studies exploring the lived experiences of persons with mental health conditions. Investigating issues such as involuntary treatment, stigma, access to services, and experiences of discrimination would provide valuable insights into the effectiveness of existing legal protections. This aligns with global calls by the World Health Organization for incorporating service-user perspectives into mental health system reforms (World Health Organization, 2021).

Third, future studies should examine the effectiveness of community-based mental health interventions in Zambia, particularly in relation to social inclusion, recovery outcomes, and reduction of institutionalization. Comparative research between institutional and community-based models would provide evidence to support policy shifts in line with the Convention on the Rights of Persons with Disabilities, especially Article 19 on independent living.

Additionally, there is scope for comparative legal research analyzing how other jurisdictions have implemented CRPD-compliant mental health laws, particularly in areas such as supported decision-making and safeguards against coercion. Such studies would provide practical models and best practices that could inform legal reform in Zambia.

Finally, future research should explore the intersection between mental health, socio-economic factors, and access to justice, including the role of poverty, gender, and rural–urban disparities in shaping access to mental health services and protection of rights. This would support the development of more inclusive and equitable mental health policies.

Overall, advancing research in these areas will be essential for informing evidence-based policy reform, strengthening implementation, and ensuring that Zambia's mental health system evolves into a fully rights-based and person-centred framework aligned with international human rights standards.

REFERENCES

1. Bartlett, P., & Sandland, R. (2007). Mental health law: Policy and practice (3rd ed.). Oxford University Press.
2. Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L., Saraceno, B., & Saxena, S. (2011). Human rights violations of people with mental and psychosocial disabilities: An unresolved global crisis. The Lancet, 378(9803), 1664–1675. https://doi.org/10.1016/S0140-6736(11)61458-X
3. Gostin, L. O., & Gable, L. (2004). The human rights of persons with mental disabilities: A global perspective on the application of human rights principles to mental health. Maryland Law Review, 63(1), 20–121.
4. Kapungwe, A., Cooper, S., Mwanza, J., & Mwape, L. (2010). Mental illness—stigma and discrimination in Zambia. African Journal of Psychiatry, 13(3), 192–203. https://doi.org/10.4314/ajpsy.v13i3.54783
5. Kapungwe, A., et al. (2010). Mental health service challenges in Zambia.
6. Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., Swartz, L., & Patel, V. (2010). Poverty and common mental disorders in low- and middle-income countries: A systematic review. Social Science & Medicine, 71(3), 517–528. https://doi.org/10.1016/j.socscimed.2010.04.027
7. Ministry of Health Zambia. (2013). National health strategic plan 2013–2016. Government of Zambia.
8. Ministry of Health Zambia. (2017). National mental health policy. Government of Zambia.
9. Minkowitz, T. (2006). The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from non-consensual psychiatric interventions. Syracuse Journal of International Law and Commerce, 34, 405–428.
10. Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., & UnÜtzer, J. (2018). The Lancet Commission on global mental health and sustainable development. The Lancet, 392(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X
11. Republic of Zambia. (2019). Mental Health Act No. 6 of 2019. Government Printer.
12. Sikwese, A., Mwape, L., & Mwanza, J. (2017). Mental health care in Zambia: Policy development and challenges. Medical Journal of Zambia, 44(2), 95–102.
13. Sunkel, C., Sartor, C., & Henderson, C. (2019). Stigma, discrimination and mental health in Africa: A systematic review. International Journal of Mental Health Systems, 13(1), 1–14.
14. United Nations. (2006). Convention on the Rights of Persons with Disabilities.
15. World Health Organization. (2011). Mental health atlas 2011: Zambia profile. WHO.
16. World Health Organization. (2013). Mental health action plan 2013–2020. WHO.
17. World Health Organization. (2017). Mental health atlas 2017: Zambia country profile. WHO.
18. World Health Organization. (2021). Guidance on community mental health services: Promoting person-centred and rights-based approaches. WHO.
19. World Health Organization, & United Nations. (2019). Mental health, human rights and legislation: Guidance and practice. WHO.