

# **BasicNeeds** *BasicRights*

SEEKING RELIABILITY AND QUALITY ASSURANCE IN LOW AND MIDDLE INCOME  
COUNTRIES

CASE STUDY: MTWARA PROGRAMME:

BY

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## **ABSTACT:**

*BasicNeeds is an International Non-Governmental Organisation built on a philosophy of building inclusive communities where people with mental illnesses, through development realize their own rights. The goal of the Organization is to see to it that the basic needs of mentally ill people are met and their basic rights respected. BasicNeeds implanting a model (Mental Health and Development) that acknowledges the integration of mental health services into primary health care and socioeconomic inclusion of poor mentally ill people and their carers. The approach of integrating mental health services into primary health care brings remarkable changes and challenges. Therefore, the aim of this study was to review the approach used by BasicNeeds in collaboration with health workers in the implementation of community mental health in the community. The methods used in this study were key personnel interview, focus group discussion and review of BasicNeeds documents.*

*Following the information collected from the field it was revealed outreach is a good approach of deliver mental health services near to the community but it is not sustainable since the implementation approach is under the existing structure of government and is it is very costly. It also noted that, the implementation of community mental health in the Mtwara Programme, there is no component of psychotherapy although it is important part in mental health services. Furthermore, the study revealed that some of the generalists who received training in the pilot areas are transferred to the other regions of the Tanzania and employs other staffs who do not have enough skills on mental health and treatment in the Programme area. This affects the implementation negatively. A further finding was that, community mental health services are hindered by drug shortage. The study also observed that outpatient clinics are not good for mentally ill people since they are mixed with other patients and they have to join the queue. Some of them refuse and go away without drugs for instance the manic people.*

## CHAPTER ONE

### 1.0: INTRODUCTION:

Mtwara region lies in the far south of Tanzania. For various reasons the south of Tanzania, Mtwara being the most outlying part, has a long history of political marginalisation making it one of the poorest. As such it is one of the most challenging areas of Tanzania to work today. Poor communication infrastructure is a snag to economic activity and development in general.

The administrative region is divided into six districts vis-à-vis Mtwara municipal, Mtwara rural, Masasi, Tandahimba and Newala and Nanyumba new district. The Mtwara district has two councils - Mtwara urban and Mtwara rural. BasicNeeds implements the Community Mental Health Development model in all the five districts, modules has been piloted in one ward in each district and currently its has been expended in five districts within the region. In collaboration with MEHATA (Mental Health Association of Tanzania), the Organisation has trained 161 generalist health workers (clinical officers and nurses in primary health care level- dispensaries and health centres) who had no skills and knowledge on mental health care have been trained on how to diagnosis and provide treatment to mentally ill people. As a result, many mentally ill people have been reached and now have access to treatment. At the end of December 2007, the programme out reached 10,842 people with mental illness and epilepsy from both the programme pilot ward and health facilities within the region. This is an increase by 25.5% from December 2006. Among of them, 1963 were patients from eight programme wards and 8,879 from the rest of the health facilities of trained generalist mental health care workers within the region. Patients with mental illnesses were 3,630 while 5,249 were epileptic. Interestingly 1,055 patients reported to stabilise during the reporting period (January to December) both from the programme wards and health facilities. Similarly, a total of 1,347 out of 1,633 stabilised from the pre-existing wards where the

programme has long been implemented reported to remain stabilised for the whole period of January to December 2007.

### **1.1: Background information:**

In Tanzania, there are very few mental health services. Mental health treatment is only provided in large hospitals and this makes it very difficult for people in deprived rural areas to access treatment. This means there is a focus on institutionalising patients, rather than treating people in the community. There are only eight psychiatrists in the whole country working in the public sector and none of them are in Mtwara region. This is because of the long history of political neglect of the southern corridor. With the exception of the ten-bedded wards for admitting acute cases of mental illness, there is an acute shortage of trained personnel and services for mentally ill people. A handful of psychiatric nurses' co-ordinate mental health services in the region.

