The United Republic of Tanzania

Ministry of Health Community Development,
Gender Elderly and Children

MENTAL HEALTH
SITUATIONAL ANALYSIS
REPORT

March, 2021

Releasing children from poverty
Compassion in Jesus' name
INTERNATIONAL TANZANIA

TANZANIA NON-COMMUNICABLE DISEASES
Prevention and Control Programme

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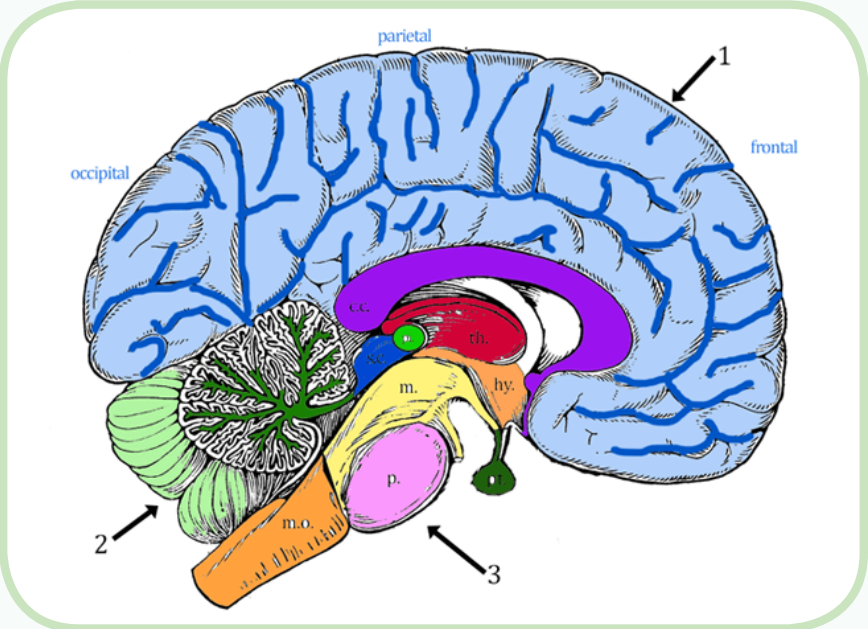

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TABLE OF CONTENT.

ACKNOWLEDGEMENT

This Mental Health situational analysis report was produced after fourteen days of fieldwork in 8 regions of Tanzania mainland namely; Arusha, Dodoma, Iringa, Dar es Salaam, Mtwara, Mara, Geita, and Mwanza.

Analysis work both qualitative and quantitative (aggregated data) and technical inputs from Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), Directorate of Curative Services in collaboration with Compassion International Tanzania (CIT).

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Dr. Aifello Sichalwe

CHIEF MEDICAL OFFICER

EXECUTIVE SUMMARY

Mental Health (MH) is among the major contributors to the global burden of diseases with about 300 million people are afflicted with at least one form of mental disorder worldwide; however, mental health remains neglected in the majority of underdeveloped countries Tanzania included. In sub-Saharan Africa where many people are living in poverty, the impact of mental health has sustained the vicious cycle of poverty in the households of low and middle income countries(LMICs). Given that poverty and poor financing mechanism pose a serious challenge towards access to mental health services in the developing world, interventions that give more attention to the promotion of mental wellbeing and preventing ill health offers cost-effective measures with the highest benefits for individual and society as a whole.

In the medical fraternity, the mental health profession faces the biggest challenges in terms of resource allocation and has the biggest shortage in terms of human resources. The current psychiatrist to population ratio is at 0.0625 for 100,000 people, while 0.0375 psychologists for a population of 100,000 individuals, and a huge burden of mental health care has been carried out by mental health nurses for many years. Tanzania being a resource-limited country, implementation of mental health care is largely influenced by many factors such as the policy on mental health, financial barriers, poor level of health system preparedness as well as the belief system, knowledge, and attitudinal factors on both providers and beneficiaries of mental health care that significantly affect mental health care in the country. In light of this, the Ministry of Health in collaboration with CIT conducted a survey to assess the prevailing situation of Mental Health services in the country.

The objectives of this survey were to, i.) to identify the current political support for Mental Health care, including budgets, policies, plans, legislation, and welfare benefits, ii.) to determine health indicators for Mental Health iii.) to determine knowledge and attitude regarding Mental Health among members of the community in the country, iv.) to explore health care workers overall experiences, challenges in terms of shared decision making, access to care and Mental Health-related information with the patients, v.) explore the care taker's knowledge, attitude, perception and belief system about Mental Health and vi.) to explore patients experience regarding satisfaction with Mental Health services, access to information, shared-decision making on treatment and overall challenges regarding living with mental illness and access to care.

The situation analysis report revealed that there is apolitical will and commitment despite several challenges in terms of policy implementation and inadequate allocationof budget for mental health services. There is a significant treatment gap linked to access to care and human resource in MH care.

This survey underscores the need to review factors that hinder the implementation of mental health policies and address limitations where necessary. Interventions that provide more attention to the promotion of mental well-being and prevention of mental ill-health appear to offer a practical approach.

Furthermore, a review of mental health policies and guidelines to address their gaps and limitations will be of great benefit.

Over the course of the past five years, there is an increasing trend in the attendance of mental health services in the country. Although several centers provide mental health services, there is still scarcity in the provision of MNS services. Other services including psychological, counseling, child and adolescent mental health continue to have a huge treatment gap.

As for community knowledge regarding mental health, the majority of the participants were able to identify at least one cause of mental illness while less than half were able to describe what happens to people with mental illness in terms of behavior and experience. At least half of the participants identified at least one psychiatric condition and thought that psychiatrists and psychologists should take care of or attend people with mental illness.

Mental health care workers, in general, acknowledged the benefits of shared decision making with patients, however, they voiced their challenges of working environment including a shortage of staff, the inadequacy of knowledge and necessary skills hinders them in providing the best care to their Patients in general, and also acknowledged the benefits of receiving treatment, though access to care was reported as a major obstacle in the recovery process. Some patients voiced their dissatisfaction with the level of care they receive citing the negative attitude and beliefs of health care workers being the main factors that hinder their care. They also reported that many of them are kept oblivious to their treatment plan and play no part in the recovery process.

Prof Abel N. Makubi
PERMANENT SECRETARY

INTRODUCTION AND BACKGROUND

The World Health Organization(WHO) defines Mental Health as "a state of well-being in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and can contribute to his or her community"(1). To achieve Mental Health, an individual must understand one's conditions concerning their psychological and emotional wellbeing and their access to Mental Health care in the community.

Mental Health is an issue of major concern in both the developed and developing world, with a lifetime risk of more than 25% for any psychiatric disorder; most people are either directly or indirectly affected. With more than 13% of the global burden of diseases attributed to neuropsychiatric disorders, and about three-quarters of this burden are in low- and mid-income countries where 76% to 84% of patients with mental health challenges do not receive any care (2). The situation is further compounded when less developed countries experience long periods of violent political conflicts (3) and thus highlighting the gap and the need for mental health care (4,5).

Low coverage of health services and limited financial capacity for mental, neurological, and substance abuse (MNS) has a profound impact on the already compromised economy of households in LMICs and thus negatively affect the quality of life, reduce productivity and ultimately reinforce a vicious cycle of poverty (6–8). As the majority of mental illnesses start in early adulthood, the association between mental illness and loss of productivity and eventual poverty has been well demonstrated in sub-Saharan African countries(9–11).

Currently, Tanzanian health sector has improved over the past few decades. Number of health facilities have significantly increased and many individual health issues including mental health are now reached even in previously less accessible areas. However, this mode of provision of health care does not accommodate increased needs for mental health services in the country.

As poverty and inadequate financing mechanisms make access to mental health a serious challenge to the majority of the sub-Saharan Africa population, greater attention to mental health promotion, and prevention measures suggest a cost-effective approach to face the increasing burden of mental disorders, and limitations of existing treatment methods. Therefore, policies promoting mental health integrated with a programmatic intervention that targets vulnerable populations will be beneficial (12). Social determinants of poor mental health and resilience to face the risks can be addressed by promoting mental health and implementing intervention for at-risk populations and potentially break the vicious cycle of poverty and mental ill-health in LMICs(8,13). Measures that promote mental health and preventive intervention early in the lifespan can potentially offer the highest benefits for individual and societal wellbeing through improving earning, less dependency on social services, reducing rates of criminal behavior, and reducing out of wedlock births (14).

In Tanzania, an estimated 7 million people are living with mental disorders and substance abuse, and over 1.5 million living with depressive disorders, majority of whom being females. With a total expenditure of only 43 Tanzanian shillings allocated on mental health per person, and Disability-adjusted life years (DALYs) of 2,727 per 100,000 population, mental health needs are seriously unmet and thus improvement in financing is of crucial importance(15).

Tanzania like many other resource-limited countries has its turbulence history with the provision of Mental Health services stretching backin 1927 when the British colonial administration built Mirembe hospital in the Dodoma region to handle mentally ill patients from all over Tanganyika(15). Later, in 1951 a forensic psychiatric unit known as Broadmoor (currently, Isanga Institute) was established and after independence in 1961 psychiatric units were introduced in all regional hospitals. In the 1980s government started piloting and scaling up Mental Health services to primary health care as per WHO recommendations.

