THE UNITED REPUBLIC OF TANZANIA
NATIONAL AUDIT OFFICE

ISO 9001:2015 Certified

PERFORMANCE AUDIT REPORT ON THE AVAILABILITY OF MENTAL HEALTH CARE SERVICES IN THE COUNTRY

CONTROLLER AND AUDITOR GENERAL

MARCH, 2024

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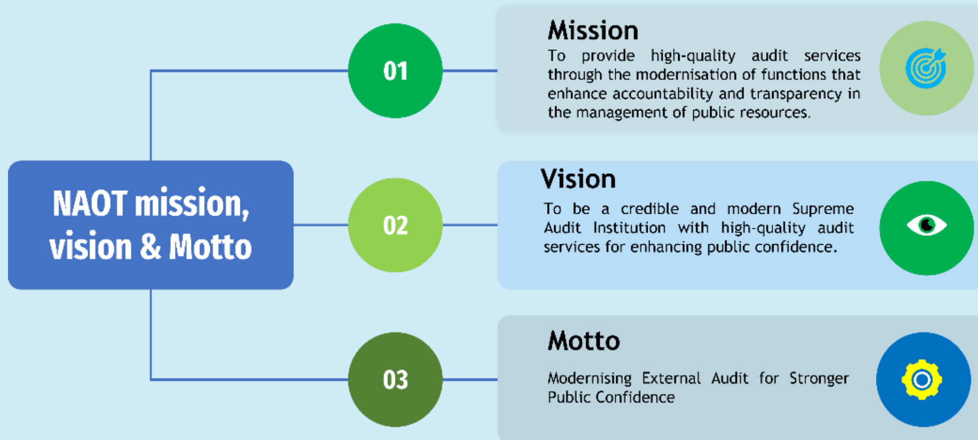

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PREFACE

Section 28 of the Public Audit Act, CAP 418 [R.E. 2021] gives mandate to the Controller and Auditor General to carry out Performance Audit (Value-for-Money Audit) to establish the economy, efficiency and effectiveness of any expenditure or use of resources in the Ministries, Departments and Agencies (MDAs), Local Government Authorities (LGAs) and Public Authorities and Other Bodies which involves enquiring, examining, investigating and reporting, as deemed necessary under the circumstances.

I have the honour to submit to Her Excellency, the President of the United Republic of Tanzania, Hon. Dr. Samiaa Suluhu Hassan, and through her to the Parliament of the United Republic of Tanzania, the Performance Audit Report on the Availability of Mental Healthcare Services in the country.

The report contains findings, conclusions, and recommendations directed to the Ministry of Health, the President's Office - Regional Administration and Local Government and the Ministry of Community Development, Gender, Women and Special Groups.

The Ministry of Health, the President's Office - Regional Administration and Local Government and the Ministry of Community Development, Gender, Women and Special Groups had the opportunity to scrutinise the factual contents of the report and comment on it. I wish to acknowledge that discussions with the ministries have been useful and constructive.

My Office will carry out a follow-up audit at an appropriate time regarding actions taken by the Ministry of Health, the President's Office - Regional Administration and Local Government and the Ministry of Community Development, Gender, Women and Special Groups in implementing the recommendations given in this report.

I would like to thank my staff for their commitment to preparing this report. I also acknowledge the audited entities for their cooperation with my Office, which facilitated the timely completion of the audit.

Charles E. Kichere
Controller and Auditor General
United Republic of Tanzania
March, 2024

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ABBREVIATIONS AND ACRONYMS

BRN	:	Big Results Now
BSHF	:	Basic Standard for Health Facilities
CC	:	City Council
CCHP	:	Comprehensive Council Health Plan
CEA	:	Chief External Auditor
CHMT	:	Council Health Management Team
DAG	:	Deputy Auditor General
DC	:	District Council
ECT	:	Electroconvulsive Therapy
EEG	:	Electroencephalogram
IASC	:	Inter-Agency Standing Committee
LGA	:	Local Government Authority
MD	:	Medical Doctor
MHT	:	Mental Health Tanzania
MNH	:	Muhimbili National Hospital
MNMH	:	Mirembe National Mental Health Hospital
MoCDGWSG	:	Ministry of Community Development, Gender, Women and Special Groups
MoH	:	Ministry of Health
MRI	:	Magnetic Resonance Imaging
MSD	:	Medical Store Department
MTEF	:	Medium-Term Expenditure Framework
MUHAS	:	Muhimbili University of Health and Allied Science
MVC	:	Most Vulnerable Children
NCD	:	Non-communicable Diseases
NGOs	:	Non-Governmental Organization
PA	:	Performance Audit
PHC	:	Primary HealthCare
PO-PSM	:	Professional and Operational Public Service Management Scheme
PO-RALG	:	President's Office - Regional Administration and Local Government
PSS	:	Psychosocial Care and Support Services
RHMT	:	Regional Health Management Team
RRH	:	Regional Referral Hospital

SAIs	:	Supreme Audit Institutions
SDGs	:	Sustainable Development Goals
SOPs	:	Standard Operating Procedures
SWA	:	Social Welfare Assistant
SWO	:	Social Welfare Officer
URT	:	United Republic of Tanzania
VEO	:	Village Executive Officer
WEO	:	Ward Executive Officer
WHO	:	World Health Organization

DEFINITION OF TERMS

Term	Definition
Healthcare facility	Point of Healthcare Service includes hospitals, health centres, dispensaries and specialized clinics. Others are Pharmacies, ADDOs, MSD warehouses, health laboratories, diagnostic centres, radiological units, and maternity and nursing homes.
Mental Health	A state of well-being in which an individual realizes their abilities, can cope with the normal stresses of life, can work productively and can contribute to their community (WHO, 2014)
Mental Disorder	A recognized, medically diagnosed condition arises from a complex interplay between a person's genes and the environment using internationally established diagnostic criteria.
Mental Healthcare Services	How effective interventions for mental health are delivered. Typically, Mental Healthcare Services include outpatient facilities, mental health day treatment facilities, psychiatric wards in a general hospital, community mental health teams, supported housing in the community, and mental hospitals.
Psychosocial disabilities	Refers to people who have received a mental health diagnosis and who have experienced negative social factors, including stigma, discrimination and exclusion. People living with psychosocial disabilities include ex-users, current users of the mental health care services, as well as persons who identify themselves as survivors of these services or with the psychosocial disability itself.
Vulnerable groups	Certain groups have an elevated risk of developing mental disorders.
Point Level	include but not limited to social welfare offices, community rehabilitation centres, health facilities, children's homes, crisis centres for emergencies, one-stop centres, schools, police gender and children desks, retention homes

EXECUTIVE SUMMARY

Background of the Audit

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape our world. Mental health is a basic human right. And it is crucial to personal, community, and socio-economic development.

Despite the guidelines and directives provided by the World Health Organization (WHO) for organizing Mental Healthcare Services, the sub-Saharan African population (including Tanzania) continues to face various challenges in meeting mental health needs. These challenges include a shortage of human resources for mental health, particularly at the primary healthcare level, inadequate training of mental health professionals, improper allocation of mental health personnel, limited access to essential medications, conflicting priorities, and inadequate insurance coverage for mental disorders, and the persistence of social stigma.

The main objective of the audit was to determine whether the Ministry of Health (MoH), Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG), and the President's Office-Regional Administration and Local Government (PO-RALG) have adequately ensured the availability of Mental Healthcare Services to ensure that individuals in need receive timely and appropriate Mental Healthcare Services in the country. The audit covered five (5) financial years (2018/19 to 2022/23).

Main Audit Findings

Identification of Mental Health Patients was not Effectively Done at the Community Level

The audit revealed a lack of identification of individuals with mental challenges at the community level. Rather, identification was focused on drug abusers, elderly, disabled, vulnerable children, and those facing childhood pregnancy. This has been attributed to inadequate funding for

social welfare services andthe absence of Social Welfare Officials at lower levels, including villages and streets. There are only 2.8% of required Social Welfare Officers at the ward level and none at the village level, thus causing insufficient identification of individuals with mental health challenges. This is hindering officers' ability to identify individuals with mental health issues and highlighting a financial constraint.

Psychosocial Care and Support Services were not Effectively Mainstreamed into Plans, Budgets, Policies, Programs, Interventions and Strategies at All Levels

The audit revealed the President's Office - Regional Administration and Local Government's (PO-RALG's) inability to integrate psychosocial services into plans effectively. This resulted in incomplete coverage for various groups, including mentally ill individuals, and insufficient mainstreaming of psychosocial activities, comprehensive coverage, and prioritization of specific groups. This has been attributed to inadequate communication and coverage of key performance indicators for Psychosocial Support Services (PSS), affecting the preparation of LGAs' strategic plans by the Ministry of Community Development, Gender Women, and Special Groups.

Also, the audit noted a lack of monitoring and evaluation by the Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG) and the PO-RALG for implementing Psychosocial Support Services (PSS). This deficiency prevents the identification of challenges hindering effective PSS implementation and the development of a corresponding action plan.

Insufficient Resources (Experts, Infrastructure, Medical Equipment and Medicines) to Facilitate the Provision of Mental Healthcare Services

The audit noted that inadequate availability of experts at all levels of healthcare facilities whereby the Ministry of Health and President's Office - Regional Administration and Local Government (PO-RALG) did not ensure the availability and adequate distribution of experts at all levels for the provision of Mental Healthcare Services at national, zonal, regional, district Hospitals.