### **1.2. Community mental health programme in Mtwara:**

Community mental health is a mechanism developed for easy access of mental health services by mentally ill people. BasicNeeds Mtwara has been implementing a community mental health programme in Mtwara since 2003 through various funders. These include Comic Relief from UK, which supported the programme from 2003 to 2006. The implementation cut across the whole model which includes community mental health, research and policy, sustainable livelihood, capacity building capacity, management and administration. Another funding organisation which supported community mental health from 2005 to 2006 was the Health Care Foundation. The aim of the project was to build capacity of generalist health care in mental health care and mainstream mental health services into primary health through mental health outreach clinics. Furthermore, there was a small scale funding from the Turdor trust from 2006 to 2007. This supported the review of stabilized mentally ill people so that they can engage themselves in sustainable livelihoods. The current project is supported by the European Union, and it cuts across all the five modules. This will last for three years from 2008 to 2010. Besides this funder there is small projects funded by Medicor Foundation focus on young carers who take care of the mentally ill people. In general, the aim of all these funders is to ensure that the basic needs of mentally ill people are met and their basic rights respected. The BasicNeeds has both medical and psychological treatment is its integral components. The programme however, does not give direct treatment to the ill; instead it encourages service providers to go to the mentally ill people in their communities so that more of them can access treatment from health facilities. BasicNeeds supports regional and district health

personnel and also work in partnership with traditional healers and other stakeholders to improve community based mental health care in Mtwara region and feed that experience into the development of a national mental health policy.

## **CHAPTER TWO**

### **2.0. PURPOSE OF THE STUDY:**

The aim of this study is to review the approach used in the implementation of community mental health in the Mtwara programme and identify possible successes and challenges so as to recommend viable recommendations for the improvement of the programme

#### **2.1. Specific objectives of the study:**

This study set out to achieve the following specific objectives:

- To review the implementation approach of the community mental health in the Mtwara Programme
- To get ideas from the stake holders about community mental health in the community

## **CHAPTER THREE**

### **3.0. RESEARCH METHODOLOGY:**

#### **Case study location:**

Mtwara region lies in the far south of Tanzania. The administrative region is divided into six districts vis-à-vis Mtwara municipal, Mtwara rural, Masasi, Tandahimba and Newala and Nanyumba new district. The study was conducted in both five districts in the specific wards where the programme areas are located.

**Data Collection:**

The case study was conducted from May to June 2008. In order to capture the feelings, perceptions, facts and experiences the study employed an exploratory qualitative methodology which uses participatory tools such as in-depth and key informative interview with key personnel's. Individual interviews were carried with five district mental health coordinators who are mental health nurse, clinical officers and community volunteers. Other participatory tools were four focus group discussions (FGDs) with mentally ill people and their caregivers. Questions were prepared to guide the interview and the focus group discussion. These were supported by a review of BasicNeeds documents including life stories, process documents, meeting reports and six monthly research reports.

**Analysis**

Analysis were done by review of documents, review of interview sheets/meetings notes, review of field notes of observation and review of annual impact report and annual country research report of 2007. Report was developed based on the documents reviewed.

## CHAPTER FOUR

### 4.0. DISCUSSION:

#### 4.1. Approach of Implementation of community mental health in Mtwara programme:

The Tanzania's mental policy draft of 2006 emphasizes integration of mental health service into primary health care, the policy further stated regions and districts health sectors to mainstream in the general mental health activities into they plans. Likewise clients (mentally ill people) are at the periphery as far as possible; and that mental health at primary health care should supervised by District Mental Health Coordinators. The Council and Health Management Teams have local responsibility of coordinating health services and the District Mental Health Coordinators serve on this team. The roles of BasicNeeds in this process have included identifying gaps in the provision of services, promoting policy priorities, assisting with personnel power planning and training. At implementation level, BasicNeeds work with Municipal/district councils through involving different professionals like mental health nurses, community development workers, generalist health workers including clinical officers/Nurses at primary health care level and doctors. At the community level, the Organization has build partnerships with local governments, traditional healers, local leaders, community based organizations and the mentally ill people through user groups.

#### 4.2. Accountability each stakeholder in the implementation of the community mental health module:

##### 4.2.1 Generalist health workers; (Psychiatric nurses, clinical officers, mental health coordinators and other trained generalist health workers):

BasicNeeds implements the module by using the existing structure of the government in different ways. In collaboration with government health workers, BasicNeeds implements the model by providing training to the generalist health workers on mental health care so that they can be able to deliver the mental health services at primary health care level so as to influence the Government to reallocation of resources on mental health including funds for purchasing psychotropic drugs for

the mentally ill people. The services are provided through outpatient and outreach clinics after every one month but for new cases, mental health services are provided every day through outpatient clinics. Currently, in the programme areas, BasicNeeds and district councils implement only outpatient's clinics for sustainability and keeping on ongoing of the services after BasicNeeds faced out. However out reach clinics will be continuing in some new areas (wards) and later will be shifted to outpatients' clinics for the districts continue to provide services. Despite the ongoing mental health services at out reach and outpatients clinics, the shortage of mental illness and epileptic drugs hindering the whole services for mentally ill people.