In the early 2000s, the government of Tanzania endorsed Mirembe to become a specialized Mental Health hospital in the country. As of the year 2005, there were six regional hospitals with in-patient services as stand alone psychiatric units, while in the remaining 14 regions the mentally ill patients were treated in general wards. However, the government's goal of establishing curative regional Mental Health services in all regions did not succeed for various reasons including limited and/or absence of infrastructures, human resources, and others to mention a few. This has hampered the integration of Mental Health into the health care services at all levels and the community at large. By the year 2017, all 28 Regional Referral Hospitals, 3 Zonal hospitals, National hospital, and 1 specialized Mental Health hospital were providing Mental Health services.

Mental Health and Alliedprofessions are among the neglected areas in the medical fraternity with very little investment or resource allocation. Tanzania is facing a shortage of human resources for Mental Health.Furthermore, several factors hinder the implementation of Mental Health care services, this may include failure to comply with policy that promote access to affordable care to all, plans that are difficult to implement due to financial barriers, resulting to poor level of health system preparedness at all levels of health care organization (16). On the other hands, both beneficiary and provider factors play a major role, attitudinal barriers such as beliefs about mental illness and structural barriers such as lack of time, resources, and medicines hinders access to Mental Health Services.

The Ministry of Health Community Development, Gender, Elderly and Children (MoHCDGEC) through Curative Department in collaboration with Compassion International Tanzania (CIT) adopted the six building blocks of WHO which are Governance, Infrastructure, Human Resource for Health, Service Delivery, Finance and Health Management Information System to conduct a Situation Analysis on Mental Health to understand the current prevailing situation of Mental Health -in the country.Furthermore, promotional activities and preventive interventionswithin the Mental Health sectorin the country were reviewed.

OBJECTIVES

Purposeof this situation analysis

The purpose of this work was to enable MoHCDGEC to understand the existing situation upon Mental Healthin health facilities and community in terms of political support, financing, human resources, preventive and promotion activities, as well as investigating theknowledge, exploring attitudes and beliefs of providers and beneficiaries associated withMental Health and the use of mental healthservices.

SPECIFIC OBJECTIVES

1. To identify the current political support for Mental Health, including budgets, policies, plans, legislation, and welfare benefits
2. Contribution of mental Health, Neurological and Substance Abuse conditions in the Non Communicable Diseases in the Country.
3. To explore management and coordination of mental health information systems across the health facilities in the country.
4. To investigate knowledge and attitude regarding Mental Health among members of the community in the country.
5. To explore barriers that affect access to Mental Health care and Mental Health-related information with the patients.
6. To explore the care taker's knowledge, attitude, perception, and belief system about Mental Health.
7. To explore patients' satisfaction with Mental Health services.

METHODOLOGY

The mental health situational status was assessed using the PRIME tool adapted to specific areas of interest which included, (a) Political commitment and support, (b) Mental Health budget, (c) Mental health policy. The questionnaire was provided to members of RHMT, RRH-Management and CHMT as well as key mental health focal persons from ministry to district level.

The overall process included a desk review of official documents, quantitative surveys, and qualitative interviews.

Desk review

Involved reviewing documents such as Health policy 2007, Comprehensive Hospital Operational Plans (CHOP), Mental Health guideline, NCD strategic plan 2016-2020. Human resource for mental health were assessed by reviewing facility human resource registry and human resource distribution list at the regional and council human resource registries. District Health Information System (DHIS), Service registries and clinical reports were used to determine types of mental services provided.

Quantitative and Qualitative surveys

The quantitative approach was employed mainly to assess the community knowledge and attitude regarding Mental Health among community members in the country.

Sample size estimation

A minimal sample size of 385 was calculated based on Kish Lesley formular, $N=Z^2pq\ /d2$. P was estimated at 0.5 as it provides the minimal sample size estimation. Thus a calculated minimum sample of 385participants was reached. Adjusted for 20% non-response rate, a sample of 462 was recruited.

A sample of462participants was interviewed across 8selected regions Arusha, Dar es salaam, Geita, Iringa, Mara, Mtwara, Dodoma and Mwanza. A proportionate sampling method was followed where the number of participants from each site was proportional to percentage contribution in the combined population of all regions, and this was followed by a systematic sampling method for each sampling frame.

Interviews were conducted with officials at the ministry of Health including theDirector of Curative Services, Assistant Director of NCD, Program Manager NCD, National Mental Health Coordinator, Regional Medical Officer (RMO), Health Secretary, Pharmacist, Mental Health Coordinator, Matron/Patron, HMIS Focal person and Service providers, DistrictMedical Officer (DMO), District Mental Health Coordinator and Service providers and Community (Service providers at health facility and other providers) levels. Beneficiaries at National Hospitals, Specialized Mental Health Hospital, Regional Hospitals, Districts Hospitals, Health Centers, Dispensaries and community were also interviewed about the services provided, on perceived benefits, strength, challenges, and obstacles regarding the provision of mental health services in the country.The

qualitative part involved in-depth interviews(IDI), key informant interviews(KII) and Focused Group discussion(FGD).

In-depth interviews were conducted to health care workers and beneficiaries. To understand their perspective on the availability of infrastructure, human resources, medicine, and finance in providing care to people living with mentally illness and those with substance use disorders.

Key Informant Interviewswere conducted to individuals taking care of close relatives with mental illness, these included parents, guardians, relatives or anyone involved in the welfare of the people living with mentally illness. Aimed at understanding their general knowledge of Mental Health and related services, challenges faced, and how they deal with them.

Focused group discussions (FDGs)were conducted toservice providers, people living with mental illness and substance use disorder(s), and their social networks. Aimed to understand their engagement to Mental Health services provided

Data analysis

The quantitative analysis was done using the SPSS version 21 program to determine the frequency and proportions of the variables.

The qualitative data were analyzed through the thematic analysis framework suggested by Braun and Clarke (2006). The authors highlighted six phases of thematic analysis which include: familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. NVivo and Microsoft Word programs were used to support data organization, coding, and themes identifications. In producing a report in this study, the data were presented as summaries and narratives and were illustrated with examples and quotations, capturing respondents' perspectives and experiences.

RESULTS/ FINDINGS

i. To identify political support for Mental Health care, including budgets, policies, plans, legislation, and welfare benefits.

The analysis of the existing situation revealed there is a political will and commitment within the government system as reflected by the presence of Policy Statement on Mental Health within Health Policy of 2007 and establishment of Mental Health section at the Ministry of Health as well as presence of Mental Health Coordinators from National to Council level. The National Healthy Policy is well translated in the mental health policy guideline of 2006 and the mental health Act of 2008. Furthermore, these policy documents are translated into implementable plans through Health Sector Strategic Plans (HSSP-IV) and the National Strategic Plan for Prevention and Control of NCD 2016 – 2020. The mental health policy guideline/strategy includes the integration of MH in PHC in all regions. Mental health is indirectly addressed in many other sectoral policies, these include Child Policy 2016 that address child protection as a key component in the policy. The Law of Child Act 2009 and its regulations further stressed on child protection against inhuman treatment of all kind. Mental health featured well in Elderly Policy 2003 (Sera ya Wazee 2003) and other Policies that addressed people with disabilities.

Political will is further evidenced by the level of commitments made by the high-level officials including the Head of State. In 2012, then the President of the United Republic of Tanzania his Excellency Jakaya Mrisho Kikwete launched a methadone Clinic at Mwananyamala Hospital under the Mental Health Department and acknowledged the importance of treatment for people with Substance Use Disorders and his support for the expansion of these services within Mental Health care settings in the country. This was followed by the Prime Minister announcing himself to be an ambassador to help those who require such services. The commitment to mental health is further demonstrated by the fact that each year, Tanzania joins WHO and other nations to commemorate mental health day with official statements and directives to the officials and the general public on the directions to take from a Global theme.

As for the Mental Health budget, MH services received around 1 - 3% of total budget expenditure in the year 2018/2019. These excluded salaries and other benefits to MH staff. The biggest portion of the MH budget goes to the medications and support for inpatients services that include meals, accommodation and other operational costs as many in patients stay longer in facilities than intended duration. In some cases, facilities might be forced to arrange for the repatriation of clients from MH hospital or forensic facility. Furthermore, to ensure there is adequate number of skilled staffs, the government allocates mental health budget and funds to support the training for specialization in Psychiatry as one of the favored areas for Post-Graduate training.

Currently, MH services are provided from dispensaries to district levels with more than 50% of all councils with mental health nurses providing most of these services. Where there is no well-established standalone mental health services, these services are provided as an integral part of medical services under the departments of internal medicines or routine outpatients care at the Health Centre and Dispensary levels. There are some initiatives to integrate mental health services in other settings such as maternal and reproductive health clinics chronic services. There are collaborative programs at regional levels in Dar Es Salaam and Mbeya regions where MH is integrated into maternal mental health. In almost all HIV care, here are comprehensive HIV counseling services that address psychological and social issues including peer-led initiatives especially for those living with HIV and their social networks. Due to a critical shortage of skilled personnel, only a few facilities managed to have integrated services and in many places, services are not structured to accommodate acute mental health care. Mental health services are not included in National Service Availability and Readiness Assessment (SARA) Surveys, however there are components on availability of essential medicines in which we can use as a proxy indicators for availability and readiness of mental health services in the country. According SARA 2017 report on availability of essential medicines, out of 5 least available essential medications, three were essential medications for mental health disorders that include Fluoxetine caps/tab (1%), Carbamazepine (3%) and Haloperidol (3%). *(SARA Surve 2017)*

Currently, there are more than 69,000 clients who receive substance use disorders treatment in facilities in the selected regions. The services include methadone treatment for those with opioid use disorders, and Sober Houses, Narcotic Anonymous sessions, and counseling units for other substances at all levels of care. Many of these clients receive services without paying for the services with the exceptional of the few, especially those attended outside of the public health facilities.