There was an inadequate number of staff at national-level hospitals for the provision of mental healthcare services. Mirembe National Mental Hospital had a critical shortage of Geriatric psychiatrists, Addiction specialists, Child

and Adolescent psychiatrists, Speech and language therapists, and Forensic Psychiatry cadres, with a 100% gap. On the other hand, the availability of psychiatrists, psychologists, clinical neurologists, and psychiatry nurses did not meet the requirement. Similarly, Muhimbili National Hospital had a 95% deficiency of psychiatry nurses and a 21% deficiency of Psychiatrists from the required number.

Similarly, staff at Zonal Referral Hospitals were unavailable to provide mental healthcare services. The Audit team reviewed the psychiatry staff establishment at Zonal Hospitals and noted that there were no experts at Benjamin Mkapa Zonal Hospital and no psychiatry specialists compared to the required categories and numbers by the Basic Standard for Health Facilities, 2017. Moreover, an insufficient number of psychiatrists at Regional Referral Hospitals for the provision of Mental Healthcare Services was noted at Tabora, Dodoma and Mbeya Regional Referral Hospital.

However, for occupational therapists, two out of the five visited Regional Referral Hospitals were noted to have gaps in staffing compared to the required number of experts according to the guidelines, particularly in Dodoma and Amana RRH, which had a 100% gap. This has been attributed to the Ministry of Health's lack of a recruitment plan for mental health professionals and the absence of a scheme of service to accommodate graduates for the psychiatrists' services. This results in limited access to care services.

Moreover, there was inadequate infrastructure to attend to adults, children and adolescent inpatients during mental healthcare services treatment. The audit noted insufficient wards at Zonal and Regional Referral Hospitals. At the National level, insufficient infrastructure for acute females, children and adolescents was reported at Muhimbili National Hospital. Generally, healthcare facilities do not have wards for admitting children and adolescents. Similarly, at the regional level, Sekou Toure, Mbeya, Dodoma, and Amana Regional Referral Hospitals did not have male, female, children, or adolescent wards. Funds were not allocated for the construction of wards, and there was a lack of Plans for the construction of wards for Mental health, leading to challenges in issuing adequate inpatient services.

However, the availability of Psychiatric Medicines, which were supposed to be supplied by the Medical Stores Department (MSD), was not adequately attained. Still, MSD managed to have medical supplies from private vendors to fill the gap. The audit team noted that during the financial year 2021/22, the highest supply of psychiatric medicines by the Ministry of Health through MSD was 20% at Mirembe National Mental Hospital, and this was only for Haloperidol medicines.

Similarly, the audit team visited the five hospitals at the regional level and noted that the highest received value was 3% of the ordered quantity. However, the audit team noted an entire supply of medicines in Mbeya and Dar es Salaam (Amana) Regional Referral Hospitals.

Unavailability of Rehabilitation Services for Skills Development, Community Integration and Recovery-Oriented Supports

The audit revealed that out of 26 regions, only five had rehabilitation centres for mental healthcare services: Kilimanjaro, Mwanza, Dar es Salaam, Dodoma, and Kigoma. Only three of these are government-owned, while the remaining two are charity centres, thus creating barriers for rural patients. Moreover, the audit revealed that of the three zonal hospitals, one had a rehabilitation centre, i.e. Mbeya Zonal Referral Hospital. Benjamin Mkapa Zonal Referral Hospital had no mental healthcare rehabilitation centre since they depended on the nearby Mirembe National Mental Hospital to provide the services. At the national level, Mirembe National Mental and Muhimbili National Hospitals had rehabilitation services.

The audit revealed that two mental healthcare rehabilitation centres, Hombolo in Dodoma and Vikuruti in Dar es Salaam, are in poor condition due to dilapidated buildings, kitchen, and toilet facilities. The Mbeya Zonal Rehabilitation Centre is abandoned and not functioning, to the extent that the people living around it have invaded the place and are carrying out agricultural activities.

The Audit found a lack of standard guidelines for designing and constructing necessary infrastructure for rehabilitation centres for mental healthcare services, hindering their overall development. The audit revealed a shortage of Mental Healthcare Services rehabilitation experts in the country, with an observed gap of 72% at Muhimbili National Hospital and

75.8% at Mirembe National Mental Hospital. This has been contributed to by the absence of a recruitment plan to capacitate the rehabilitation services, leading to limited access to rehabilitation services.

However, the audit found that no follow-up programs for monitoring and supporting community integration of rehabilitation programs were carried out due to limited resources and a lack of proper data. Rehabilitation data was not integrated into the Health Management Information System (HMIS) at all levels, and there was no centralized collection or analysis of data, highlighting the absence of national indicators built on rehabilitation data. The Medium-Term Expenditure Framework for the Ministry of Health shows no budget provisions were set aside for the rehabilitation of mental healthcare services, leading to insufficient healthcare services management to ensure its adequacy.

General Audit Conclusion

Despite significant efforts to ensure the availability of mental healthcare services, the Ministry of Health, the Ministry of Community Development Gender, Women and Special Groups, and the President's Office – Regional Administration and Local Government have not ensured adequate availability of Mental Healthcare Services in the country. In general, the Audit noted inadequacy in the identification of individuals in need of Mental Healthcare Services, provision of psychosocial care at the community level, Resources (infrastructure, experts, medical equipment, and medicines) for the provision of Mental Healthcare Services, Providing comprehensive rehabilitation services that focus on skills development, community integration, and recovery-oriented supports, and; Ensuring awareness programs are put in place.

Main Audit Recommendations

Recommendations to the Ministry of Health

The Ministry of Health is urged to:

(i) Develop national clinical guidelines and standard operating procedures for the provision of mental health rehabilitation services and design of rehabilitation infrastructures for the provision of the mental healthcare services;

(ii) Ensure availability of competent personnel for children and adults and needed equipment for adequate availability of mental healthcare services; and

Recommendations to the PO-RALG

The President's Office - Regional Administration and Local Government is urged to:

(i) Ensure the provision of adequate implementation of PSS guidelines that include the provision of identification at the point levels and adequate follow-up on the patients.

Recommendation to the MOCDGWSG

The Ministry of Community Development Gender Women and Special Group is urged to:

(i) Ensure that Social Welfare Officers at the village level, community case workers, and other relevant personnel are adequately trained and equipped to identify and register PSS clients. Also, provide clear guidelines for Social Welfare Officers to follow when identifying and registering clients and establish a database for the provision of PSS Services.

CHAPTER ONE

INTRODUCTION

1.1 Background Information

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape our world. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.

According to the WHO Mental Health Report Transforming Mental Health for all of 2022, close to 15% of the world's working population is estimated to experience a mental disorder at any given time. It was estimated that 280 million people suffer from depression, 25 million people have schizophrenia, 283 million people suffer from alcohol use disorder, 36 million people suffer from drug use disorder, 50 million people have epilepsy, 55 million people have Alzheimer's and other dementia, and 703,000 people die by suicide every year.

According to the Mental Health Situational Analysis Report of 2021, In Tanzania, the common mental health disorders identified are depression, anxiety and substance abuse. It was estimated that 7 million people are living with mental disorders and substance abuse, and over 1.5 million are living with depressive disorders, the majority of whom are females.

According to the Ministry of Community Development Gender Women and Special Groups, National Guidelines for the Provision of Psychosocial Care and Support Service (2020), psychosocial care and support services (PSS) are necessary in addressing these situations and need to be adequately delivered to well guided, skilled and knowledgeable practitioners, by making psychosocial care and support services more available, accessible and affordable.

1.2 Motivation for the Audit

The need to conduct the Audit was motivated by various factors as follows:

(a) Increased Number of Patients and Deaths due to Mental Disorders

According to the Ministry of Health Annual Health Sector Performance Profile, 2022 it was reported at Mirembe National Mental Hospital, there was an increased number of patients who attended mental illness treatment from 3,472 patients in 2019 to 5,060 patients in 2022, equivalent to 31% of the patients. Also, the Tanzania Mental Health Profile of 2020 estimates that the burden of mental illness has contributed to the suicide mortality rate of 8.15 per 100,000 population. Similarly, the Annual Health Sector Performance Report of 2022 from the Ministry of Health estimates the burden of mental illness has increased from 386,358 patients to 2,102,726 patients from 2012 to 2021, respectively, which has increased by 82%.

According to 2019 research[1] data from the World Health Organization (WHO), One (1) in every Eight (8) people in the world has mental health issues. Also, the WHO Mental Health ATLAS 2017 report noted that in Tanzania, 5 out of 100,000 people have committed suicide due to mental health problems such as anxiety, depression, anger, and drug abuse from 2014 to 2019.

(b) Absence of Mental Health Policy

Tanzania lacks a comprehensive mental health policy, and the amended Mental Health Act of 2008 is outdated. It does not adequately address the current needs and challenges regarding the availability of Mental Healthcare Services. The absence of policy and outdated legislation hinders the development and provision of effective mental healthcare services.