#### **4.2.2. Community Based Organisation and Non governmental organisation:**

BasicNeeds also is in a partnership with community based organisations and non-governmental organisations in the Programme area in awareness creation and identification of the mentally ill people in the community. The Programme provides those skills on how to identify the mentally ill people and influence them to attend clinics. In general, partner organisation contributes much in identifying the mentally ill people since they work very close with people in the society.

#### **4.2.3. Traditional healers:**

Traditional healers are among the stakeholders who implement the module. During the implementation, it has been noted that, when people suffer from mental illnesses the first person to contact is a traditional healer. This because lack of mental health services within their community, community lack of information regarding the cause of mental illness and mental health in general and believe that, mental illness is associated with witchcraft things. Therefore, another way of identify mentally ill people is through traditional healers. BasicNeeds provided skill to traditional healers on mental illness, best practises on caring mentally ill people and basic human rights. Followed these training, traditional healers they agreed that once people with mental illness visit them, they will influence them to attend hospital in case they fail to treat them.

#### **4.2.4. Local leaders:**

Local leaders include such people as traditional leaders, clan leaders etc. These also have the responsibility of raising awareness in the community. BasicNeeds organised meetings with all local leaders in the programme area and shared experience with them about community mental health intervention at community level. They were very excited and later on contributed a lot in awareness rising in the community during their general meeting with the community.

#### **4.2.5. Traditional birth attendant:**

BasicNeeds has been working with traditional birth attendants since the programme started. Different meetings with traditional were carried as part of creating awareness about mental illness especially on epilepsy. During meeting it noted that, some of the illness initiated during birth delivery and also during parental care for instance the moulding of head for young children. One traditional birth attendant; Hadija Hamisi had the following to comment: “...***We do it so as to make a body of a child in a good structure, for instance; we mould a head so as to make it round in shape.***” Somoe Saidi (another traditional birth attendant also has the following to add, “.....***Certainly, the child had his head been molded just after been born. This is our culture and we have to practice it as the merely way of sustaining our culture. As you can see in our areas, all people are their head being rounded as they had been moulded soon after their birth.....***”. There fore, during the meeting, they advised not to mould the head of young children since it affect the development brain and some times can lead to epilepsy or any kind of mental illness. It observed that, in this area, there are many people suffering from epilepsy, probably is due to the moulding of the head for the children. Therefore, in the implementation of community mental health, traditional birth attendant is very key people to share information as one way of preventing mental illness and awareness creating.

#### **4.2.6. Community development officers, ward executive officers and village leaders**

These are government employs Officers at ward level, BasicNeeds has been work in partnership with these officers as a key people in the implementation of community mental health since they work very close with community. Therefore the first stage was introductory meetings to ward and community leaders about community mental heath. Introduction to ward and community leaders was fundamental for them to have a clear understanding of what is community mental health. During these introduction meetings it was noted that community volunteers are key people in the identification of the mentally ill people as well as influencing them to attend treatment in primary health centres/dispensaries.

#### **4.3. Training to community volunteers on community mental health**

Community volunteers were trained on mental health and how to identify people with mental illnesses in the community and convince them to attend clinics. In addition, community volunteers

were trained on making follow up visits to the mentally ill people at their homes and also on how to gather information, how to fill individual files, report writing and participatory data analysis.

#### **4.4. Training of generalist health workers on mental illness and treatment**

Mental health care has been integrated into primary health care system through training, support of health management teams at national, regional, and districts levels, and the use of existing resources within the area. Due to the shortage of psychiatrists in Tanzania especially in Mtwara, the implementation followed (preceded?) by the training of generalist health care so that they can be able to provide mental health services in primary health care. The training started with mental health coordinators as trainers of trainees (TOT). Thereafter, the mental health coordinators conducted training to generalist health workers including clinical officers and nurses. During the trainings, few traditional healers were invited so as to share experiences on how to treat mental illness and also to identify the mentally ill people and advise them to attend clinics. Currently, traditional healers refer mentally ill people to near dispensaries or health centres. However, during one of the interviews, the mental health coordinator of Mtwara district, Mr Edwini Milanzi he had the following to comments. *“ .....Although there was a detailed training to generalist health care, refresher and on-job training are still needed. This is because some of the generalists who trained on mental health services in the pilot areas are transferred to the other regions of Tanzania and replace other staffs that do not have enough skills on mental health and treatment. Also for those who are transferred to other areas, the government should develop a mechanism to ensure that, they will implement what they learnt from mental health services so that they can provide health services to the mentally ill people in that area...”* In general, the trained generalist health workers do not implement what they learnt from mental health and treatment training apart from those in the Programme areas once they get transferred to other parts of Tanzania.