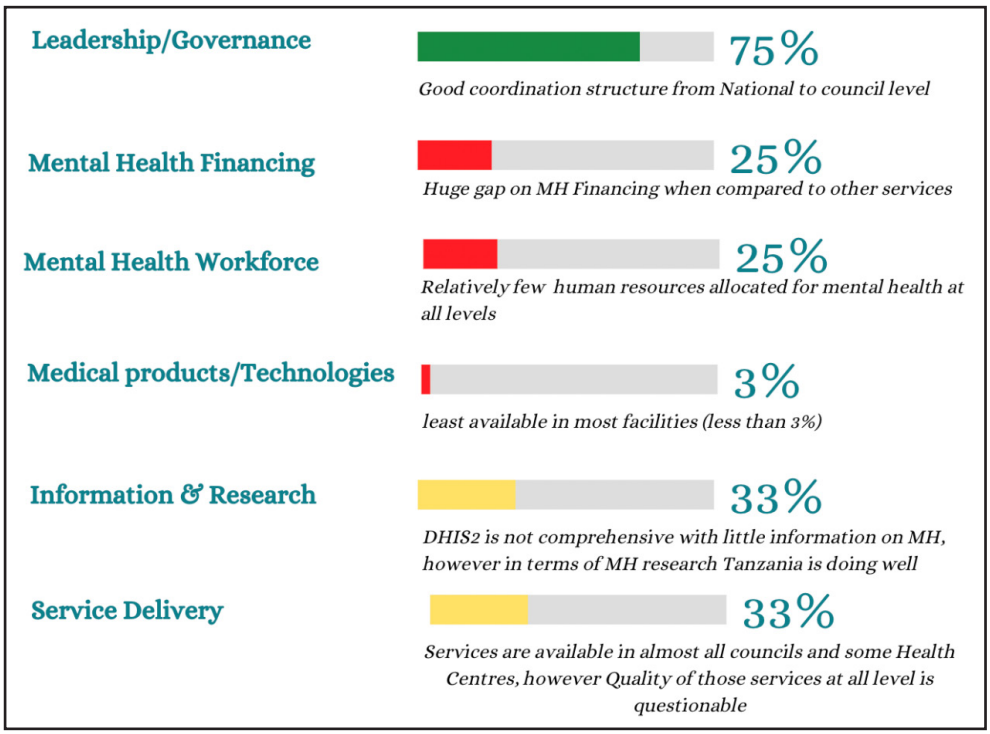
To reach the vulnerable population, the Health Policy provides an exemption to all patients with chronic conditions including patients with mental disorders. The exemption policy is mainly for those who cannot afford the cost of services and covers all basic mental health services. To access other services such as radiological and other high-cost diagnostic or treatment services, patients might need to get the approval of the facility in charge through the social welfare department.

As for the mental health promotion and prevention, currently there is not specific budget allocation for mental health promotion: however, through the NCD basket several activities have been performed for several years to improve community awareness on mental health.

Several official documents including health policy 2007 highlights on health promotion especially on educating, advocating and empowering individuals on healthy behaviour; however, the policy does not address in detail the mental health promoting behaviour.

The overall picture for the current status of mental health system is not very promising, as almost major components of building resilient mental health systems has very poor performance. Out of six blocks only Leadership structure and list of essential medicines has some improvement. Otherwise there is extreme shortage of Human Resources for Mental Health, Services are of poor quality and not adequate, funds allocated for mental health services is extremely low and very poor Health Management Information for Mental Health that doesn't capture enough information to assist planning for the Mental Health care. Fig 1 below, summarizes these findings in colour codes, with Green being well performing component, yellow moderate performing and red poorly performing components.

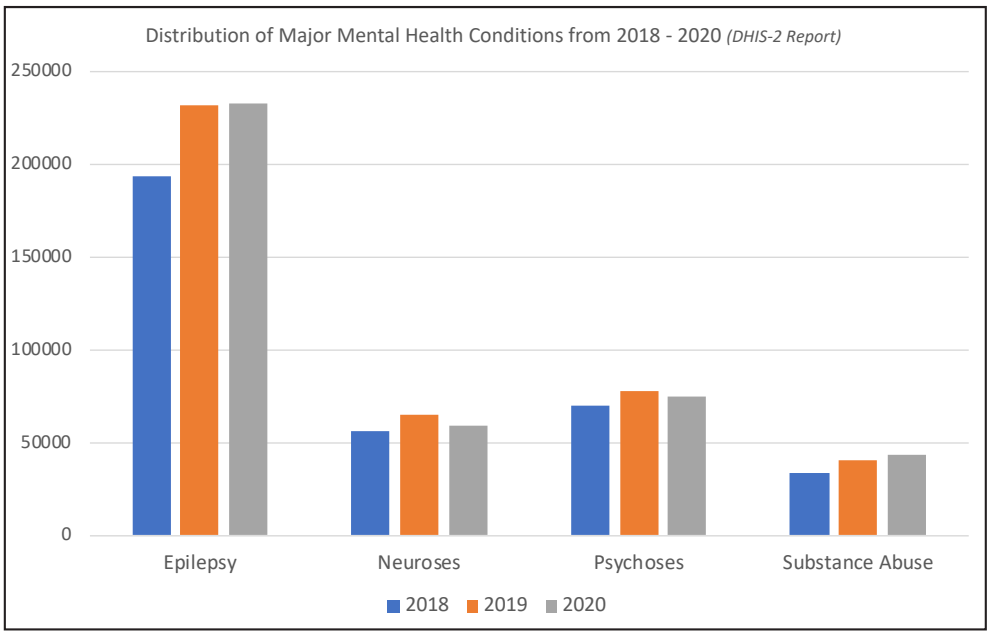
Review of WHO Six Building Blocks of Health System Using Prime Tool



II. Contribution of mental Health, Neurological and Substance Abuse conditions in the Non Communicable Diseases in the Country

This report was compiled from DHIS-2 for 2015 and recent data of two consecutive years from Jan – Dec in 2018 and 2019. The finding revealed that Psychiatric and neurological disorders including Neurosis, epilepsy, psychotic and substance abuse contributed significantly to the burden of disease at the national level with 17% of all cases of non-communicable diseases attended at facilities. Between 2015 and 2019, there was an increase in the number of patients with neuropsychiatric and neurological disorders attended at health facilities,See Figure 2 below.

Figure 2: **Annual frequency of major Mental HealthCondition for each disorder/condition for the respective year. (Data retrieved from DHIS 2 for each respective year)**



III. To explore management and coordination of mental health information systems across the health facilities in the country.

The information was gathered from the Regional Office, at least one Council and at leastone community-based service. The areas of interests were the status of human resources for mental health; availability of health care services including essential medicines as well as community led mental health services. It was revealed that, extreme shortage of human resources for mental health at all levels. The number of staffs was low with the highest number being nurses, followed by clinical officers and Mental Health Rehabilitation Officers. The situation is quite different at the service provision points whereby many qualified mental health staffs are assigned other duties leaving MH Service provision point critically under staffed.

The overall status of the provision of mental health services for the eight visited regions showed that Dar es Salaamhad the highest number of centers followed by Mwanzaand Dodoma regions. As for the inpatient services, Geita had seven centers, Iringa nad Mtwara had one center each. Of the visitedregions Dar es Salaam had three centers while Iringa,

Arusha, Mwanza and Dodoma each had one center. Dodomahad seven MH rehabilitation facilities while community mental health services had only Mwanza and Mara regions had community mental health services. Sober houses were available in all regions except Geita and Mtwara while centers for children and adolescents with special needs were available in all regions except Arusha, Geita and Mtwara.

Apart from Dar es Salaam with more than 10 psychiatrists, the rest of the visited regions had no psychiatrist available for mental health carewith only Mbeya region had 1 psychiatrist and Mwanza Region had 3 psychiatrists respectively.

IV. Community knowledge, attitude, and perception about mental illness (quantitative survey)

The community survey of 462 participants from both Urban 355 (76.9%) and rural 107(23.1%) settings was conducted, comprising of females 282 (61.1%) as the majority. The majority of 284 (61.5%) of the participants were below 35 years of age. A slight majority (52.4%) of the participants completed secondary school/equivalent education, 169 (36.5%) completed primary education, while 20(4.3%) did not complete primary education, and 31 (6.7%) attained tertiary education.

