# Development of a Mental Health Policy and System in Tanzania: An Integrated Approach to Achieve Equity

**Joseph Mbatia, M.D., M.Sc. Psychiatry**
**Rachel Jenkins, M.D., F.R.C.Psych.**

***Objective:*** **Although most donor and development agency attention is focused on communicable diseases in mainland Tanzania, the importance of noncommunicable diseases, including mental illness, is increasingly apparent.** ***Methods:*** **This report describes a ten-year collaborative project (1999–2009) to meet these challenges through a sustainable mental health policy introduced across Tanzania. The country used an integrated approach, combining situation appraisal, integrated mental health policy and planning, mechanisms for sustainable implementation with largely local resources integrated into local systems, and monitoring to fine-tune the implementation.** ***Results:*** **The project led to inclusion of mental health in relevant health policy instruments, treatment at the primary care level, stronger referral and intersectoral coordination, and a focus on rehabilitation and public education.** ***Conclusions:*** **Although much remains to be done, Tanzania's commitment to mental health is now sustainedly embedded within its policies, national and local budgets, and training activities. (*Psychiatric Services* 61:1028–1031, 2010)**

*Dr. Mbatia is affiliated with the Department of Mental Health, Ministry of Health, Dar es Salaam, United Republic of Tanzania. Send correspondence to Dr. Jenkins, Department of Health Services Research, Institute of Psychiatry, de Crespigny Park, London SE 5 8AF, United Kingdom (e-mail: rachel.jenkins@kcl.ac.uk).*

In Africa investments in mental health care systems have been limited (1). A previous initiative in two regions of Tanzania in the early 1980s, although successful in the short term, did not continue and was not disseminated after the donor funding ended (2). Tanzania is one of the poorest countries in the world, with a per capita annual income in 2005 estimated to be about $340 (U.S.), which rose to $400 in 2008 (3). Poverty in Tanzania is a major barrier to development, and the 2003 Tanzania Participatory Poverty Assessment cited environmental challenges, macroeconomic conditions, poor governance, disease, and cultural beliefs and practices as the main causes of poverty. The proportion of the population living below the basic-needs poverty line in 2000–2001 was 36%, with 92% using firewood and charcoal for cooking, 89% using traditional pit latrines, and 43% using an unprotected water supply (3).

Key contextual factors include a large geographic area (946,799 $km^2$); poor communications infrastructure; and rapidly rising population, from 33.6 million in 2002 to an estimated 41.0 million in 2009 (75%–80% rural), with 55% under age 19 and a life expectancy of 51 years. Health expenditure per capita was only $6.80 in 2004, rising to $11 in 2008. For a long time, Tanzania hosted more refugees than any other country in sub-Saharan Africa, estimated at 800,000 as of 1999 and falling to 360,000 in 2008 (4), mostly from Rwanda, Burundi, and the Democratic Republic of Congo.

We conducted the first population-level epidemiological survey of mental disorders in mainland Tanzania (5–7). Routinely collected police data for suicide are serious underestimates; however, a careful epidemiological study of mortality in the Morogoro region in 2001 indicated a rate of ten suicidal deaths per 10,000 women aged 18–45 (8). Alcohol is widely available (9), and its consumption is high in the refugee camps (Mbatia J, Hogan M, Jenkins R, manuscript in preparation, 2010) but less so in the cities (5,10). Tobacco use is prevalent, and substance abuse and HIV-AIDS are rising (10). Mental health care in Tanzania is predominantly government funded. Previously in the purview of the Ministry of Health and Social Welfare (MOHSW), budgeting for and funding of health care have been decentralized since 1999 to local district councils as part of treasury reforms, leaving the MOHSW with its core technical functions of policy, legislation, regulations, performance guidelines, standards of care, monitoring, and evaluation. Funds for mental health remain limited.

Mental health specialist care is delivered in district, regional, and zonal (average .5, 1.5, and 6.0 million catchment populations, respectively) outpatient clinics and regional and zonal inpatient units of approximately 20 beds each. Care is also available at the national referral hospitals at Dodoma (Mirembe, the former asylum, and Isanga, the forensic unit), Dar es Salaam (Muhimbili University Hospital), and Mbeya. The total number of hospital beds for a population of over 38 million is less than 900 (less than one bed per 35,000 population). In practice, when the national hospitals

are excluded, in most regions there are only 20 beds per 1.5 million.