(c) Inadequate Mental Healthcare Services

Inadequate Mental Healthcare Services in Tanzania are the result of significant challenges, with services often unavailable or inaccessible to many parts of the country. Various stakeholders have highlighted and

[1] https://www.who.int/news-room/fact-sheets/detail/mental-disorders

reported this issue, including government bodies, NGOs, and international organizations. This was also reported by the research article titled "Mental Healthcare Services and Delivery System at Temeke Hospital in Dar es Salaam, Tanzania," written by Ambikile and Iseselo and published in BioMed Central Psychiatry Journal (2017) 17:09, which reported that the inadequate mental services in Tanzania are a significant challenge that requires attention and improvement. The mental health needs of the population are often unmet due to various reasons, including insufficient mental healthcare services facilities and the limited number and misallocation of mental healthcare professionals.

(d) Presence of Stigma and Cultural Beliefs

According to the situation analysis conducted by the Ministry of Health National Adolescent Health and Development Strategy 2018 – 2022, it was reported that awareness about mental health, mental illness, and acceptance of treatment for mental health is very low in Tanzania, primarily due to social stigma.

A research article titled "Mental health stigma and mental health-seeking behaviours among caregivers of children with mental health problems in Tanzania", carried out by Ambikile J.S. and Iseselo M.K. in Dar Es Salaam, examined the perceptions and attitudes of caregivers in Tanzania towards mental health issues. The findings revealed that caregivers were affected by society's cultural beliefs, whereby they often experience stigmatization and social exclusion due to their association with children having mental health problems. This points to the presence of stigma surrounding mental health in Tanzanian society.

1.3 Design of the Audit

1.3.1 Audit Objective

The main objective of the audit was to determine whether the Ministry of Health, the Ministry of Community Development, Gender, Women and Special Groups, and the President's Office - Regional Administration and Local Government have adequately ensured the availability of Mental Healthcare Services to ensure that individuals in need receive timely and appropriate Mental Healthcare Services in the country.

Specific Objectives of the Audit

Five specific audit objectives were used to address the main audit objective. The specific objectives of the audit assessed whether;

(i) The process for identifying individuals in need of mental health care is in place and functioning properly;

(ii) Psychosocial care and support services are available at the community level and are provided on time;

(iii) Resources (infrastructure, experts, medical equipment and medicines) for the provision of Mental Healthcare Services are sufficient;

(iv) Comprehensive rehabilitation services that focus on skills development, community integration and recovery-oriented supports are adequately provided;

(v) Mental Healthcare Services awareness campaigns are appropriately planned and implemented from the national to the community level; and

(vi) Coordination among entities in the provision of Mental Healthcare Services is adequate.

1.3.2 Audit Scope

The main audited entities were the Ministry of Health (MoH), the Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG) and the President's Office – Regional Administration and Local Government (PO-RALG). This is because the MoH is responsible for developing policies and guidelines on healthcare and overseeing their implementation. Also, it is responsible for supervising Mental Healthcare Services from the national to the regional level in the country.
The Ministry of Community Development, Gender, Women and Special Groups was covered because it provides psychosocial care and support to the community. Furthermore, PO-RALG is responsible for implementing guidelines related to the provision of both Mental Healthcare Services and

psychosocial care and overseeing and supervising the provision of healthcare from the District to the lower levels of the Government.

The focus of the audit was on assessing the availability of Mental Healthcare Services in the country whereby the audit assessed the identification mechanisms of mental health-challenged individuals, provision of psychosocial care at the community level, availability of sufficient resources (infrastructures, experts, medical equipment and medicines), provision of rehabilitation services, provision of awareness and coordination among actors on the provision of both Mental Healthcare Services and psychosocial care in the country.

The audit focused on the effectiveness of the identification of mentally challenged persons and the provision of referral to the appropriate service point. On the availability of provision of psychosocial care, the audit assessed the mainstreaming of psychosocial care support services into plans, budgets, policies, programs and interventions; documentation and follow-up of the referral cases; and the standard of the psychosocial services provided following the guideline.

On the availability of sufficient resources for the provision of Mental Healthcare Services, the audit assessed the availability and distribution of experts at all levels, the availability and adequacy of the infrastructures for the provision of Mental Healthcare Services such as wards, beds, etc. and the availability of medical equipment and medicines. Regarding the provision of rehabilitation, the audit assessed the availability of rehabilitation centres with structured plans for skills development, facilities, and staffing to support comprehensive rehabilitation services, as well as follow-up programs for monitoring and provision of support to the community.

With regards to the provision of awareness of Mental Healthcare Services to the communities, the audit assessed the availability of plans for the provision of Mental Healthcare Services, the mechanism in place for the creation of awareness on mental health, the implementation of the awareness campaigns, and sufficiency of the mechanisms for the provision of awareness programs. The audit focused on the coordination among entities in the provision of mental healthcare services and the availability

of a functioning coordination system with the main stakeholders and a reporting system among the main actors.

The Audit covered all mental health-related problems and individuals, i.e., children and adults. The scope of the audit was five (5) financial years from 2018/19 to 2022/23. This period was chosen since it allowed the auditors to establish performance trends in providing Mental Healthcare Services in the country.

1.3.3 Assessment Criteria

Audit criteria were drawn from legislation, standards, good practices, and Strategic Plans to assess mental healthcare availability. The following are the broader assessment criteria for each of the specific audit objectives:

Identification Process in Reaching All Members of the Community

According to the National Guideline for the Provision of Psychosocial Support Services at the client level, social workers should design a PSS intervention plan that addresses the uniqueness of each client –no one size fits all, and actively engage the clients in identifying their PSS needs/problems and solutions. They should also provide relevant information to the clients to help them make informed decisions.

The National PSS guideline requires the MOCDGWSG to advocate for resource mobilization to facilitate the effective implementation of these PSS guidelines.

According to Section 28(3) of the Mental Health Act, 2008, every mental health care facility shall put in place measures to ensure family and community involvement in the care and management of persons with mental disorders persons in the mental health care facility and establish strategies for continuity of care.

Availability of Psychosocial Care and Support Services at the Community Level

According to the National Guideline for the Provision of Psychosocial Support Services, one of the goals is to ensure the provision of standardized

and quality psychosocial care and support services that are responsive to all key and vulnerable populations for their optimal psychological and social well-being.

Function 6 of the RHMT ensures quality services in all councils by promoting the quality of the region's health, social welfare, and nutrition services through supporting the CHMTs.

The National Guideline for the Provision of Psychosocial Support Services states that "the service point level includes but is not limited to social welfare offices, community rehabilitation centres, health facilities, children's homes, crisis centres for emergencies, one-stop centres, schools, police gender and children desk, retention homes, and approved schools". Social welfare service providers in these service points should coordinate and support providing PSS services to the clients.

According to the health sector strategic plan V 2021-2026, the availability and management of Mental Healthcare Services in communities and healthcare facilities at all levels is a priority. First, the country is supposed to have adequate health workers with mental health specialities at all levels (including the Primary Healthcare level) to meet the demand for Mental Healthcare Services and psychological counselling. Secondly, counselling and therapy need to be embedded in regular health services. Outpatient and ambulatory services are supposed to be established in health facilities.

Availability of Resources (Infrastructures, Human Resources, Quality Tools, Equipment and Medicine) for Provision of Mental Healthcare Services

According to Section 31(1)(e) of the Mental Health Act, 2008, the National Council for Mental Health shall facilitate the mobilization of resources for developing Mental Healthcare Services in collaboration with the Ministry responsible for health.

According to Section 17(1)(e), the Board shall deliberate and recommend ways and means of improving the conditions of a mental health care facility and services for the welfare of patients and the staff.

The Health Sector Strategic Plan IV 2015-2020 states that one of the BRN priorities is a balanced distribution of health professionals over the country and simplifying administrative processes to enable such distribution within the Regions between Councils and within Councils. Distribution of skilled HRHSW will be strategically aligned with priority service delivery areas and priorities underserved areas in line with BRN plans.

Availability of Comprehensive Rehabilitation Services

According to the National Rehabilitation Strategic Plan of 2021-2026, national clinical practical guidelines are important to ensure that rehabilitation interventions have been proven effective and to standardize care nationwide. However, no national clinical practice guidelines for rehabilitation have been developed yet.

Furthermore, the National Rehabilitation Strategic Plan of 2021-2026 requires that rehabilitation should be available at all levels of healthcare, from tertiary care to primary healthcare settings. When needed, it should be available in community settings such as homes and schools.

According to Section 17(1)(a) of the Mental Health Act, 2008, on the establishment of the Mental Health Board, one of its functions is to review individual detailed reports on selected patients of the forensic psychiatric hospital to ensure that individual patients have active rehabilitation and care programs that are regularly reviewed and updated.

The Strategic and Action Plan for the Prevention and Control of Non-Communicable Diseases in Tanzania 2016 – 2020 states that the country will develop and implement a national policy and plan in line with the 2013-2020 global mental health action. This will include mental health promotion, prevention, treatment, and recovery services.

According to the World Health Organization's (WHO) Report on "Rehabilitation in Health Systems Guide for Action", 2019, Rehabilitation is an increasingly important health service in light of ageing populations and the rising prevalence of Non-Communicable Diseases (NCDs). Furthermore, as access to healthcare interventions expands, rehabilitation is needed to maximize their effectiveness and impact.

The National Non-Communicable Diseases Strategic Plan 2021-2026 states that based on the Universal Health Coverage (UHC), one of the processes for providing Mental Healthcare Services is the rehabilitation of patients.