Table 2: Mental Health services available in the region

TYPE OF MENTAL HEALTH	REGION							
	IRINGA	ARUSHA	MWANZA	DODOMA	MARA	DAR ES SALAAM	GEITA	MTWARA
OPD services (Distr & RRH)	4	4	4	9	3	25	7	8
MAT Services	1	1	1	1	0	3	0	0
In Patient Services (Dist & RRH)	1	0	0	0	0	0	7	1
Mental Health Rehabilitation	1	0	1	7	1	1	0	0
Sober Houses	1	5	2	1	1	10	0	0
Community	0	0	2	0	2	0	0	0
National/Regional Hospitals	1	0	1	1	0	2	1	0
Services for Children with special needs	0	1	18	2	2	1	0	0
Correction centers for minors	0	1	0	0	0	1	0	0
TOTAL NUMBER OF FACILITIES	**10**	**12**	**29**	**21**	**9**	**43**	**15**	**9**

Table 3: Socio-demographic characteristics of the participants			
Variables		N	%
Gender	Female	282	61.1
	Male	180	38.9
Age in years	16-25	162	35.1
	26-35	122	26.4
	36-45	74	15.9
	46-55	62	13.5
	Above 55	42	9.1
Education	Primary Incomplete	20	4.3%
	Primary complete	169	36.5%
	Secondary/equivalent	242	52.4%
	Tertiary education	31	6.7%
Residency	Urban	355	76.9%
	Rural	107	23.1%

Perceived causes mental illnesses

Regarding the causes of mental illness, more than 80% of the participants agreed that life stress (84.8%), alcohol/drug use (84.6%), and accidents (87.9%) were among the causes of mental illness. More than 75% of the participants agreed that Issues of the family (75%), organic (77.8%), and death of a loved one (78.8%) were among the causes of mental illness. Around 70% of the participants agreed that Child abuse (73.1%) and loss of employment (69.2%) were among the causes of mental illness. Few participants had agreed to environmental factors (52%) and genetics (45.2%) being the causes of mental illness.

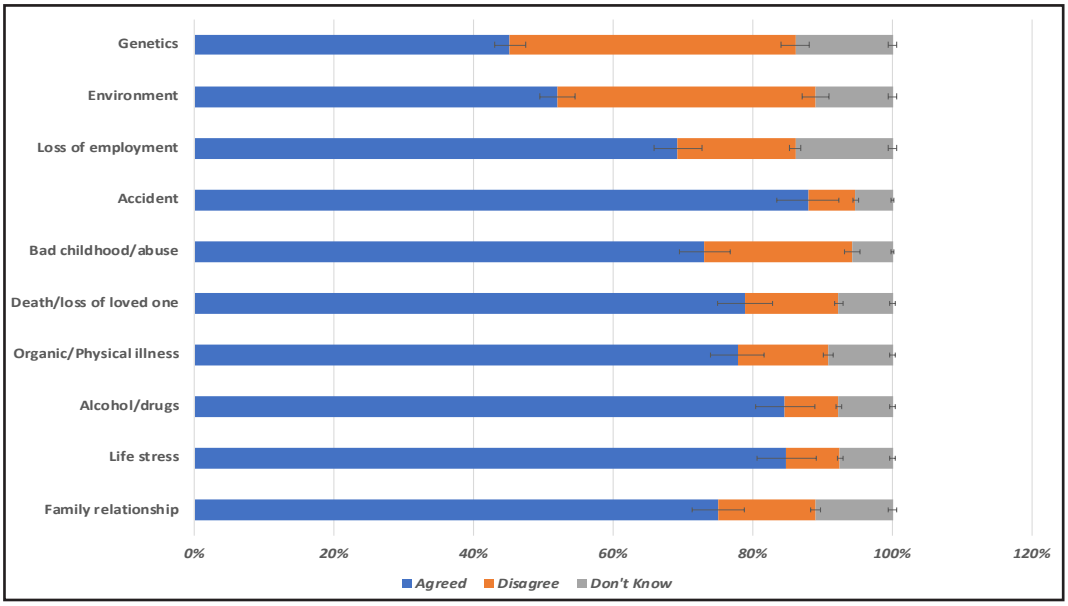
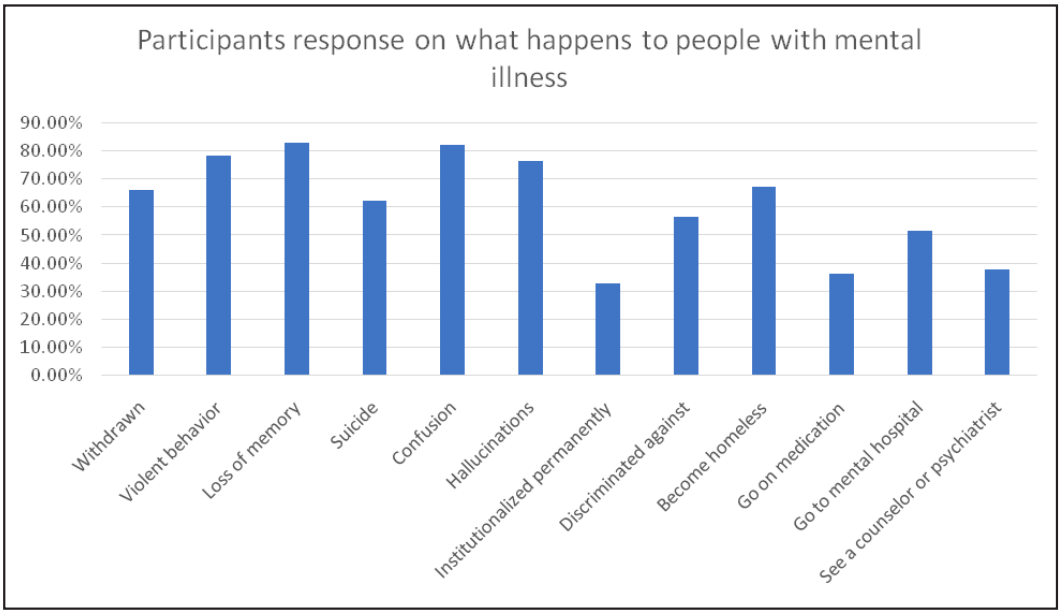


Fig 3: Perceived causes of mental illness

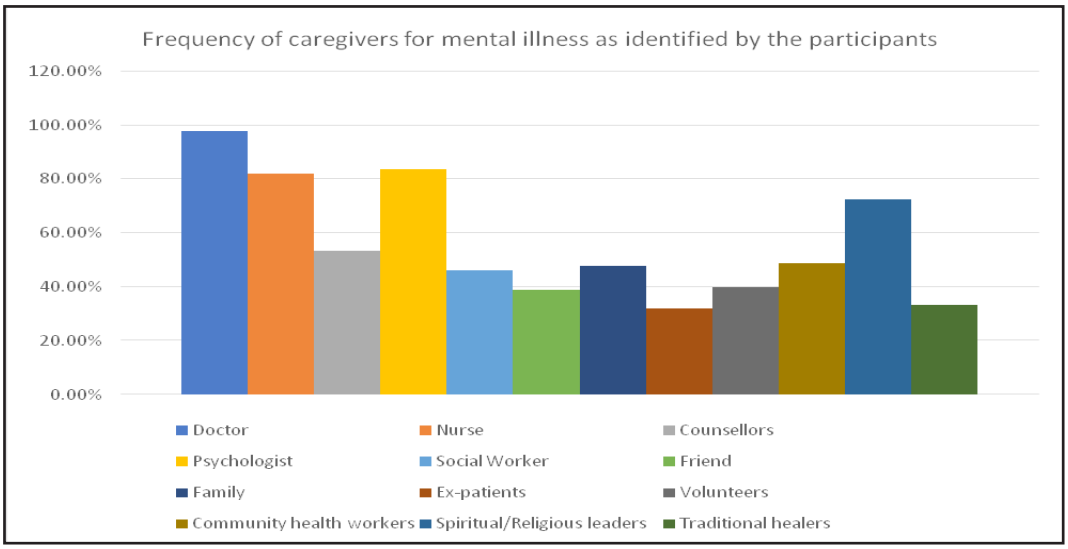
What happens to people with mental illness?

In response to the question, "what happens to people with mental illness" most participants reported memory loss (83.1%), confusion (82.2%), and violent behaviour (78.4%) as the conditions that occurs in people with mental illness. Few people agreed that people with mental illness see a counselor/psychiatrist (37.5%), go on medication (36%) and end up institutionalized permanently (32.7%). (See table 3)



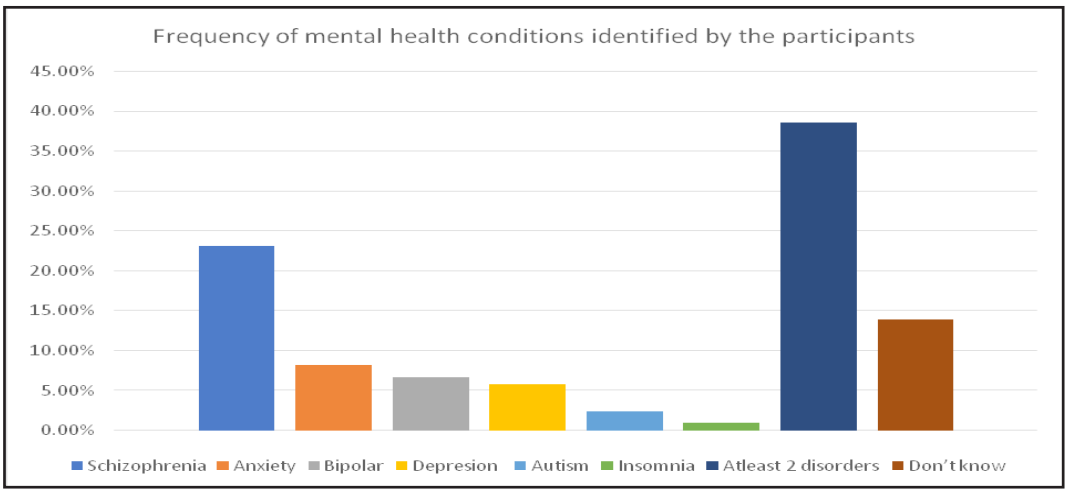
Who should care for people with mental illness?