There were 11 psychiatrists in 2001, which increased to 18 in 2009, of whom 13 are in the public sector, three are in private practice, and one each is serving a mission or nongovernment organization (NGO); only four psychiatrists practice outside Dar es Salaam. There are approximately 460 mental health nurses. Psychiatrists and nurses are concentrated in the major urban centers, and a high proportion of the psychiatric nurses have been redeployed to medical or surgical clinics, so the specialist service for nearly all regions and districts is largely delivered by extremely overstretched psychiatric nurses. The only mission hospital with dedicated psychiatric beds is Lutindi, which functions as a rehabilitation center. Several regional rehabilitation villages for people with long-term severe mental disorders that were established in the 1980s have suffered from logistical geographic problems (such as local transportation difficulties from the psychiatric unit to the rehabilitation village), so that patients' relatives and staff supervising the rehabilitation workers find it difficult to visit.

Primary care services are delivered through health centers (average catchment population 10,000) and dispensaries, which are staffed by general nurses and clinical officers who have received a small amount of basic training about mental disorders, diagnosis, and treatment but have hitherto not received in-service training or supervision for mental health. The supply of essential psychotropic drugs did not meet demand in 17 of the 20 regions in the country, especially in the rural areas, and patients were forced to either finance their own supplies or go without them.

A situation appraisal of ten major prisons identified a shortage of health workers, neglect of prisoners with mental illness, prisoners accessing cannabis, inappropriate imprisonment of people with mental disorders, weak support of prison health care by public mental health workers, lack of psychiatric treatment plans, and lack of mental health competence among prison health workers.

This brief report describes a long-term collaborative project between the MOHSW and the World Health Organization Collaborating Centre Institute of Psychiatry (WHO CCIOP), which used an integrated approach to mental health policy development and implementation in Tanzania between 1999 and 2009.

## Methods

A multifaceted and comprehensive program was instituted that combined situation appraisal to inform planning, sustained national policy dialogue, strengthening the coordination of mental health services, supervision and training of clinicians and staff, development workshops, production of toolkits and guidelines, establishment of intersectoral partnerships, and public education through radio and television service announcements.

We conducted a country-level situation appraisal, which involved identification and analysis of national and local data and documents, as well as site visits to relevant sectors (health, education, social welfare, police, prisons, and NGOs) at national, regional, district, and primary care levels. These visits were accompanied by consultation and discussion with professionals, clients, families, and other stakeholders and regional workshops. With this information, we constructed a mental health profile of Tanzania (www.mental-neurological-health.net), conducted pilot studies of population prevalence of disorders and associated risk factors (5–7), assessed knowledge and attitudes of primary care workers (11), and determined the prevalence of disorders among people attending primary care clinics (Mbatia J, Shah A, Parker E, et al., unpublished manuscript, 2010).

Dialogue with policy makers from MOHSW and other key ministries addressed the need for national mental health policy and for a mental health section within the ministry in order to represent mental health in generic policy development and to coordinate mental health care for Tanzania. In addition, there was a need to integrate mental health into overall health sector reforms.

Organizational and operational interventions included establishment of the Section of Mental Health within the Directorate of Curative Services. The National Mental Health Resource Center of Tanzania was also established. Coordination of district mental health services was strengthened through establishment of regional oversight and improvements at the district level. The coordination of primary care district mental health services was also strengthened, and supervision levels were established to build in oversight and accountability. District training and transportation budgets were revised to include mental health care needs in these areas, and a rolling fund was established to facilitate supply of psychotropic medication. Management information systems for the health sector also were modified to include mental health care services. The national mental hospital was transformed into a national training hospital (reduced from 1,000 to 500 beds), with responsibility for advanced training of nurses and assistant medical officers. WHO primary health care guidelines for mental health care were adapted and distributed, and training toolkits were constructed and disseminated.

## Results

The policy dialogue ensured successful establishment of the sector of mental health in the Directorate of Curative Services and of the National Mental Health Resource Center, plus integration of mental health into the health sector reform plan from 2001 onward. Formal mental health policy guidelines support the Tanzanian health policy and were included in the National Package of Essential Health Interventions of 2001, the Medium-Term Expenditure Framework (MTEF) of 2003, and the National Strategy for Non-Communicable Disease of 2009–2015. Therefore, mental health appears as an integral component of health care at all levels, with defined interventions from primary care to tertiary hospitals. The National Essential Drugs List outlines the type of psychotropic medicines to be provided from tertiary to primary care treatment settings, and these are now generally available. Mental health legislation and tobacco

control legislation have been passed (12,13), and there is a longstanding interministerial drug strategy (14).