Availability and Promotion of Awareness Campaigns on Provision of Mental Healthcare Services

According to Section 31(1) (a) of the Mental Health Act,2008, "the functions of the National Council for Mental Health shall be to review and monitor the status of mental health in Mainland Tanzania and related problems, mental health promotion, prevention programs for substance abuse and advice the Minister".

According to Section 31(1)(c) of the Mental Health Act,2008, "the functions of the National Council for Mental Health shall be to (c) encourage and facilitate community involvement and non-governmental organizations in the promotion of mental health and prevention of substance abuse and mental disorders".

1.4 Methods for Sampling Data Collection and Analysis

Methods for sampling, data collection, and analysis used by the audit team are presented below:

1.4.1 Sampling Methods

A purposive sampling method was used to select healthcare facilities that provide mental healthcare services in the country.

The Seven (7) geographical zones were ranked based on types and the total number of types of healthcare facilities available in the respective zones. The types of healthcare facilities considered are Health Centres, District, Regional Referral, Zonal Referral, and National and National Super Specialized Referral Hospitals, as indicated in **Table 1.1**.

Table 1.1: Selected Zone based on Number of Health Facilities

Geographical Zones	Type of Healthcare Facilities	Available Zonal or/ and Super Specialist Hospital	Status
Western	4	-	Selected
Lake	5	v	Selected
Southern Highland	5	v	Selected
Northern	5	v	Not Selected
Southern	5	v	Not Selected
Eastern	6	vv	Selected
Central	6	vv	Selected

Source: *Auditors' Analysis from the Health Facility Registry (HFR) Portal[2] (2023)*

Key Information

Indicator	Available Type of Health Facility
1	Health Centres
2	Health Centres, District Hospitals
3	Health Centres, District and Regional Referral Hospitals
4	Health Centres, District, Regional Referral and Zonal Referral Hospitals
5	Health Centres, District, Regional Referral, Zonal Referral and National Referral Hospitals
6	Health Centres, District Hospitals, Regional Referral, Zonal Referral, National Referral and National Super Specialized Referral Hospitals
v	Availability of Zonal Referral or Super Specialist Referral Hospital providing Mental Healthcare Services
vv	Availability of both Zonal Hospital and Super Specialist Hospital providing Mental Healthcare Services

From **Table 1.1,** five (5) out of seven (7) geographical zones were selected based on the type of healthcare facility and availability of either Zonal or Super Specialist Hospitals. The audit visited Southern Highland, Central, Lake, Western and Eastern Zones facilities. These zones have an equal presentation of all the criteria that have been adhered to. Regions were chosen from the selected zones as described below.

[2] https://hfrs.moh.go.tz/web/index.php?r=portal%2Findex, Accessed on 6th June, 2023

A sampling of the Covered Regions

The sampling of regions was based on the number of healthcare facilities and availability of Zonal or Super Specialist Hospital in the regions. Regions were chosen based on the ranks given, the total number of healthcare facilities available in the particular region, and the availability of zonal or super special hospitals based on the provision of mental healthcare services. The number of healthcare facilities included Health Centres, District, Regional, Zonal, and National Hospitals. Each region selected for the assessment had a minimum of three different healthcare facility levels.

Table 1.2: Selection of Regions

Zones	Regions	Health Facilities	Rank	Availability of Zonal And Super Specialized Hospitals	Sample Selected
Eastern	Dar-es-salaam	1367	H	vv	Dar Es Salaam
	Pwani	509	M	-	
	Morogoro	672	M	-	
Western	Kigoma	347	L	-	Tabora
	Tabora	449	L	-	
	Shinyanga	349	L	-	
	Simiyu	265	L	-	
Central	Dodoma	605	M	vv	Dodoma
	Singida	318	L	-	
Lake zone	Mara	413	L	-	Mwanza
	Mwanza	648	M	v	
	Geita	300	L	v	
	Kagera	411	L	-	
Southern Highlands	Iringa`	343	L	-	Mbeya
	Ruvuma	446	L	-	
	Rukwa	260	L	-	
	Katavi	149	L	-	
	Njombe	375	L	-	
	Mbeya	507	M	v	
	Songwe	262	L	-	

Source: *Auditors' Analysis from the Health Facility Registry (HFR) Portal[3] (2023)*

[3] https://hfrs.moh.go.tz/web/index.php?r=portal%2Findex, Accessed on 6th June, 2023

Key
H – High represents regions with a number of healthcare facilities above 1000
M – Medium represents regions with a number of healthcare between facilities 500 - 999
L – Low represents regions with a number of healthcare between facilities 1 - 499

From **Table 1.2**, five regions were chosen based on the availability of super specialist hospitals providing Mental Healthcare Services, zonal hospitals, and the number of healthcare facilities available in the region. The audit team visited the available National, Zonal, and Regional Hospitals. The five selected regions covered were Dar es Salaam, Tabora, Dodoma, Mwanza, and Mbeya.

A sampling of the Visited Local Government Authorities

A purposive sampling technique was used to select LGAs visited based on the number of healthcare facilities available and the rural or urban setup of the LGA, as detailed in **Appendix 2**.

Table 1. 3: Selected LGAs for Site Visit

Region	Selected LGAs	Set up
Dar es Salaam	Dar es salaam CC	Urban
Mwanza	Sengerema DC	Rural
Dodoma	Kondoa DC	Rural
Mbeya	Mbeya CC	Urban
Tabora	Urambo DC	Rural

***Source:** Auditors' Analysis from the Health Facility Registry (HFR) Portal[4] (2023)*

From **Table 1.3,** five (5) LGAs were selected, whereby three (3) LGAs are in a rural setup, and two (2) LGAs are in an urban setup. The five (5) regions are Dar es salaam CC, Sengerema DC, Kondoa DC, Mbeya CC, and Urambo DC.

The Audit team covered the Health and Social Welfare Sections in each LGA. In each selected LGA, the audit team visited the district hospital and social welfare officers at the ward level.

[4] https://hfrs.moh.go.tz/web/index.php?r=portal%2Findex, Accessed on 6th June, 2023

1.4.2 Methods for Data Collection

Both qualitative and quantitative data were collected to provide strong and convincing evidence on the performance of the Ministry of Health (MoH), Ministry of Community Development, Gender, Women and Special Groups (MOCDGWSG) and President's Office – Regional Administration and Local Government (PO-RALG) regarding the availability of Mental Healthcare Services in the country. The audit team used different methods to collect information from the audited entities and other stakeholders. These methods included *interviews, document reviews, and physical observation,* as detailed below:

(a) Documents review

The Audit team reviewed documents from MoH, MOCDGWSG, PO-RALG, selected Regional Secretariats, Local Government Authorities (LGAs), and hospitals to get comprehensive, relevant and reliable information on the availability and provision of Mental Healthcare Services.

Different documents were reviewed to obtain information about the availability of Mental Healthcare Services. Reviewed documents from the audited entities fell within the period under audit, i.e., from July 2018 to June 2023. These included planning documents, performance and progress reports, medium-term expenditures, and monitoring and evaluation reports.

A list of documents reviewed and the reason for reviewing them is in the attached **Appendix *3***.

(b) Interviews

Interviews were held with officials from MoH, MOCDGWSG, PO-RALG, and the selected healthcare facilities on the availability of Mental Healthcare Services. Also, interviews were held with officials from the selected Regional Secretariats (RSs) and Local Government Authorities (LGAs) for data verification. Furthermore, interviews were used to validate information from the documents reviewed. The list of officials interviewed is presented in the attached ***Appendix 4.***

(c) Physical Verification and Observation

The audit team observed the state of Mental Healthcare Services provided in the country by visiting the selected healthcare facilities. The audit team observed the status of healthcare facilities, including infrastructure such as wards, isolation rooms, and washrooms. The audit team also verified the number of beds and patients in the wards, the equipment needed, and the available staff at the facility.

1.4.3 Methods for Data Analysis

The collected information was analyzed using both qualitative and quantitative methods to obtain facts and sufficient information regarding the availability of Mental Healthcare Services.

Analysis of Qualitative Data

Content analysis techniques were used to analyze qualitative data by identifying different concepts and facts from interviews or document reviews and categorizing them based on their assertions. The extracted concepts or facts were either tabulated or presented as they were to explain or establish the relationship between different variables originating from the audit questions. The recurring concepts or facts were quantified depending on the nature of the data they portrayed, and the quantified information (concepts/facts) was then summed or averaged in spreadsheets to explain or establish the relationship between different variables.

a) Analysis of Quantitative Data

Quantitative information with multiple occurrences was tabulated in spreadsheets to develop point data or time series data and relevant facts extracted from the figures obtained. The tabulated data was summed, averaged, or proportionate to extract relevant information and relationships from the figures. The sums, averages or percentages were presented using different types of graphs and charts depending on the nature of the data to explain facts for point data or establish trends for time series data and other quantitative information/data with single occurrence was presented as they are in the reports by explaining the facts they assert.

1.5 Data Validation Process

Ministry of Health (MOH), Ministry of Community Development Gender Women and Special Groups (MoCDGWSG) and President's Office Regional Administration and Local Government (PO-RALG) were given the opportunity to go through the draft performance audit report and comment on the figures and information presented. They confirmed the accuracy of the figures and information presented in the audit report.