Most of the participants strongly agreed that either a doctor (97.6%) or a psychologist (83.6%) should care for people with mental illness. A significant minority(72.2%) of the participants agreed that spiritual or religious leaders should care for a patient with mental illnesses.



Mental Health conditions identified by the participants.

Out of the 462, majority of the participants (38.5%) reported to be familiar with at least two of the presented mental health conditions. Most of the participants reported be familiar with schizophrenia (23.1%), followed by anxiety disorders (8.2%), bipolar disorder (6.7%), depression (5.8%), autism (2.4%) and insomnia (1%).About 14% (13.9%) of the participants reported not to be familiar with any of the mental conditions presented during the survey.



V. Health care workers overall experiences and challenges in terms of shared decision making, access to care and access to Mental Health-related information

The respondents/informants expressed mixed feelings regarding "their overall experiences and challenges in terms of shared decision making, access to care, and access to Mental Health-related information. Regarding their experiences in dealing with mentally ill patients, it was found that an unfavourable work environment weakens their day-to-day capabilities of discharging their duties. The participants indicated that most of the hospitals do not have adequate drugs and other medical supplies. Hospitals fell- short of professional staff and had found the available team to have inadequate knowledge in dealing with mentally ill people. Following a limited number of professional staff, the caregiving staff is forced to ask for help and refer patients to other hospitals for further management and care. In this context, one of the respondents had this to say:

"Dealing with people living with mental illness is interesting; however, time for counselling them is limited due to overload. Besides, there is a shortage of drugs, professional staff, office, and places to attend the patients" (March 2020)

Such a comment shows that caregiving staff work under poor working environments such that, they experience difficulties in providing their expertise to the patients accordingly. Therefore, it implies that patients with mental illness do not enjoy standard health care hence impairs recovery.

In dealing with people with mental illness, the informants pointed out inadequate knowledge of Mental Health. Most respondents expressed that they are working in an environment where they feel less confident on their abilities in carrying out their routine duties in managing patients. They highlighted that sometimes patients are treated very poorly, which is perhaps inappropriate reflecting their illness's nature. It was further voiced that in some cases, the treatment of these patients is not given enough consideration as per their mental health challenges.

Participants also cited that negative beliefs held by the patients' relatives affected corporations toward patients care. Some parents think that mental illness is not real and has nothing to do with biological disturbances. They relatives that the problem is mainly caused by witchcraft; therefore, there is no need to attend the Mental Health Clinic for treatment; thus, they go to the traditional healers instead.

Another experience shared by the participants was that in starting treatment, the patients only participate in the initial stages of management; after that, the patients are left alone to attend the clinic. This creates a challenge for the patients to follow treatment plans like adhering to the treatment as per instructions. Likewise, many patients are

subjected to stigma in their society. In most cases, they cannot interact with community members they are feared that they can harm them. Regarding this, one of the respondents remarked:

"We see here that many of our patients experience stigma from their peers. Whenever they want to socialize with their friends and relatives in their societies, people stay far from them. I guess, they feel mentally ill patients are not reliable, sometimes they are okay, and sometimes they are not okay" (March 2020).

The observation indicates the existence of a negative attitude towards mentally ill patients. The thinking is that patients cannot recover to live a productive and healthy life. This observation shows that society thinks that people living with mental illnesses are not reliable even at a state of remission and can easily relapse back to being ill; something that is likely to affect treatment and outcome. Moreover, it was reported that a significant proportion of patients lack insight into their mental illness, thus compromise their overall management. Participants said that patients, in general, lack the knowledge to identify possible triggers of their conditions and initial symptoms. In this case, when informed that they had signs of mental illnesses, they tend to disagree. The findings also revealed that most of the patients and their relatives are from lower socioeconomic status. They cannot afford treatment; therefore, caregivers found it futile to adhere to the prescribed therapy.

Further to this, the participants were asked to share their views on providing health-related information to a mentally ill patient. The findings show that the participants underlined community conscientization as a key to a mentally ill patient receiving or not receiving care as reflected upon patients when in need of psychiatric care. Participants expressed that the community needs to be educated on the leading causes and effects of their existing mental health condition. They added that it is crucial to extend counselling services to the community to become less confused at the initial stage of medication. The participants thought, integrating recovering mentally ill patients into the community could be beneficial. Participants felt it was equally important to provide information about the need to start medication timely and sustainably after diagnosis. In subscribing to this line of thinking, one of the respondents said:

"To me, I think it is a wise thing to start with community conscientization. Most of the patients are ignorant of triggers and accelerators of the mental illness. Maybe this is a root cause of why we have many mental illness cases that could sometimes be avoided. Even stigmatization is not a good thing. The mentally ill patient should not frequently experience relapse back to a severe state. The current isolation mentality is inhumane and should not be accepted" (March, 2020)

The above quotation indicates that there is low community awareness of mental illness cases. As a corollary of this, the community regards these patients as not ordinary human beings. Because of a lack of community awareness, the patients do not receive any form of therapy, worsening their symptoms and delays the recovery process. Health-related information to a mentally ill patient found noteworthy is the need to have parental involvement in the patients' medication process. It was clear that the patients' parents need to be involved from the beginning of treatment and throughout their care. Specifically, the parents need to be involved in making a very close follow up on the adherence to the prescribed medications. The participants also thought it is crucial to inform the patients of their diagnosis and his/her parents timely to help them prepare for the subsequent management plan. The participants who shared their views in this sub-theme also felt that it is suitable for parents to be subsidized for medication costs to ensure sustained treatment.

Moreover, the participants were asked to state their opinions on providing health-related information to a mentally ill patient. The in-depth interviews with the participants revealed that it is beneficial to share various health-related information with the patients. Notably, they stated that health workers should educate on the importance of adhering to medication without a stop. The participants also thought that is useful to enlighten on the causes of mental illness and the importance of starting treatment as early as possible and continuing with medication. From the interview, it was also clear that the patient needs to understand the rationale of attending the follow-up clinics regularly and the consequences of not adhering to medication and treatment as prescribed. Participants voiced that patients should view mental illness like other common chronic illnesses and reassure patients about their health status for better recovery. It was also pointed out that the patients also need clear information on the potential side effects of medications they use and the importance of preventing themselves from other diseases. One of the participants' views in this context is quoted underneath:

> *"This is a very good question. "I am of the opinion that is much health-related information required for mentally ill patient. However, I think patients should be given education on many aspects including why they should adhere to medication continuously until they become well and stop their medications before complete recovery. Also, the information on causes of illness, benefits of continuing with medication and the importance of regular attendance in a clinic"(* March, 2020).

Another participant in his remarks also echoes similar sentiments:

> *"The patients do not have adequate education regarding their Mental Health status. Sometimes they come here, and we start medication properly but after sometimes they drop out and they disappear completely. In this case, I think they need to be educated on the importance of attending the clinic regularly and taking up*

medication as prescribed. I also think that they need information on the consequences for not taking medication properly, taking mental illness as a medical condition similar to other disorders, the reassurance of patients about the illness and status of their health whenever necessary, and about the side effects of medications, prevention from other disease conditions" (March, 2020).

The above remarks show that the delay of recovery for many mentally ill patients is attributed to a lack of necessary health-related information regarding their illness. As a result, they think they can attend a clinic just if they have time to do so and not because it is critical for their health and well-being. Another Health-related information found important was on disease triggers such as interacting with peers who are abusing drugs. Once a mentally ill patient is tempted to use the same, he/she can delay recovery, then worsen the problem. The interviews also revealed that the patients needed feedback on their diagnosis. Participants stressed that the patients need to know what follows after the diagnosis. Mainly, they need to get the best result from the treatment, build trust, and understand medicine's usefulness, adhering to medication, knowing the importance of medicine use.

During the interview, the participants were also asked their opinions regarding shared-decision making when treating a patient with mental illness. The findings showed that most participants concurred and thought this approach could help achieve a favourable treatment outcome and build a therapeutic alliance. One of the participants had the following to say regarding the usefulness of the shared-decision making approach for the treatment of a patient with mental illness:

"Shared decision making on the treatment is of great importance and plays a critical role in adherence to treatment or medication, and even avoiding things that might worsen the illness. Though not all the time, this approach can be applied at the initial stage of the treatment, probably when the patient has the insight into their illness" (March, 2020)

From the participant's opinions, it can be discerned that a shared decision-making approach can work in mentally ill patients' treatment process. However, a caution was made that not all the time this approach can prove useful; it can mostly work when the patient has insight.