#### **4.5. Consultation meeting with mentally ill people and their carers:**

The aim of the consultation meeting were to understand general lives of mentally ill people and their carers, also to understand their needs and to discuss what to be done (the way forward) on findings observed. Process documenter gathers all information coming out from the mentally ill people and carers. The process documents are stored in terms of soft copy in BasicNeeds server and also printed hard copies. These process documents are used in quarterly and annual report through participatory analysis with stakeholders. The information documented are number of mentally ill people and carers who participates in the consultation meeting (sex and their age), their

voices, about their lives and they way of improving their lives. Mentally ill people and carers are able to express their views. Consultation meetings were the initial stage of identifying mentally ill people at ward level. BasicNeeds in collaboration with local partner organization and all leaders at ward level organized the meetings. A the end of each meetings, all participants including mentally ill people agreed the role of each other on the needs of mentally people including access to treatment.

#### **4.6. Outpatients and outreach clinics in the programme areas.**

In Mtwara region, there are 5 community psychiatric nurses. This is equivalent to 1 community psychiatric nurse in each district. There is no ward with bedded for inpatients but rather there is only one psychiatric unity at Ligula Regional Hospital in Mtwara region. This is only hospital in Mtwara where there is psychiatric unity. In this hospital, Regional Mental Health Coordinator in collaboration with other health workers review all patients brought at the hospital.

##### **4.6.1. Outpatient's clinics:**

BasicNeeds in collaboration with Government health workers carried out different kinds of clinics. Outpatients' clinics were carried out in dispensaries, health centres and also in hospitals. This service is for the mentally ill people who stay near these health centers. The services in the hospitals vary from those in the health centres and in dispensaries. The outpatient clinics are carried out once per month for old cases but for new cases is very day. In the hospitals there are psychiatric these are not there in the dispensaries and health centres. For instance in the hospitals for new cases, once mentally ill people attend clinic, the first stage is registration. This is done by a nurse who provides them with card. The second stage is to see clinical officers<sup>1</sup> for diagnosis and if she/he has a mental illness the clinical officers refer them to the psychiatric unit and get full diagnosis. The prescription of drugs is done in the psychiatric unit. The follow up cases/old cases are attended directly in psychiatric unit. In the dispensary/ health centers there are no psychiatric units but there are clinical officers/ nurses who have been trained on mental illnesses and treatment. Therefore, for new cases the first stage is that the trained clinical officers or nurses do the registration followed by diagnosis since there are no psychiatrists in primary health facilities diagnosis of mentally ill people and description of drugs are undertaken by trained generalist health workers on mental. One of the psychiatrist nurses had the following to comments during interview ***"...Outpatient clinic is a challenge for the mentally ill people since they are mixed with other patients and they have to join the queue. Some of them refuse and go away without drugs....."*** Currently no any mental health unit has bee established at primary health care level, mentally ill people have been mix with other patients.

##### **4.6. 2. Outreach clinics:**

Outreach clinics were conducted in the areas where there are no health facilities. This is because most of the people who live in rural are poor and they don't have bus fare. In order to solve this problem, BasicNeeds in collaboration with government health workers conducted outreach clinics in the community. The outreach clinics are established near the community either at ward office. Ward office is the head quarter of each ward; it is an office where the office of ward executive officer, ward education coordinator and ward councilor are found. Ward Councilor is the

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<sup>1</sup> Clinical Officers are health worker who diagnosis patients and make prescription of drugs accordingly.

chairperson of the Ward Development Committee (WDC) which is made up by village executive officers and village chairpersons of each village found in a ward. Furthermore, outreach clinics are carried out at primary school and secondary school places or at any other place which is conducive for patients to explain their problem to health workers and for drug prescription in the community. The session, involved community volunteers who provides patients follow-up progress reports and also to bring new mentally ill people whom they identified. During these sessions community volunteers also submit follow up reports and bring new mentally ill people whom they have identified. Furthermore, there are mental health coordinators who come with drugs together with ward clinical officers who participate in the diagnosis and drug prescription in collaboration with mental health coordinators. The outreach is conducted every other month, as such drugs which are provided to the mentally ill people are enough for one month. One of the community volunteers from Mahuta had the following to say “...**Outreach is a good approach of delivering mental health services near the community but it is not sustainable and it will cause problems once the programme ends. For instance now, people are relapsed because currently there are not outreaches. They don't have bus fare to go to the dispensaries or hospitals. Epileptic people are more in dangerous because when they stopped using drugs the illness changed to be even more severe...**”

Previously BasicNeeds in collaboration with the Government carried out outreach clinics. At present, the project stopped due to lack of funds. Outreach clinics have stopped for 3 months now following our present funder (EU) doesn't support it. However, we have got another funder who is going to support outreach clinics starting from August 2008. Furthermore, follow ups and home visits is still going on by community volunteers. Some of the mentally ill people manage to make follow up of drugs in the distant health centres and dispensaries and some of them fail due to lack of bus fare.