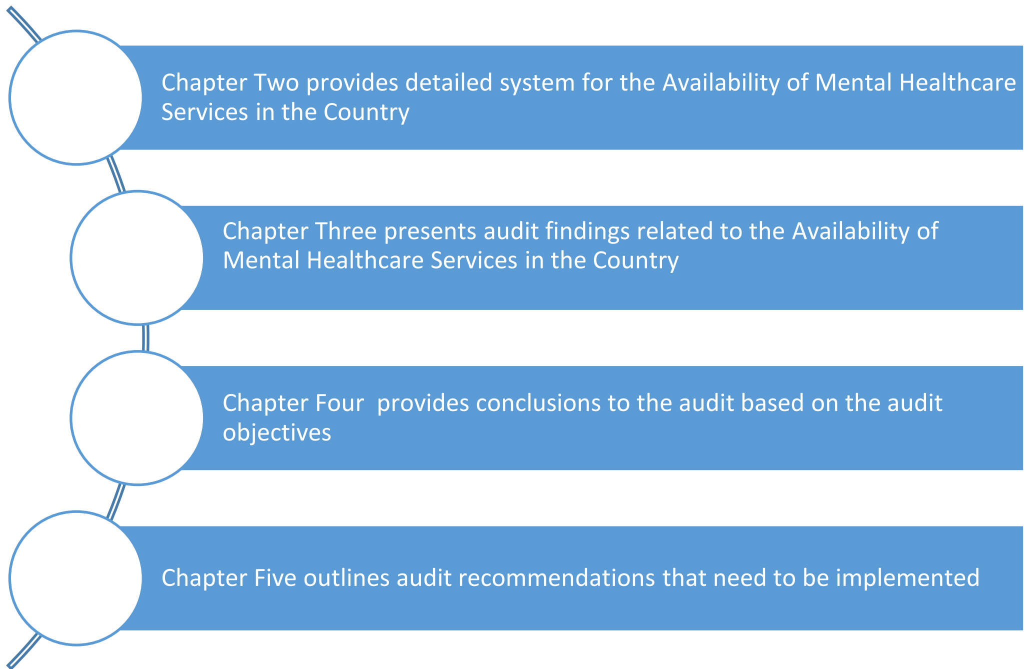
Furthermore, the information on the availability of mental healthcare services in the country was cross-checked and discussed with experts to ensure validation of the information obtained and presented.

1.6 Standard Used for the Audit

The audit was done in accordance with the International Standards for Supreme Audit Institutions (ISSAIs) on performance audits issued by the International Organization of Supreme Audit Institutions (INTOSAI). These standards require the audit to be planned and performed to obtain sufficient and appropriate evidence to provide a reasonable basis for the audit findings and conclusions based on the audit objectives.

1.7 Structure of the Report

The remaining parts of this report cover the following:



CHAPTER TWO

SYSTEM FOR THE PROVISION OF MENTAL HEALTHCARE SERVICES IN THE COUNTRY

2.1 Introduction

This chapter describes the system for providing Mental Healthcare Services in Tanzania. It covers the legal, policy, strategic, and institutional framework for providing Mental Healthcare Services in the country. It furthers the mandates and roles of key players, responsibilities, and the relationship between key stakeholders.

2.2 Legal Framework Governing the Provision of Mental Healthcare Services in the Country

The following section explains policies, laws, and regulations that govern the provision of mental healthcare services in the country.

2.2.1 Governing Policies

a) Health Policy, 2007

This policy aims to give direction to expanding and strengthening the scope and quality of mental healthcare services. The policy has provided statements that give direction to mental healthcare services providers, such as the government will review and improve the laws, regulations, guidelines, and procedures for providing care to the mentally ill based on dignity and justice. In collaboration with other stakeholders, the government will ensure that mental healthcare services reach many citizens according to their requirements. Also, in collaboration with stakeholders, the government will strengthen the delivery system services and management of mental healthcare services in the country, and the community will be involved in improving the provision of health services.

2.2.2. Governing Legislation

Only one legislation governs the provision of Mental Health Care Services in Tanzania.

a) Mental Health Act, 2008

This Act was established to provide for the care, protection, and management of persons with mental disorders and also to provide for their voluntary or involuntary admission in mental health care facilities to ensure safety around society.

2.2.3 Sustainable Development Goal, Strategic Plans and Guidelines

The provision of Mental Healthcare Services is also guided by the 2030 Agenda, different international strategic plans and guidelines as detailed below;

(a) Sustainable Development Goal No. 3

To have a better and more sustainable future for all, global goals also insist that by 2030, premature mortality from non-communicable diseases will be reduced by one-third through prevention and treatment, and mental health and well-being will be promoted. The performance of attaining this goal can be measured by considering the sustainable provision of Mental Healthcare Services in the country.

(b) Strategic Plans

This section describes the strategic plans that govern the availability of mental healthcare services, both local and international, that are not only countrywide but also internationally guided to ensure that they are adequately provided in the country. This includes:

(i) World Health Organization Mental Health Action Plan (2013-2020)

According to the Action Plan of the Mental Health Action Plan 2013 - 2020 that WHO established, it states that in the Sixty-fifth World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level.

It takes a comprehensive and multisectoral approach through coordinated services from the health and social sectors, emphasising promotion, prevention, treatment, rehabilitation, care and mental health recovery. Also, strengthen the level of implementation, progress and impact for member states and the secretariat and international, regional and national level partners and propose critical indicators and targets.

Moreover, the developed Mental Action plan has several objectives to strengthen effective leadership and governance for mental health, to provide comprehensive, integrated and responsive mental health and social care services in community-based settings, to implement strategies for the promotion and prevention of mental health and to strengthen information systems, evidence and research for mental health.

(ii) Health Sector Strategic Plan IV

The Health Sector Strategic Plan for 2016-2020 describes that "the country will develop and implement a National Policy and plan aligned with the 2013-2020 global mental health action, such as mental health promotion, prevention, treatment and recovery services, mental healthcare services will continue to be integrated into health services and community programs through better guidance and tools for healthcare professionals, ensuring stigma reduction for people with mental illnesses will be part of health promotion programs and MoH to improve the distribution of specialized cadres, with mental health training so that their capacities are optimally utilized".

(iii) Health Sector Strategic Plan V

The Health Sector Strategic Plan V (July 2021- June 2026) describes the Government's aim in the health sector to reduce morbidity and mortality from Non-communicable Diseases by implementing and stimulating preventive measures addressing lifestyle-related and mental health risk factors and environmental factors, implementing early detection of chronic diseases through screening and early treatment of non-communicable conditions of public health importance, and Mental Healthcare Services will be expanded to the council level, alongside support to reduce addiction and substance abuse".

(iv) The Ministry of Health Strategic Plan

Strategic and Action Plan for the Prevention and Control of Non-Communicable Diseases in Tanzania (2016 – 2020)

The Ministry of Health has set interventions for the management of mental health in the country through prevention, treatment and promoting mental health and well-being and also strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. The strategic plan has established the following strategic interventions to manage mental health in the country: attain commitment to increased and sustained financing for NCDs and review existing policy and legislation to increase resources and improve the prevention and control of NCDs.

National Rehabilitation Strategic Plan of 2021-2026

The Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) has set objectives for strengthening rehabilitation that will guide the direction of government and non-government stakeholders towards a common goal. The plan aligns with the Government's priorities, as stated in the Health Sector Strategic Plan (HSSP) IV, to reach all households with quality healthcare.

Strategic objectives underpin the achievement of this vision: to strengthen rehabilitation leadership, planning, and generation of evidence and

information; increase the availability of rehabilitation services and expand financing; strengthen and expand the rehabilitation workforce; and increase the access and provision of assistive products.

(c) Guidelines for Management of Mental Health

The Ministry of Community Development, Gender, Women and Special Groups has developed guidelines that are essential for the provision of Mental Health and Psychosocial support care in the country at all levels of the community, and this includes:

(i) National Guidelines for the Provision of Psychosocial Care and Support Services

These National Guidelines for Psychosocial Care and Support Services (PSS) are designed to guide the provision of standardized quality services to help individuals and families cope and overcome life adversities in the country. Quality provision of psychosocial care and support services will also improve the population's overall health and social well-being, including attaining the National Vision 2025.

(ii) Standard Operating Procedures for the Provision of Psychosocial Care and Support Services

These SOPs have been developed to enable PSS providers to respond to psychosocial care and support needs effectively, efficiently, and consistently. They provide a practical guide for psychosocial care and support service providers to deliver quality and standardized psychosocial care and support services throughout the country.

The SOPs are aligned with the National Guidelines for Provision of Psychosocial Care and Support Services, 2020. The objectives of this guideline are threefold: improve the quality of PSS provided to all individuals across the country, enhance the quality of PSS provided to all families across the country, and improve the quality of PSS provided to communities across the country.

(iii)Guidelines for the provision of Mental illness treatment at healthcare facilities

Different guidelines govern the provision of mental illness treatment at healthcare facilities, as detailed below;

I. Standard Treatment Guidelines (STG) and National Essential Medicines List Tanzania Mainland (NEMLIT)

The STG and NEMLIT aim to provide health practitioners with standardized guidance in making decisions about appropriate Mental Healthcare Services in the country.

The Ministry's policy is that all public and private health workers in Tanzania will promote and adhere to these Standard Treatment Guidelines. The prescribing, purchasing, labelling, and dispensing of medicines should be done using generic names as much as possible and consistent with the level classification in the STGs and NEMLIT.