Participants also expressed their views on the patient accessibility of medical health centres. Most of the participants felt that in general, patients have low access to health facilities. It was emphasized that most patients fail to attend health centres because of geographical locations. Some centres are located far from the patient place of residence, and others fail to attend the clinic because they cannot meet the required expenses. The participants believed that health centres have a limited number of care providers compared to the number of patients, and

thus the parents decide to keep the patient at home. Participants also mentioned the inadequacy of community awareness on Mental illness to be a stumbling block for patients' regular attendance at the Mental Health clinic. The interview further revealed that many patients failed to attend the clinic because of negative attitudes and beliefs, including the superstitious outlook. The patients and their parents feel that mental illness is a result of witchcraft, so the way forward is to rush to the traditional healers for the treatment. At this point, one of the participants has the following to say:

> *"Access to Mental Health care is still limited. The services are not as adequate as they ought to be. I think access is also hindered by the fact that many community members don't have a proper understanding of Mental illness. The situation is linked to beliefs that do not perceive such conditions need modern health care"* (March, 2020)

Concurring to the same line of thinking, another participant added: *"Many are brought to hospitals far from service centres - many patients do not have a fare to attend the clinic. Also, many of our patients come to the clinic very late because of religious reasons or superstitious beliefs"* (March, 2020)

Apart from gathering participants' views on patient accessibility of medical health centres, an attempt was made to explore the challenges in providing care for mentally ill patients. The overall perceptions showed that the poor working environment is a big challenge to accomplishing objectives. The participants mentioned that many clinics have a shortage of rooms to accommodate an increasing number of patients. The participants had feelings that medical supplies available are not adequate compared to the number of the patient. Even the low motivation among staff to work with this unit is not sufficient.

The following quote from one of the participants suffices to emphasis the above point:

> *"Regarding the challenges, I think challenges are so many here. To mention a few, facilities lack medications and medical supplies such as drugs. We also lack specialists in mental health care, particularly dealing with such kinds of patients from the beginning to recovery. We also don't have supportive educational materials that we can share with the community to improve their awareness of this matter"* (March, 2020).

Also, participants noted that some patients are very aggressive such that it becomes difficult to control them for treatment as they pose a physical threat to the caregiver. Another issue pointed out is low community awareness. It was stated that the community is not aware of how to live up with such "kind of patient". In this case, it is a normal case that sometimes the patient comes to without any parent or relative support.

The participants also mentioned the limited financial resource as another challenge that hinders the effective delivery of Mental Health Services. They had ideas that they fail to carry out outreach programs because of limited funds, and the patients feel impossible to access the medication.

VI. Caretakers' knowledge, attitude, perception, belief about Mental Health issues: awareness of the availability and access to Mental Health services, how they cope with life stressors and challenges related to the mental illness of self and the loved one.

When exploring knowledge, attitude, perception, belief about Mental Health issues, awareness of the availability and access to Mental Health services, how they coped with life stressors and challenges related to the mental illness of self and loved one: key informants (parents, relatives, guardians, and teachers) were interviewed. The general feeling amongst the respondents was a demonstration of aggressive behaviours was a key feature. The respondents pointed out that patients with mental illness are featured by the frequent anger and physical threats towards others in most cases. Patients with mental illness are also fond of using alcohol. In this context, said one of the respondents:

"In my view, patients with mental illness are less friendly. Whenever we are with them, we are not sure of what will happen to us. They always get angry very quickly, sometimes for very trivial matters". Regarding the relative's illness, one said: *"Sometimes I see him roaming around drinking alcohol of which to me the use of alcohol is an accelerator to his illness"* (March, 2020).

Judging by these responses, it can be argued that anger, attacking people physically and substance use are some key perceived features of mental illness. The respondents also mentioned the unusual behaviours as other features of the mentally ill person. It was stated that at some point, a mentally ill person decides to urinate anywhere without care. When asked about the possible triggers of the mental illness, the respondents had the feeling that drug abuse such as marijuana, life difficulty, and genetics are the possible causes of the illness. Participants felt that the community needs to become educated on attending the clinic regularly to identify warning signs and symptoms. It was also reported by the participants that there should be improved health services. Participants emphasized that health services need to start when a woman is pregnant to protect the newborn baby to become mentally healthy.

The respondents were also asked to comment on the availability of Mental Health services; in their opinions, the participants thought that the Mental Health services are scarce. They reported medical expenses were the primary reasons attributed to access to treatment. They also spotted geographical challenge to be among reasons leading to the inaccessibility of health services. Some health centres that offer Mental Health services are located far from the patient's residence, making

it difficult to attend the clinic. The participants added that sometimes overcrowding makes service impossible, thereby making other patients go back home unattended. Regarding the availability of health services, one of the respondents stated:

> *"I think Mental Health services are generally scarce. If the patients go to the clinic, for example, he/she finds that the medical expenses are too expensive to afford. Some health centres are located very far from where the patients or even the patient's relative reside. You can imagine yourself if that health facility is attended with such an overwhelming number of patients"* (March, 2020)

Based on this remark, it can be ascertained that many patients fail to access health services due to the long distance between their homes and the health centres. It can also be argued from the findings that Mental Health services are still not easily affordable such that the patients and the relatives cannot afford it. In turn, the parents or relatives decide to stay with a patient untreated.

The key informants were also asked to respond to how you cope with life stressors? The findings generally suggested that the participants had a positive attitude. In this case, they react to events as they come. Whenever a challenge happens, they accept it has already happened, and nothing can reverse the situation. The participants also expressed that they work very hard to earn a living and meet life challenges. The interview also reported that sometimes they practice self-caring and seek support from others when the situation becomes unusual. Some of the participants also clearly demonstrated that they rush to the clinic for consultation when they get any Mental Health issue. It was also interesting to note that participants said that prayers are also one way of coping with Mental illness issues. In this regard, one of the respondent's remarks:

> *"I always stand before God for help if I experience mental illness symptoms or even before signs because mental illness is challenging to handle. For example, if it occurs to me, I rush to the hospital for diagnosis and possible medication, which soothes the condition. You should not forget that life is difficult, so life becomes even more stressful and worsens the situation if you don't work. You know that stress is one of the causes of mental illness. In my view, I think through working hard to earn your living legally, you may prevent yourself from mental illness"* (March, 2020)

In light of the above observations, the majority of respondents believe they use prayers, self-caring, and seeking professional help as a coping mechanism for mental stress. Moreover, the participants were asked to express their views on how they deal with mental issues at home or in a classroom context if they were teachers. Their thoughts were that they keep a positive attitude by considering it as similar to other cases. When it happens, family involvement is taken as an essential step to brainstorm

the way forward. Responding to the question: "What are the challenges or threats to your well-being and that of your child/student/relative? Patients reported the stigma from the community that people with such illness cannot interact with others since some act bizarrely like stripping naked and becomes an embarrassment to the relative or parents. They further reported that the seriously mentally ill patients engage in sexual activity, which creates room for other diseases.

Lastly, the respondents were asked to share their opinion on the question: Within your community, what do people believe about mental illness? Generally, parents and relatives believe that mental illness is a chronic disease with no cure. Once someone gets a mental illness, the treatment is just for decelerating the illness for relief but not a complete cure. On this view, one of the members argued that,

"*Mental illness is chronic, you cannot cure a victim completely, most people get relief for a short time, and once they finish their medications, they relapse, and the condition persists. You may find that some of the caretakers at their home become hopeless with the treatment and stop sending the sufferer to a health facility*" (March 2020)

The above quotation indicates that some of the patients are not sent for treatment because even if they are sent for the treatment, they do not get sustained remission, so even those who send their patient may despair and stop sending the patients for treatment.

Similarly, regarding the peoples' beliefs on mental illness, the participants expressed that mental illness is taken as a curse from one's parents. They believe that the disorder is born out of one's mistreatment of his parents or commits certain sins. Some participants also thought the illness is emanated from the overuse of drugs. Mental illness was linked to witchcraft. One of the participants aptly remarked:

> "*There is no disease with no root cause for its occurrence. Mental illness may be caused by drug abuse for a long time. I sometimes believe that the disease results from the curse that a parent has put on his kid perhaps because of the maltreatment to one's parents, this belief exists among Muslims, Christians as those of other faiths alike. I know some believe that mental illness comes from bewitchment in case someone envied because of one's success, or talents*" (March, 2020)

VII. Patients' experiences regarding satisfaction with Mental Health services.

An attempt was made to seek answers to the objective: "Patients' experiences regarding satisfaction with Mental Health services, access to information, shared-decision making on treatment and overall challenges regarding living with mental illness and access to care" At this point, participants expressed about the services they receive from health care providers as well as the community in terms of access to information,

shared decision making on treatment and the challenges they face in their daily life. They pointed out

They pointed out that, the necessary information they need is on the comprehensive instructions about the number of medications/tablets they are supposed to take, the frequency, and duration to use the medications in their lives. In this regard, one of the participants said:

> *"I need to know the duration of my treatment as now it is two years since I started treatment, and I can feel myself recovered from the illness. Unfortunately, up to this moment, I am not yet informed of the date of my graduation"* (March 2020)

During the discussions, the patients also showed an interest in knowing the status/progress of their fellow patients who are actively taking their dose to make a reference and be motivated to take their dose effectively. Regarding the challenges, the patients expressed the challenges they face within the community and the health facilities. They reported being despised by the service providers in their health facilities, especially when they delay to arrive at the centres. Agreeing with this line of thinking, one of the patients reported that:

> *"Once you come late to the centre, you will not get service. You will find the service providers are angry and hesitant to give the medicines"* (March 2020)

The patients also experienced a challenge of stigmatization in their community. They reported a kind of humiliation by the police force or other people, especially in the moment of active illness when they act bizarrely like walking around in streets or taking people's properties. They tend to get beaten severely; also, they experience contempt from the community as they are seen roaming around streets and sometimes eating filth t or walking naked. As one of the patient-reported:

> *"Some people insult me when I walk around the streets and call me a zombie. Some people chase me when seeing me beside them and tend to hit me with sticks or stones."* (March 2020)

On the other hand, patients expressed the benefits they get on keeping receiving treatments. They showed that one of the advantages of starting treatment is that they keep them away from exercising drug abuse. Not only that but also they said that once they get treatments, they get relief and hence help them to interact with the community in a better way. Patient-reported that the health centres are available through some of the reported distance from the health facilities makes it challenging to access treatment. The availability of service centres helps them get treatments regularly, and hence they improve from their illness.