#### **4.6.3. Outreach and outpatient clinics mental health services:**

BasicNeeds organized mental health services in collaboration with government health workers in the respective areas. Following the identification of the mentally ill people afterward, it encourages the mentally ill people and their carers to attend clinics either through outpatient or outreach clinics. During clinics, mental health coordinator or trained clinical officers or psychiatric nurses make a diagnosis of the patients. These are government health workers who have been trained on mental health and how to diagnosis any mental disorder by BasicNeeds in collaboration with MEHATA – Mental Health Association of Tanzania. Therefore, during diagnosis, there are interviews with either the mentally ill people or carers and sometimes with both of them. Some of the questions address issues such as how the illness started, the duration of the illness, the treatment already taken, the signs and symptoms of the illness, whether the ill still continue with treatment etc. All this information is filled in the clinical files. Sometimes health workers can decide to change the drugs if there are side effects or if there were no remarkable changes in the health status over a certain period. Therefore health workers diagnose and at the same times prescribe. Therefore the information from clinical files and individual files are compiled and mental health coordinators prepare a quarterly report and submit it to BasicNeeds. This report is used by Research officers in updating statistical tracking sheet. The report contains different information including the number of the mentally ill people reached by age, sex and their diagnosis, the number of cares, the number of people who are relapsed, the side effects, the number of the mentally ill who have stopped treatment, the number of the mentally ill who have stabilized etc.

#### **4.7. Resources required for providing mental health services:**

The resources required in mental health services depend much on the type of services and geographical location of the place. For instance, outpatient clinics need many resources as compared to outreach clinics. During outpatient clinics the resources required are essentially human (mental health coordinators or trained clinical officers and nurses) and drugs at the health centers. The resources required for community mental health services are expensive. Health workers have to move from their work place to the village to establish outreach. Therefore BasicNeeds pays them per Diem and transport. Also the community volunteers participate in the outreach sessions also get some money for transport. Apart from that, BasicNeeds has one to three members of staff who also participate and BasicNeeds pays them per diem together with fuel for the car. In general the following are resources which are needed to carry out outreach clinics:

- Per diem for health workers since they have to move from the work station and establish outreach clinics in the community
- Transport for health workers
- Psychotropic drugs, since now there are shortage of drugs in the health centers
- Transport for community volunteers like bicycles during home visit of the mentally ill people
- Vehicles
- Fuel for vehicles during monitoring
- Per diem for BasicNeeds staff during monitoring
- Furniture and stationeries like files for individual files. This is for keeping individual records of the patients and other files for keeping records and laptops.
- On job training which includes hiring psychiatric doctor as consultancy to review the patients.

The mental health coordinator for Mtwara rural had the following to say during an interview “....**We can't carry out outreach sessions in the villages without drugs. Shortage of drugs hinders the whole process of outreach.....**”. In general, outreach sessions are very expensive since it does not follow the existing structure of the government. During our field back stocking, Edwin Milanzi (Mental health coordinator of Mtwara district) had the following to comment: “...**Assume the BasicNeeds project is phased out, will the outreach session continue? Probably, the outreach will phase out also since the government will be not able to carry out the outreach since it does not operate under government system. Apart from that, the process is very expensive for the government. In such case, the outreach approach in the community mental health is not sustainable.....**” He continued by saying that outreach approach is a way of

bringing mental health services near the community but it is better to inform them that outreach is a temporary service and later on they are supposed to get services from the dispensaries or health centres. Outreach is a kind of awareness creation so that the people in the community can know the importance of using drugs. Although in some of the areas dispensaries or health centres are located far away, knowing the importance of the right treatment, they can be able to travel 7 km or more looking for treatment. The researcher also interviewed some health workers about outpatients so that they can comment on that. They had the following to comments, **“...Outpatients is a very good approach because it is a way of integrating mental health services into primary health services. However, the shortage of drugs is a snag to the whole process. Therefore in order to succeed drugs should be given the first priority. The integration should incorporate the issue of drugs distribution at primary health care since without drugs there are no outpatient clinics for the mentally ill people at primary health care level.....”** During discussion it noted that, outpatient clinics needs less resources than outreach clinics. The following are resources required during outpatients clinics:

- Psychotropic drugs, since now there are shortage of drugs in the health centers
- Transport for community volunteers like bicycles during home visit of the mentally ill people.
- Vehicles
- Fuel for vehicles during monitoring by BN staff
- Per diem for BasicNeeds staff during monitoring
- Furniture and stationeries like files for individual files. This is for keeping individual records of the patients and other files for keeping records
- On job training which includes hiring psychiatric doctors as consultancy.
- Rooms for mental health services at health centre/ dispensary. This is because at health centre's no psychiatric unit. Computers are needed also for keeping records. But this is fixed cost.
- Computer for keeping records

The different in resources between outreach and outpatients clinics is that, outreach need more resources such as per diem and transport for health workers every month while outreach no payment of such kind but needs resources like rooms for attending mental illness cases which is fixed costs.

Furthermore, mental health coordinators had this to say about drugs distribution: **“Although we a received training on drug prescription, still there are some drugs which are not allowed to be distributed in the health centers and dispensaries. How do we integrate mental health**

**services without enough drugs...**” That was clear because some of the mental illness drugs are not allowed to be distributed in primary health centers. This is because in previous times there was a shortage of personnel who know how to prescribe. Currently, through training, there are enough generalist health workers who know how to prescribe but still (WHO) policy and government policy on essential drugs do not allow drugs like medicate injection, carbamazapine, Stelazine, Theoridazon and others to be distributed in the primary health care level.

#### **4.8. Follow up of patients:**

There are follow up visits made during home visits. Community volunteers in the respective ward do this work. Community volunteers make home visits at least thrice a month. During follow up, community volunteers check whether the ill use drugs properly, if there are side effects of the drugs, any other diseases apart from mental illness and taking all other records concerned with him/her and fill in the individual files. The report of patients is submitted to the mental health coordinator during outpatient/outreach clinics. The mental health coordinator uses the report from community volunteers and the information from clinical files to prepare monthly and quarterly reports. Clinical files are kept in the health centres while individual files are kept by community volunteers in their home places. “....**Follow up of patients every month is a very tedious work because of the distance. We need bicycles so that we can reach people in the far areas in the village.....**” One of the community volunteers lamented during focus group discussion. Transport facilities for community volunteers are very important for accurate data collection. As of now they can't manage to make home visits to all patients because of distance.

#### **4.9. Alternatives drugs:**

In the community, especially in the rural areas, people use some herbs and other treatment from traditional healers in treating mental illness and epilepsy. Unfortunately, there is no evidence showing that the herbs and other medicines from traditional healers can treat mental illness although some people still believe that the treatment works. Sometimes if there is a shortage of certain kind of drugs in the hospital/health centers, psychiatrists can use alternative drugs to solve the problem. For instance the alternative drugs for fluephenazine injection are sterazine or

chlorpromazine while the alternative drug for haloperidol is thioridazine. But the alternative drugs are not very effective to the patients. During a focus groups discussion, Mwanahamisi Dadi (a stabilized mentally epileptic patient) had the following to comment: ***“...Alternative drugs are not effective. In previous time I used but now the doctor changed my drugs. He gives me other types of drugs, which are not effective. Last month I felt dizzy and fell down. I explained my problem during outpatient clinics but the Doctor said that the drugs that he gave me previously are not available in dispensary.....”*** During an interview with Doctor Hauli (Retired Psychiatric from Muhimbi Referral Hospital in Dar es Salaam who work as consultant with BasicNeeds programme) he had the following comments about alternative drugs. ***“.....In general, the alternative drugs are effective like other drugs. The problem is the knowledge of how to prescribe those drugs. I noted that problem during an on-the-job training and review of patients in the Programme areas. Our health workers still have problems with drug prescription especially on alternative drugs. Therefore, intensive training is needed in order to clear out this problem....”*** He also said that other cases of mental illness do not need treatment by drugs. It depends on the cause of the illness. For instance some of the mental illness is caused by frustration or hardship of life. Therefore, for such kind of illness, psychosocial therapy is need. In the implementation of community mental health in Mtwara programme, there is no component of psychical therapy and it is a very important part in mental health services.

#### **4.10. Review of patients:**

Review of patients is done by Psychiatric Doctor (Dr. Hauli), a retired psychiatric from Muhimbili National hospital). The review of patients is done after very three month during outpatients or outreach clinics but it also depend on availability of fund. During review session, psychiatric doctor assess the health of all patients and advise the mental health coordinator/clinical officers either to change the drugs of patients, or to decrease or increase the dosage of drugs or to stop the drugs of patients if he/she recovered completely. Apart from that, psychiatric doctor evaluate the performance of mental health coordinators on how they attend patients and drugs prescription and advise them accordingly.