2.3 Roles and Responsibilities of Key Actors

Several stakeholders are involved in ensuring the availability of Mental Healthcare Services. The key stakeholders involved in the Provision of Mental Healthcare Services include the Ministry of Health, Ministry of Community Development, Gender, Women and Special Groups, President's Office - Regional Administration and Local Government.

Their roles and responsibilities are as explained below:

The Ministry of Health

The Ministry of Health (MoH) manages Mental Healthcare Services in the country. The Ministry provides technical guidance and collaborates with organizations involved in service delivery. It defines, controls, and promotes the sustainability of quality standards while setting policies for social welfare.

Table 2. 1: Roles of the Departments in the MoH

Department	Roles in the Provision of Mental Healthcare Services in the Country
Directorate of Curative Services (DCS)	• To formulate, review and oversee the implementation of curative health policies, laws, regulations and guidelines. • To oversee the provision of general and specific curative services • To coordinate the provision of pharmaceutical and diagnostic services and curative services for mental health.
Non-Communicable Diseases, Mental Health and Substance Abuse Section	• Facilitate the development of NCD, Mental Health and Substance Abuse guidelines. • Facilitate the integration of mental health and substance into primary care services. • Coordinate treatment and referral guidelines for NCD and mental disorders. • Provide guidelines on quality NCD and mental healthcare service standards. • Promotion of community participation in NCD and provision of mental healthcare.

Source: Auditors' Analysis of the Roles and Responsibilities in MoH (2023)

Ministry of Community Development, Gender, Women and Special Groups

Through its social welfare division, the Ministry promotes the well-being of vulnerable individuals, families, groups and communities and enhances their participation through client-focused policies, programs and services. To provide equitable, fair, quality and sustainable standards of social welfare services to the communities, specifically to vulnerable groups, through the following interventions:

- Coordinating, managing, supervising and monitoring community rehabilitation Programs for children who conflict with the law, including children living and working on the streets; and
- Capacitating parents/caretakers, child care workers and fit persons with caretaking skills and psychosocial care support services.

President's Office - Regional Administration and Local Government

The Ministry has intervened as the vital implementor of the provision of Mental Healthcare Services in the country because it directly touches the community at the regional and council levels.

(i) Department of Health, Social Welfare and Nutrition

The department has responsibilities concerning the availability of adequate mental health care services in the country, such as (i) facilitating monitoring and evaluation to improve good governance in the provision of health services in Regions and Councils, (ii) interpreting policies and guidelines related to the development and financial strategy of the Health Sector and social welfare, (iii)monitoring and evaluation of social welfare services provided in regions and councils, (iv)coordinating capacity building and providing administrative support to regions and councils.

(ii) Regional Health Management Team (RHMT)

The Regional Health Management Team in the respective Regional Secretariat comprises a Regional Mental Health Coordinator who reports to the Ministry of Health and a Regional Social Welfare Officer who reports to PORALG and the Ministry of Community Development, Gender, Women and Special Groups.

The Regional Secretariat, through the Regional Medical officer and Social Welfare Officer, is responsible for monitoring, coordination, supervision and reporting (the reporting should use available reporting tools, including District Case Management Systems), ensuring that quality social welfare and medical services are provided throughout the implementation of the services.

(iii)Council Health Management Team (CHMT)

This comprises the Council Mental Health Coordinator, who reports to the Ministry of Health and the Council Social Welfare Officer, who reports to PO-RALG and the Ministry of Community Development, Gender, Women and Special Groups.

The Local authorities, through the Council Medical Officer and Social Welfare Officer, are responsible for ensuring that quality Mental Healthcare Services are provided at the council level and reported at the regional level.

Healthcare Facilities

The National Health Policy of 2007 describes a healthcare facility as a point of healthcare service provision that includes hospitals, health centres, dispensaries and specialized clinics.

(a) Mirembe National Mental Health Hospital (MNMHH)

Mirembe National Mental Health Hospital is a super-specialized hospital developed to improve mental health for a high-quality livelihood. This development objective represents the highest level of results envisioned by MNMHH. However, other key players also significantly contribute towards achieving this development objective. Such other players will be influenced by the level of financial resources available, structures, processes and systems, staff and management adherence to core values, and the demand for accountability on the part of mental patients/clients' families and communities, as well as MNMHH capacity at both strategic and operational levels.

The functions of MNMHH include providing preventive services to mental health, providing super specialized treatment and care to people with mental disorders, providing education and information on mental health to the community, advising the prison officers on the evidence-based way of managing prisoners with mental illnesses and to advise courts on mental health and mental disorder defenders.

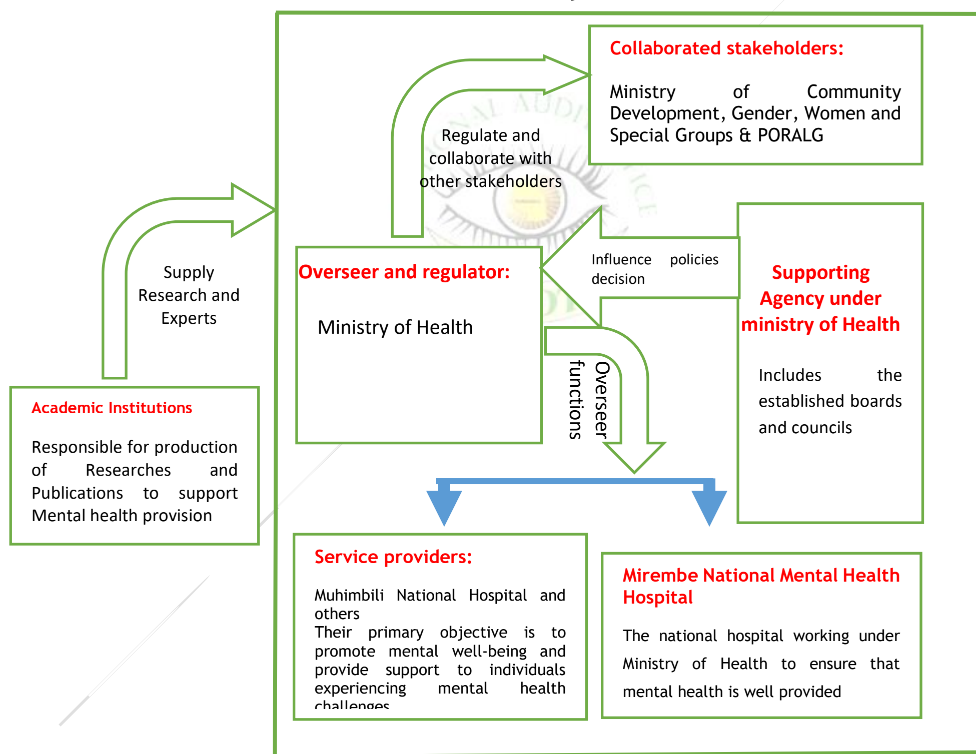
(b) Muhimbili National Hospital

The Muhimbili National Hospital, through its Department of Psychiatry and Mental Health, plays a direct role in providing care for patients with mental health problems who are suffering from psychological, psychiatry and neuropsychiatry. The department also provides rehabilitation services, which include psychosocial interventions such as psychotherapies (individually, couple, family or group), occupational therapy, resolving

social problems, and long-term rehabilitation at Vikuruti rehabilitation village, which is situated in Chamanzi area (Mbande).

Whereby the function of the Department of Psychiatry and Mental Health is to provide services with both inpatient and outpatient services to patients with all mental health problems, patients with comorbid medical conditions, neuropsychiatry disorders, elderly patients with mental and memory problems, patients with pervasive childhood developmental disorders and patients with substance use disorders. This department also manages the rehabilitation section.

Figure 2. 1: Relationship of Key Stakeholders on Availability of Mental Health in The Country