DISCUSSION ON KEY OBSERVATIONS

This survey revealed the presence of political will and support regarding the matters related to mental health services provision. Although the available health policy acknowledges and provides guidelines for addressing the mental health issues; however, the implementation of MH programs still faces serious challenges that hinder the MH care which can be attributed to limitations of these policies and programs.

Like other parts of the world and less developed countries in particular, mental health is not given enough attention despite being among the top causes of disabilities and contribute significantly to burden of diseases as reflected by about 17% of all NCDs to be related to MNS disorders while the total expenditure on MH is just around 1% in Tanzania. This low funding allocation does not mitigate an already compromised MH care system with a treatment gap of up to 80% in some LMICs, Tanzania included (2).

With the constrained budget coupled with inadequate human resources, the Mental Health situation could potentially face a dire situation if effective interventional programs are not put in place. For a rapidly growing population of Tanzania with a current population of more than 50 million, there are less than 40 practicing psychiatrists' majority of who are based in Dar es Salaam (the biggest city in the country). However, several steps have been taken to mitigate the situation including enrolling more medical doctors in specialized training in Psychiatry by offering sponsorships and starting new residency programs at various institutions the latest being the University of Dodoma. Furthermore, task shifting has also been utilized significantly in mental health, where nurses have played a significant role in MH care throughout the country for many years.

The mental health policy guideline, in general, include the integration of MH health services in a general medical setting, maternal care, the vulnerable population including those with HIV and substance use: however, implementation of these programs continue to face hurdles. Lack of skilled personnel and standard guiding protocols for integrating MH care in day to day patient care offers practical challenges. Although counseling services for psychological and social challenges are provided in HIV care and substance use disorders, major psychiatric disorders including major depressive disorders are not well addressed. Furthermore, the guidelines do not fully address the mental health of adolescents who are also among the vulnerable populations with profound adverse impact if not adequately addressed. Although the ministry of health under the One Plan II (2016-2020) has integrated adolescent health in general in the national roadmap strategic plan to improve vulnerable populations, including adolescents in Tanzania, there is little emphasis on adolescent mental health (17).

Regarding mental health promotion and prevention, these methods lag behind in terms policy and guidelines, as well as implementation at communities and facility levels. Current policies and guidelines hardly emphasize the matter; this could be attributed to the lack of mental health action plan with clear detailed

strategies that addresses all aspects of mental health from promotive and preventive on one hand, to curative care on the other. In resource constrained setting like Tanzania, the promotion of mental health and preventive strategies offers a cost-effective approach to mitigate overwhelmed health system faced with lack of human resources, insufficient funding, poor access in care, and long-term implications of mental health conditions. Models based on preventive and promotional methods are not just supplementary but will also provide the potential of cost-effective interventions that narrow treatment gap and improve long term outcome (1,16,18–21).

As for assessing knowledge and attitude on mental health/illness, a significant proportion of participants were able to identify causative factors of mental illness including life stress, family issues and alcohol/drug use. However, fewer participants were able to identify genetics as one of the causative factors for mental illness. Although majority strongly agreed that doctors and psychologists should be responsible for managing people with mental illness; there are minority of patients who are treated by mental health specialists. This suggests that availability and access to mental health services in developing countries may be strong predictors of the treatment gap and not merely poor knowledge and attitude towards mental illness (22).

The work showed that healthcare workers dealing with people living with mental illness face several challenges mainly to do with working environment including work overload, shortage of medications and lacking enough competence. This is similar observations in other LMICs with limited resources, MH , faces critical challenges related to insufficient funding, unreliable financing mechanism, and reduced access to care that negatively affect sustainability and quality mental health care systems (16,23).

Both patients and people who care for them expressed their frustration and dissatisfaction with the overall health care system. Caretakers, in particular, cited medical expenses, chronic nature and unpredictability of the illnesses while patients were particularly dissatisfied with the lack of information sharing, shared-decision making, quality of care and over the stigma they receive from the community and health care providers. This highlights the common observation where recipient attitude, belief, and level of satisfaction is relatively poor and may predict overall outcome and the need for better education and cultural understanding about mental health care in the developing world (24,25).

The current mental health situation in Tanzania is complex and influenced by many factors some of which are historical that has shaped the health system since colonial period, socio-economic that directly affect the governance, Infrastructure, Human Resource for Health, service Delivery, finance and Health Management Information System and cultural that influences. A comprehensive multifaceted approach can potentially improve the overall outcome in the field of mental health care.

Limitations

The survey, causal relationship cannot be ascertained and instead we can have associations between the variables of interest at best.

There were inaccessibility and inadequate mental health information from DHIS2 and mental health coordinators in general.

Conclusion

There is a serious gap in the state of mental health in a country that can be attributed to the limitation of resources and attitudinal issues with the community and health care workers in general. However, in general, the health system has a good foundation which Mental Health can build upon and improve the overall provision of mental health care and services.

Recommendations

A systematic national wide survey should be conducted to determine the magnitude of mental illness and factors associated with outcome.

Mental health action with clear strategic plan is essential to integrate mental health in general medical settings. These goals must be measurable and evaluated at specific interval and reviewed whenever necessary.

Being a resource limited country, promotive and preventive programs are necessary and cost-effective methods for settings. These interventional programs must address the risks across lifespan, focus on improving awareness about mental illness, reduce stigma and advocate on positive healthy behaviour that promotes mental wellbeing.

The Ministry responsible for Health in collaboration with training and research institutions must forge a sustainable roadmap that focus on training of experts in mental Health at all levels so as to improve capacity building and increase a much needed workforce in mental health.

Mental health sector should have a specific budget allocation that ensures smooth implementation of programs including both curative and noncurative, as well as strengthening health information management system for improved operational effectiveness

Annex 1:

Table 1: Desk review summary

1.	SUPPORT	BASELINE SITUATION/ANSWERS	Source/Evidence	Stage
1.1	Political commitment to mental health services	Yes: Reflected by the presence of the Mental Health Section at the Ministry of Health and the sponsorship for specialized mental health training	MOH records and University enrollment reports	N/A
1.2	Is mental health specifically mentioned in general policy?	Yes: mentioned in the policy of 2007 and to be included in the prospective policy as well.	Health Policy 2007	Implementation phase
2	**MENTAL HEALTH BUDGET**			
2.1	Mental health budget as % of the total health budget	MH services receive around 1% of total budget expenditure, this excludes salary and other benefits to MH staff.	Comprehensive Hospital Operational Plans (CHOP)	N/A
3.	**MENTAL HEALTH POLICY**			
3.1	Existence of an official approved mental health policy/strategy?	Yes: included in the mental health Act document of 2008 and mental health policy guidelines of 2006.	Health Policy 2007 & Mental Health Policy Guideline 2006	Implementation phase

3.2	Does the policy/strategy include:-	Yes	National Strategic and Action Plan for prevention and Control Of NCDs	On Review
	Integration of mental health into PHC	Yes, mental health is integrated at PHC in all regions.	Health Sector Strategic PLan	On Review
	Decentralization to districts?	Yes, there are clinics in the districts and mental health coordinators as well.		Implementation Phase
	Integration into general hospitals?	Services are mainly provided in general hospitals, under the department of internal medicine.	Manning of Health Facilities Manual	
	Maternal mental health?	Yes, There are collaborative programs at regional levels. Dar es Salaam and Mbeya	Primary Health care guidelines	Implementation phase
	HIV mental health?	Yes, there are comprehensive HIV Counselling services that address psychological and social issues.	Reproductive and child health guidelines	Implementation phase
	Substance use?	Yes, there are more than 69,000 clients who receive SUD treatment in our facilities.	Methadone clinic	
	Epilepsy?	Yes, Epilepsy is the most common NMS condition in the country, attributing more than a third of all NMS disorders attended.	DHIS report	N/A
3.3	Existence of specific policy for reaching vulnerable populations: (the poor and those with a severe mental disorder)	Health Policy, provides an exemption to all patients with chronic conditions including patients with mental health disorders.	Health Policy 2007	Implementation phase