## **CHAPTER FIVE**

### **5.0. SIGNIFICANCE/SUCCESSSES AND CHALLENGE OF THE COMMUNITY MENTAL HEALTH.**

### **5.1. Significance/Successes of the community mental health:**

There are different successes on community mental health in Mtwara programme. During the implementation of project activities, consultation meeting were carried out which were included mentally ill people and their carers. Mentally ill people and care giver were given opportunity of expressing their ideas and about their lives in general. Through this process, stigmatization to mentally ill people were reduced in some extent since people from community were agreed that mentally ill people can stand and speak in front of people and they are able to express about their lives. Furthermore, as implementation took place, different generalist health workers were trained on mental health and treatment. There about 160 generalist health workers who got train on mental health diagnosis and treatment. The trained generalist health workers are able to provide mental health treatment in dispensaries, health centers and also in district hospital. There fore, mental health services are near to the community as compared to the previous time where mental health services were provided only at region hospital and in few cases at District hospital. Currently, mentally ill people were able to get treatment within their community and go back to their home place. As a result, many mentally ill people have been reached and now have access to treatment. At the end of December 2007, the programme out reached 10,842 people with mental illness and epilepsy from both the programme pilot ward and health facilities within the region. In previous time, mental health services were not given priority during planning. During the implementation, Mtwara Programme influence CHMT member to include mental health service in the planning. Currently, mental health services are included in the planning as other health services. In previous period before the programme, people in the community believe that mental illness are associated with witchcraft things and therefore can be treated only by traditional healers although most of the mentally ill people were not stabilized. Since there are many mentally ill stabilized and go back to their activities, people in the community are now believe that mental illness are treated in the hospital and community play part to influence people with mental illness to attend hospital treatment. Furthermore, since the consulted traditional healers during the programme and shared with them about mental illness, nowadays, traditional healers are able to refer mentally ill people to hospital especially who does not stabilized through traditional healing. Another success of the Programme is that, mentally ill who have stabilized were already established their self help groups and got supported with initial capital to formulated their own activities. Different economic activities were done with stabilized mentally ill people are farming activities, processing of cashew nuts, keeping local poultry, goats and pigs and also small business. Furthermore, people who stabilized were also acceptable by community and participated in social activities such as burial ceremonies, wedding and other social issues.

## **5.2. .Challenges of community mental health:**

Mental health services are hindering by drugs shortage. Currently, in the Programme area there are shortages of psychotropic drugs in hospital, dispensaries and also in the health centres. Furthermore an outreach clinic is not sustainable since is not under government system and furthermore is very expensive. Outpatient's clinics are under government system and are less expensive as compared to outreach clinics, but Outpatient clinic is a challenge for the mentally ill people since they are mixed with other patients and they have to join the queue. Some of them refuse and go away without drug. Currently no any mental health unit has been established at primary health care level, mentally ill people have been mix with other patients.

Mental health services in the community hindering also by shortage health workers who specialized/trained in mental illness. In the programme areas, generalist health workers were trained from all health facilities but some of the were get transfer to other region and some also some of them are in study leave so , they replace other health workers who do not have enough skills about mental health services.

## **CHAPTER SIX**

### **5.0. FINDINGS AND RECCOMENDATION:**

#### **5.1. Findings:**

Different findings were generated from this study. These are presented as following:

- Traditional healers are key people in the implementation of community mental health especially in influencing them to attend hospital treatment. This because, when a person suffered from mental illness, the community believes that it is bewitching. Due to this, the fist person to contact is a traditional healer.
- Community volunteers are very key people in making home visits and influence people to attend clinics if motivated.
- In the implementation of community mental health, traditional birth attendants are very key people to share information as one way of preventing mental illness and awareness creating.

- Although there was a detailed training to generalist health carers, refresher and on-the-job training is still needed. This is because, some of the generalists who received training in the pilot areas are transferred to the other regions of the Tanzania and employ other staff who do not have enough skills on mental health and treatment.
- Trained generalist health workers transferred to other areas apart from the programme area; do not implement what they have learnt in new areas.
- Outpatient clinics are not good for mentally ill people since they are mixed with other patients and they have to join the queue. Some of them refuse and go away without drugs for instance the manic.
- Outreach is a good approach of deliver mental health services near to the community but it is not sustainable since it is not under the existing structure of government and is it is very costly.
- Community mental health services are hindered by drug shortage.
- Although there was training on drug prescription still there are some drugs which are not allowed to be distributed in the health centers and dispensaries.
- In general, the alternative drugs are effective like other drugs. The problem is the knowledge on how to prescribe those drugs. Health workers still have problems on drugs prescription especially alternative drugs
- In the implementation of community mental health in the Mtwara Programme, there is no component of psychotherapy and it is a very important part in mental health services.
- In general, the trained generalist health workers do not implement what they learnt from mental health and treatment apart from programme areas once they get transfer to other part of Tanzania