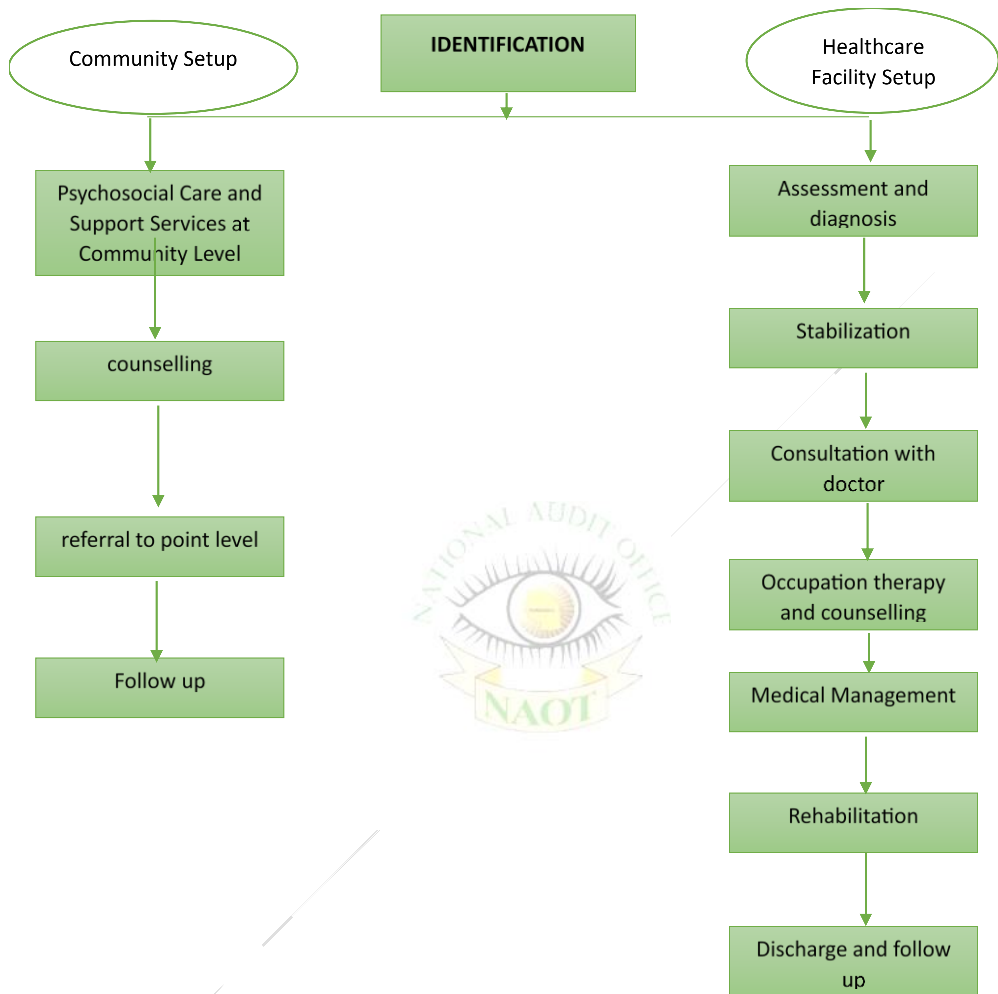
Source: Auditors' Analysis on the Relationship between Key Stakeholders (2023)

2.4 System and Process Description for Availability of Mental Healthcare Services in the Country by Ministry of Health

The following is the system and process for providing Mental Healthcare Services in the country, vested in the Ministry of Health. It provides details on ensuring quality health services on Mental Healthcare Services through the NCD, Mental Health and Drug Abuse under the Directorate of Curative Services.

The Ministry of Health manages mental healthcare services in the country from the highest levels with the delivery of care, treatment, and rehabilitation. The Ministry of Health oversees activities from the National Hospitals (including specialized hospitals), Zonal referral hospitals and Regional Referral hospitals.

Figure 2.2: Process Description of Provision of Mental Healthcare Services in the Country



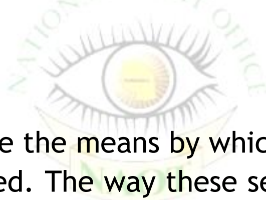
Source: *Auditors' Analysis from Guidelines and Mental Health Act (2023)*

Provision of Psychosocial Care

Identification

Identification at the community level is mainly done by Ward Executive Officers, Village Executive Officers, Social Welfare Officers, and Community Health Workers. Suppose individuals with mental health challenges are identified. In that case, they can be attended by the Social Welfare Officers at the point level (ward office, one-stop centre, etc.) by providing them with psychosocial support services. If the Social Welfare Officers at the point level feel the clients require a doctor's consultation, then the patients are referred to the health facilities for further management, such as medical treatment and occupational therapy. They are followed up until they are returned to their care.

Provision of Mental Healthcare Services



Treatment and Care

Mental Healthcare Services are the means by which effective interventions for mental health are delivered. The way these services are organized has an important bearing on their effectiveness. Typically, Mental Healthcare Services include outpatient facilities, mental health day treatment facilities, psychiatric wards in a general hospital, community mental health teams, supported housing in the community, and mental hospitals.

Parts II and III of the Mental Health Act of 2008 describe the categories for the admission of mental health patients based on the nature of the patient category. This involves voluntary and involuntary patients, legal processes, and disease management (treatment).

Treatment in a psychiatric hospital/department generally involves several stages:

- **Assessment and Diagnosis**: Patients undergo thorough assessments to determine their mental health. Accurate diagnoses help inform the treatment plan.

- **Stabilization**: Initial steps are taken to stabilize acute symptoms, ensuring the patient's safety and managing any immediate crisis.

- **Treatment Planning**: A comprehensive treatment plan is developed, incorporating therapy, medication, and other interventions tailored to the individual's needs.

- **Therapeutic Interventions**: Various therapies, including individual, group, and family therapy, address underlying issues, develop coping skills, and promote emotional well-being.

- **Medical Management**: If necessary, medications are prescribed and closely monitored to alleviate symptoms and support the overall treatment plan.

- **Rehabilitation**: Patients engage in programs focusing on skill-building, social integration, and activities that help them regain daily functioning.

- **Progress Monitoring**: Regular assessments track the patient's progress, ensuring that treatment goals are met and making adjustments as needed.

- **Discharge**: When the patient's condition improves sufficiently, a discharge plan is developed to ensure a smooth transition back to the community, often involving outpatient care and follow-up.

- **Follow-up**: Continued support is provided after discharge, often involving outpatient therapy, medication management, and ongoing monitoring.

- **Prevention and Relapse Management**: Patients are educated on relapse prevention strategies and coping skills to manage their condition effectively in the long term.

Each stage is tailored to the individual's needs and the severity of their condition, aiming to improve their mental health and overall well-being.

Rehabilitation and follow-up

Mental Health Rehabilitation Services involves essential support to people with complex and longer-term mental health problems. They include inpatient services and community teams providing clinical input to people living in supported accommodation services. This systematic review included international studies evaluating the effectiveness of inpatient and community rehabilitation services. This process includes psychosocial services to the patient. It is followed by discharging them back to the community when they have improved and being returned to their ward social officers for follow-up while in the community.

2.5 Resources for the Availability of Mental Healthcare Services

The Ministry of Health is responsible for providing quality Mental Healthcare Services in the country. Below are the budgeted and allocated financial resources for both Boards.

(a) Financial resources of Activities for ensuring Availability of Mental Healthcare Services

The following were the resources allocated to NCD, Mental Health and Substance Abuse, which operates under the directorate of Curative Services. **Table 2.2** shows that the budget for six (6) financial years under the audit has been fluctuating, while in two years, the Ministry did not allocate the funds for NCD, including mental health promotion and prevention.

Table 2. 2: Budget for Provision of Mental Healthcare Services at the MoH

Financial Year	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Budget-(In TZS Million)	0	5,000	0	274	725	725
Actual disbursement (In TZS Million)	0	400	0	27.4	58	65.25
Percentage disbursement (%)	0	8	0	10	8	9

Source: *Ministry of Health MTEF, 2017-2023*

From **Table 2.**2, it can be noted that there were significant fluctuations in budget allocation and actual disbursement over the years. The disbursement ranged between 8% - 10%. There was no budget allocation or disbursement in the years 2017/18 and 2019/20.

Table2.3:Budget for Provision of Psychosocial Services at the MoCDGWSG

Financial Year	2021/22	2022/23
Budget- (In TZS Million)	200,13,000	24,250,000
Actual disbursement (In TZS Million)	-	-
Percentage disbursement (%)	-	-

Source: MoCDGWSG's MTEF, 2017-2023

The guideline was not in place for 2017/18 to 2019/20; hence, no fund was budgeted or allocated. The guideline was launched in 2020, and budgeting started in 2021/22.

Human Resources for the Provision of Mental Healthcare Services in the Country

In ensuring the provision of Mental Healthcare Services in the country, NCD, Mental health, and Substance Abuse have to improve the human resources for effective management. **Table 2.3** indicates the required and available numbers for six years, as detailed.

Table 2. 4: Human Resources for Provision of Mental Healthcare Services

Profession	Number Required	Number Available	Gap
Directorate of Curative Services	33	11	22

***Source**: Ministry of Health Staffing level (2023)*

CHAPTER THREE

AUDIT FINDINGS ON THE AVAILABILITY OF MENTAL HEALTHCARE SERVICES

3.1 Introduction

This chapter presents audit findings on the availability of Mental Healthcare Services. The findings focused on identifying mental health patients at the community level, the availability of psychosocial care and support services, resources and rehabilitation services, and creating awareness and coordination between government entities.

3.2 Limited Availability of Mental Healthcare Services to all Healthcare levels

According to Section 5.1.8 of the health sector strategic plan V 2021-2026, the availability and management of Mental Healthcare Services in communities and healthcare facilities at all levels is a priority. First, the country is supposed to have adequate health workers with mental health specialities at all levels (including the PHC level) to meet the demand for Mental Healthcare Services and psychological counselling. Secondly, counselling and therapy need to be embedded in regular Healthcare Services.

The audit noted that mental healthcare services were not available comprehensively at each level of healthcare services, as detailed below.

(a) Insufficient Integration of Mental Healthcare Services at Primary Level Care Settings

Objective 2 of the WHO Mental Health Action Plan 2013-2030 recommends the development of comprehensive community-based mental health and integrating mental health care and treatment into primary care.

The Audit noted that the Mental Healthcare Services were not effectively integrated into primary healthcare in the visited regions.