The MOHSW has integrated mental health into primary care in most regions in mainland Tanzania, working through the Mental Health Association of Tanzania and funded by the MOHSW and various donors and NGOs. Training of general health workers in primary care in identification and management of common mental disorders is followed by supervision, monitoring, and evaluation by district mental health coordinators.

We engaged the various training organizations in discussions about strengthening curricula and methods in an effort to ensure that specialist training would meet the broad range of Tanzanian needs. Mental health professionals may be responsible for catchment populations ranging from 5.0 to 6.0 million. For them to have a sustained impact on their population, their training needs include teaching and supporting frontline primary care staff, as well as in advocating and facilitating service development and intersectoral liaison. Therefore, they need leadership, educational, and intersectoral skills in addition to the clinical and research skills of their profession. An advanced psychiatric diploma for assistant medical officers is being established to parallel the advanced diploma for nurses.

Training for regional and district mental health coordinators to train, support, and supervise primary care workers was initiated in 2004 and coordinated by the MOHSW in dialogue with the WHO CCIOP. Training in the Arusha, Kilimanjaro, Manyara, and Tanga regions was funded by the MOHSW. Training expanded to the Lake Zone regions (Kagera, Mara, Mwanza, and Shinyanga) with support from the Catholic Organization for Relief and Development Aid, the Mental Health Association of Tanzania, demand-driven district initiative funding through the Danish International Development Agency, local government, and the MOHSW. A core team of trainers supervises the training process, which is sustained with a system of quality controls. As of 2009, 94% of districts had trained mental health coordinators, compared with 0% in 2000. In addition, the local government of Vaasa, Finland, has funded training of staff in Morogoro, and BasicNeeds funded training in some wards in Mtwara and the Dar es Salaam regions. By mid-2009, a total of 3,895 primary care health workers had received at least five days of training in identification and management of severe and common neuropsychiatric disorders. Prisons have also started mental health training for their medical services staff.

A strategy to sensitize regional and district health teams, local government leaders, and traditional healers has been developed. The training for district mental health coordinators includes developing competency in integrating mental health budgets into comprehensive district health plans, which has resulted in enhanced funding.

The demand for traditional healing is higher among patients with neuropsychiatric disorders than among those with all other medical conditions. Therefore, primary care workers are encouraged to establish a working alliance with traditional healers and to encourage referrals from healers, especially for people with epilepsy or psychosis. Focus group discussions with community leaders have facilitated better community understanding and support for mental health interventions and improved case finding in the community. The number of patients with neuropsychiatric disorders attended in primary care increased sixfold between 2001 and 2007, to 118,730 patients, and the total number of recorded cumulative psychiatric cases recorded in the health system increased from 20,000 in 1999 to 685,788 in 2008.

Factors that have influenced the success of developing mental health care policies and programs include revising the overall health policy to recognize mental health as an integral component of comprehensive primary health care services; stakeholders' common understanding of the Kiswahili language, which enabled training, capacity building, and liaison in a common language; the national goal of equitably providing health services that meet or exceed standards of quality; and improved health budgets over the lifetime of the intervention. (The health sector budget was approximately 3% of the total national budget in 2001, compared with 9% in 2006–2007.)

## Conclusions

This project has integrated mental health care into primary care and has supported equitable access to mental health services, consistent with Tanzania's sociopolitical philosophy since independence and outlined in the Arusha Declaration of 1967 (15). This consistency has probably enhanced the success of the ten-year collaboration, despite the barriers faced in sub-Saharan Africa, including in Tanzania (1). This project has demonstrated the importance of using a multifaceted and comprehensive process of situation appraisal; having an open dialogue with policy makers; focusing on training to provide appropriate treatment at the primary care level; strengthening the referral system and intersectoral liaison; and providing for rehabilitation, social inclusion, and public education. Although much remains to be done, Tanzania's commitment to mental health is now embedded in its policies, national and local budgets, and training activities.


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