## **5.2. Recommendations:**

**In this study, there are short and long time recommendations.**

### 5.2.1. Short recommendations:

- Generalist health workers who trained on mental health services should be insisted to extend their services once they get transfer to other part of Tanzania. Furthermore, ministry of Health and Social welfare should develop a mechanism to ensure that the trained generalist health workers on mental health services will implement what they learnt so that they can provide health services to the mentally ill people in their areas.

- Health workers recommended that, in order to have good services for mentally ill people, dispensaries/health centres should have separate unit for them. This is because; some of the mentally ill people who are aggressive don't want to stand in queue for a period. But the best way is for Medical Assistance to pay attention and give priority in attending people who are aggressive/or children with high fever during treatment and not for them to stand on queue.
- Due to the distance, community volunteers need to be provided with transport so that they can move to far distances in making follow-ups.
- There is a need of refresher training, on-the-job training in several times so that the new employees can be equipped with skills on mental health and treatment in the programme areas.
- Outpatient is a good approach although some of the patients do not manage to reach the place. Furthermore, outpatient clinics recommended to be more sustainable since it operate under existing government structure and is not need fewer resources than outpatient's clinics.
- In order to integrate mental health services in the primary health centres, the first priority is to make sure that drugs are available. Without drugs there can not be community mental health. The integration should incorporate the issue of drug distribution at primary health centres since without drugs there are no outpatient's clinics for the mentally ill people.
- Intensive training is needed for drugs prescription on alternative drugs once there is a shortage of other drugs.
- Once a person suffered from mental illness or epilepsy, a first person to contact is tradition healer. This because lack of mental health services within their community, community lack of information regarding the cause of mental illness and mental health in general and believe that, mental illness is associated with witchcraft things

### **5.2.2. Long time recommendations:**

- Integrate current mental health training guideline for primary health workers into national medical school curriculum (long term idea and sustainable).
- There is need of influencing policy change on drugs distribution (essential drugs policy) especially in area where generalist health care got training on drugs prescription so that all

drugs of mental illness can be distributed at primary health care level since generalist health workers already trained on how to prescribe mental illness drugs.

- Psychotherapy is needed in the implementation of community mental health since there is some mental illnesses which need only counseling or need both counseling and treatment by using drugs.

## **Appendix: 1.0**

### **1. Questions guide during focus group discussion with mentally ill people and care givers.**

1. Do you know community mental health?
2. How mentally ill people diagnosed during treatment?
3. Who make diagnosis?
4. Who describes drugs?
5. How community mental health services operate within your community.
6. How do you comment about outreach and outpatients clinic services?
7. How mental services are provided during outreach and outpatients clinics?
8. Are you satisfied with the services?
9. Which is the best way of getting services? Through outreach or outpatients? And why do you think is good services?
10. What alternative treatments are available in your community?
11. Who provide the services for alternative treatment?
12. What is your opinion about alternative treatment?

### **2. Individual interview questions with mental health nurse and clinical officers:**

1. How people with mental disorders identified?
2. What happens after identification of patients?
3. Who gives a diagnosis during outpatients and outreach clinics?
4. Who prescribes medication during mental health services
5. Description of what exactly happens during outreach clinics
6. Description of what exactly happens during outpatient clinics
7. How do you keep record during clinics
8. What kinds of records are taken?
9. Who keep the record and where is it kept?
10. What resources are required for providing community mental services during outpatient and outreach clinics?
11. How do you compare outreach and outpatient clinics?
12. Which is the best practice?
13. What are the challenges when you provide mental health services to mentally ill people both outreach and outpatient clinics?

### **3. Interview question to community volunteers:**

1. Do you know about community mental health?

2. How mental health services are provided in your area?
3. How do you identify people with mental illness and epilepsy in your community?
4. How do they get treatment?
5. Who does the diagnosis and drugs prescription?
6. Who does the follow up?
7. what exactly happens during follow up?
8. How is it done?
9. What kinds of records are taken?
10. How do you keep your records?
11. What other/alternate treatments are available?
12. What is your opinion about outreach and outpatients clinics services? Which is the best practice?
13. What are the resources are needed during outreach and outpatients clinics?