4	**MENTAL HEALTH PLAN**			
4.1	Existence of an officially approved mental health plan?	There is a joint Mental Health Plan in National Strategic `Plan for Prevention and Control of NCD 2016 – 2020	NCD Strategic Plan 2016 - 2020	
5	**MENTAL HEALTH PROMOTION AND PREVENTION**			
5.1	Does the mental Health budget include mental health promotion programs?	No; however, there is an overall budget for health promotion from which mental health promotion activities have been supported. Therefore, it is difficult to pinpoint exactly how much is directed to mental health.	It's a current practice for several years.	Implemented usually by Preparation of IECs and commemoration of international days such as mental health day and suicide day.
5.2	Is there a document that addresses the promotion and prevention of Mental health?	Yes	Health policy 2007.	
5.3	Does the mental Health plan/Strategy addresses MH promotion and prevention?	Yes: NCD strategic plan touches on promotion activities however, the current process is to develop mental health plan which should address in detail the mental health promotion	NCD strategic plan	

Table 4

Table4: participants perception of the causes of mental illness				
	Agree/Strongly agree	Neutral/Undecided	Disagree	Strongly disagree
Family relationship	75%(347)	11 %(51)	8.7%(40)	5.3%(24)
Life stress	84.8%(391)	7.5%(35)	5.2%(24)	2.5%(12)
Alcohol/drugs	84.6% (390)	7.7% (36)	2.9% (14)	4.8% (22)
Organic/Physical illness	77.8% (359)	9.2% (43)	8.2%(38)	4.8%(22)
Death/loss of loved one	78.8%(364)	7.7%(36)	6.8%(31)	6.7%(31)
Bad childhood/abuse	73.1%(338)	5.8%(27)	16.3%(75)	4.8%(22)
Accident	87.9%(406)	5.3%(24)	4.3%(20)	2.5%(12)
Loss of employment	69.2%(320)	13.9%(64)	10.6%(49)	6.3%(29)
Environment	52%(240)	11%(51)	25.0%(116)	12.0%(55)
Genetics	45.2%(209)	13.9%(64)	25.0%(116)	15.9%(73)

Table 5

	Agree	Strongly agree	Neutral/ Undecided	Disagree	Strongly disagree
Doctor	19.20%(89)	**78.4%(362)**	0.5%(2)	0.0%(0)	1.9%(9)
Nurse	33.7%(156)	48%(222)	4.8%(22)	7.7%(36)	5.8%(27)
Counselor	29.3%(135)	24.0%(111)	13.5%(62)	19.7%(91)	13.5%(62)
Psychologist	32.2%(149)	**51.4%(237)**	4.3%(20)	9.6%(44)	2.5%(12)
Social worker	29.3%(135)	16.8%(78)	11.1%(51)	26.0%(120)	16.8%(78)
Friend	24.5%(113)	14.4%(67)	8.2%(38)	30.3%(140)	22.6%(104)
Family	24.5%(113)	23.1%(107)	6.7%(31)	26.9%(124)	18.8%(87)
Ex-patients	25.0%(116)	6.8%(31)	9.6%(44)	31.7%(146)	26.9%(124)
Volunteers	35.1%(162)	4.8%(22)	14.4%(67)	23.1%(107)	22.6%(104)
community health workers	28.8%(133)	19.7%(91)	11.5%(53)	24.5%(113)	15.5%(72)
spiritual/religious leaders	**41.8%(193)**	30.3%(140)	5.3%(24)	13.5%(62)	9.1%(42)
Traditional healers	20.2%(93)	13.0%(60)	15.4%(71)	19.2%(89)	32.2%(149)

TABLE 6

Frequency of the identified Mental Health conditions		
Variables	N	%
Anxiety disorders	38	8.3
Schizophrenia	107	23.1
Autism	12	2.5
Bipolar disorders	31	6.8
Depression	27	5.8
Insomnia	5	1.1
Identified more than two conditions	178	38.5
Don't know	64	13.9
Total	462	100

References

1. World Health Organization. Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. [Internet]. Melbourne; 2005. Available from: https://apps.who.int/iris/handle/10665/43286
2. Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, Kovess V, Lepine JP, et al. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. JAMA. 2004 Jun 2;291(21):2581–90.
3. Penedo FJ, Dahn JR. Exercise and well-being: a review of mental and physical health benefits associated with physical activity. Curr Opin Psychiatry. 2005 Mar;18(2):189–93.
4. Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJ, editors. Global Burden of Disease and Risk Factors [Internet]. Washington (DC): World Bank; 2006 [cited 2020 Sep 25]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK11812/
5. Wang PS, Angermeyer M, Borges G, Bruffaerts R, Tat Chiu W, DE Girolamo G, et al. Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry Off J World Psychiatr Assoc WPA. 2007 Oct;6(3):177–85.
6. Dixon A, McDaid D, Knapp M, Curran C. Financing mental health services in low- and middle-income countries. Health Policy Plan. 2006 May;21(3):171–82.
7. Knapp M, Funk M, Curran C, Prince M, Grigg M, McDaid D. Economic barriers to better mental health practice and policy. Health Policy Plan. 2006 May;21(3):157–70.
8. Lund C, Breen A, Flisher AJ, Kakuma R, Corrigall J, Joska JA, et al. Poverty and common mental disorders in low and middle income countries: A systematic review. Soc Sci Med 1982. 2010 Aug;71(3):517–28.

9. L CL. ORIGINAL PAPER Mental illness and lost income among adult South Africans.

10. Esan OB, Kola L, Gureje O. Mental disorders and earnings: results from the Nigerian National Survey of Mental Health and Well-Being (NSMHW). J Ment Health Policy Econ. 2012 Jun;15(2):77–82.

11. Addo R, Nonvignon J, Aikins M. Household costs of mental health care in Ghana. J Ment Health Policy Econ. 2013 Dec;16(4):151–9.

12. I P, A B, L S. Mental health promotion and the prevention of mental disorders in South Africa. Afr J Psychiatry. 2012 Nov 1;15(6):411–6.

13. Petersen I, Barry M, Lund C, Bhana A. Mental Health Promotion and the Prevention of Mental Disorders [Internet]. Global Mental Health. Oxford University Press; [cited 2020 Sep 25]. Available from: https://oxfordmedicine.com/view/10.1093/med/9780199920181.001.0001/med-9780199920181-chapter-11

14. Olds DL. The nurse-family partnership: An evidence-based preventive intervention. Infant Ment Health J. 2006 Jan;27(1):5–25.

15. TZ.pdf [Internet]. [cited 2021 Jan 16]. Available from: https://www.who.int/mental_health/evidence/atlas/profiles-2017/TZ.pdf?ua=1

16. Kilonzo GP, Simmons N. Development of mental health services in Tanzania: A reappraisal for the future. Soc Sci Med. 1998 Aug 16;47(4):419–28.

17. Hanlon C, Luitel NP, Kathree T, Murhar V, Shrivasta S, Medhin G, et al. Challenges and Opportunities for Implementing Integrated Mental Health Care: A District Level Situation Analysis from Five Low- and Middle-Income Countries. PLOS ONE. 2014 Feb 18;9(2):e88437.

18. Tanzania_One_Plan_II.pdf [Internet]. [cited 2020 Sep 25]. Available from: https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf

19. Petersen I, Evans-Lacko S, Semrau M, Barry MM, Chisholm D, Gronholm P, et al. Promotion, prevention and protection: interventions at the population- and community-levels for mental, neurological and substance use disorders in low- and middle-income countries. Int J Ment Health Syst. 2016 Apr 11;10(1):30.

20. Min J-A, Lee C-U, Lee C. Mental Health Promotion and Illness Prevention: A Challenge for Psychiatrists. Psychiatry Investig. 2013 Dec;10(4):307–16.

21. Castillo EG, Ijadi-Maghsoodi R, Shadravan S, Moore E, Mensah MO, Docherty M, et al. Community Interventions to Promote Mental Health and Social Equity. Curr Psychiatry Rep[Internet]. 2019 [cited 2020 Sep 25];21(5). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6440941/

22. Jack H, Wagner RG, Petersen I, Thom R, Newton CR, Stein A, et al. Closing the mental health treatment gap in South Africa: a review of costs and cost-effectiveness. Glob Health Action [Internet]. 2014 May 15 [cited 2020 Sep 25];7. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038770/

23. Ganasen KA, Parker S, Hugo CJ, Stein DJ, Emsley RA, Seedat S. Mental health literacy: focus on developing countries. Afr J Psychiatry. 2008 Apr 3;11(1):23–8.

24. Abdulmalik J, Olayiwola S, Docrat S, Lund C, Chisholm D, Gureje O. Sustainable financing mechanisms for strengthening mental health systems in Nigeria. Int J Ment Health Syst. 2019 May 31;13(1):38.

25. Holikatti PC, Kar N, Mishra A, Shukla R, Swain SP, Kar S. A study on patient satisfaction with psychiatric services. Indian J Psychiatry. 2012 Oct 1;54(4):327.

26. Yimer S, Yohannis Z, Getinet W, Mekonen T, Fekadu W, Belete H, et al. Satisfaction and associated factors of outpatient psychiatric service consumers in Ethiopia. Patient Prefer Adherence. 2016 Sep 19;10:1847–52.