Table 3. 1: Number of Primary Health facilities that integrated Mental Healthcare Services in the Country

Financial Year	Number of PHC	Number of facilities integrated Mental Healthcare Services	Number of facilities, not integrated Mental Healthcare Services
2022/2023	4172	No record available	No record available

***Source**: Auditors' Analysis on District Hospitals (2023)*

The Audit team noted that the Ministry of Health lacked accurate data on the number of healthcare facilities currently providing Mental Healthcare Services in the country.

According to the revised staffing levels for the Ministry of Health "health service facilities, health training institutions and agencies" in 2019, at the district level, there should be a Mental Health Department which should be staffed with at least one Assistant Medical Doctor (AMO), one Psychiatric Nurse and two Social Welfare Officers.

The audit revealed that in the five district hospitals visited, there was no availability of a mental health section that was to be equipped with one assistant medical officer, two psychiatric nurses, and one social welfare hospital. Only two out of five visited district hospitals, i.e., Igawilo and Kivule District Hospital, had Psychiatric Nurses trained for Mental Healthcare Services provision, as detailed in **Table 3.2**.

Table 3. 2: Integration of Mental Healthcare Services in Primary Health Care

Regions	District Hospitals	Availability of Trained Personnel	Availability of Medicine	Availability of Mental Health Section
Dodoma	Kondoa	Not available	Available	Not available
Tabora	Urambo	Not available	Available	Not available
Mbeya	Igawilo	Available	Available	Not available
Dar es Salaam	Kivule	Available	Available	Not available
Mwanza	Sengerema	Available	Available	Not available

Source: Auditors' Analysis on the Visited District Hospitals (Pharmacy Ledger, Ikama), 2023

Table 3.2 shows the integration of Mental Healthcare Services in the visited district hospitals. The causes for the limited integration of Mental Healthcare Services were the unavailability of trained Mental Healthcare Services personnel and sections in the district hospitals. As a result, there is limited provision of Mental Healthcare Services at the lower level of the community.

(b) Insufficient Integration of Mental Healthcare Services at High-Level Care Settings

Section 5.1.8 of the health sector strategic plan V 2021-2026 on Mental Health, Addiction and Substance Abuse, the availability and management of mental healthcare services in communities and healthcare facilities at all levels is a priority. First, the country is supposed to have adequate health workers with mental health specialization at all levels (including the PHC level) to meet the demand for mental healthcare services and psychological counselling. Secondly, counselling and therapy need to be embedded in regular health services.

The audit team noted that mental healthcare services were well integrated at the National and Super Specialized Hospitals, as detailed in **Table 3.3.** However, out of the 3 visited Zonal Hospitals, only one had not integrated Mental Healthcare Services, Benjamin Mkapa Zonal Hospital.

Table 3.3: Integration of Mental Healthcare Services at Higher Level

Name of Hospital	Experts	Stand Alone Facility	Availability of Wards	Availability of Acute Wards			Availability of ECT	Availability of EEG	Availability of MRI
				F	M	C			
Mirembe	v	v	v	v	v	x	x	v	x
Muhimbili	v	v	v	x	v	x	x	v	v
Benjamin Mkapa	x	x	x	x	x	x	x	x	v
Mbeya	v	v	v	v	v	x	x	x	v
Bugando	v	v	v	v	v	x	x	v	v

Source: Auditors' Analysis on the Integration of Mental Healthcare Services (2023)

Key
F- Female M - male C – Children
ECT - Electroconvulsive Therapy
EEG – Electroencephalogram
MRI – Magnetic Resonance Imaging
V available
X absence

Table 3.3 shows that in all the visited hospitals, no hospital had Electroconvulsive Therapy (ECT), which is an important treatment option primarily used for certain psychiatric conditions such as severe depression. Benjamin Mkapa Zonal Hospital had not integrated Mental Healthcare Services effectively due to the absence of mental health specialists and mental health infrastructures such as wards to provide mental healthcare services. Interviews with officials from Benjamin Mkapa Hospital indicated this was due to the availability of Mirembe Super Specialized Mental Hospital.

Partial integration of the mental healthcare services at Benjamin Mkapa Zonal Hospital affects the patients who need the intervention of two specialists, one being Mental Healthcare Services. Further clarification was sought from the MoH on why Benjamin Mkapa Hospital was not integrated with mental healthcare services. It was noted that the patients referred to Benjamin Mkapa Hospital were transferred to Mirembe National Mental Hospital because the hospital is located nearby in the region. This was noted to be contrary to the basic standard of health facilities' establishment requirements for the service provision.

3.3 Ineffective Identification of Mental Health Patients at the Community Level

According to section 9 (1) of the Mental Health Act of 2008, every Police Officer, Social Welfare Officer, Religious Leader, Ward Executive Officer or Village Executive Officer who has reason to believe that any person within the area under his jurisdiction is mentally disordered and is not under proper care or control, should immediately cause that person to be brought to a mental health facility.

According to Standard Operating Procedures (SOP) 1 on providing Psychosocial Social Services (PSS) in the community, case identification is

crucial to determine specific community PSS needs for an appropriate and effective intervention plan.

The audit team noted that there was a lack of identification of people with mental health conditions at the community level, as evidenced by the presence of mentally ill individuals on the streets. Also, the councils/district Social Welfare Officers did not have records of the identified individuals with mental illness in their respective jurisdiction brought by a Police Officer, Social Welfare Officer, Ward Executive Officer or Village Executive Officer to the health facility for proper care. Consequently, there is still a noticeable presence of mentally challenged individuals on the streets.

Non-identification at the community level was attributed to the following;

3.3.1 Inadequate Identification Process at the Point Level

Section 3.0.5 of the National Guideline on the Provision of PSS provides and coordinates PSS services at the village level. Social Welfare Officers at this level provide PSS services and play a crucial role in ensuring that all other service providers adhere to the National Guidelines for Psychosocial Care and Support Services. They also play a crucial role in determining the responsiveness of PSS services and responding to specific community members' (beneficiaries') concerns. The Social Welfare Officers at this level should identify and register PSS clients.

The review of the Annual Progress Reports of Social Welfare Services (2019 to 2022/23) from PO-RALG revealed that no mental health-challenged individuals were identified at the community level. Identification was mostly done to drug abusers, elderly people, people with disabilities, childhood pregnancy and children in vulnerable situations.

Upon reviewing the Medium-Term Expenditure Framework (MTEF) in the visited Local Government Authorities (LGAs), it was observed that individuals facing mental health challenges were not considered among the identified vulnerable groups. The identification process at the community level focused on elderly individuals, neglecting those with mental health issues.

A review of MTEF from the visited LGAs revealed that LGAs did not set aside funds to support social welfare in the identification process. Through a review of MTEF from the Dar es Salaam City Council's 2019-2020, the Audit noted that LGAs allocated a budget for identifying the elderly, people with disability, and Most Vulnerable Children from all 36 wards. Still, no budget was allocated for the identification of the elderly in need of Psychosocial Support Services (PSS), as these are among the most vulnerable groups at risk of developing mental illness due to old age and depression. The review of MTEF from the Dar es Salaam City Council's 2021-2022 revealed that the budget was allocated to support 144 community case workers to identify people with disabilities in 36 wards by June 2022, as detailed in **Table 3.4**.

Table 3. 4: Dar es Salaam CC Allocated Budget to Support Social Welfare in the Identification Process of Mental Healthcare Services

Financial Year	Activity	Budgeted Amount (TZS)
2018/19	Nil	Nil
2019/20	To identify elderly people with disability and MVCs from all 36 wards by June 2020.	11,840,000
2020/21	Nil	Nil
2021/22	To facilitate quarterly identification and registration of 70 Daycare Centers in 36 wards by June 2022.	8,400,000
2022/23	Nil	Nil

Source: *Auditors Analysis on MTEF Dar es Salaam City Council (2018/19-2022/23)*

Table 3.4 revealed that identification activities were only considered in two years, 2019/20 and 2021/22, where not all the groups, including individuals with mental disorders, were considered.

Table 3.5 below shows that out of the five sampled years, Mbeya CC only budgeted for identification activities in 2019/20, based on the people with alcohol abuse problems, as detailed in **Table 3.5**.

Table 3. 5: Mbeya CC Allocated Budget to Support Social Welfare in the Identification Process of Mental Healthcare Services

Financial Year	Activity	Budgeted Amount (TZS)
2018/19	Nil	Nil
2019/20	To conduct two (2) days of quarterly screening for people with alcohol problems and management of alcohol abuse for early diagnosis and referral of patients with three (3) HCWs by June 2020.	1,220,000
	To conduct one (1) day quarterly mental specialists' outreach visit with 4 HCWs by June 2020.	900,000
2020/21	Nil	Nil
2021/22	Nil	Nil
2022/23	Nil	Nil

Source: *Auditors Analysis on Mbeya City Council MTEF (2018/19-2022/23)*

As shown in **Table 3.5,** Mbeya CC did not prioritize budgeting for identification activities from 2020/21 to 2022/23 because they did not plan for the activities; thus, the social welfare system did not identify any mentally challenged individuals.

Sengerema DC started budgeting to identify mentally health-challenged individuals in 2022/23, as detailed in **Table 3.6**.

Table 3. 6: Sengerema DC Allocated Budget to Support Social Welfare in the Identification Process of Mental Healthcare Services

Financial Year	Activity Name	Budgeted Amount (TZS)
2018/19	Nil	Nil
2019/20	Nil	Nil
2020/21	Nil	Nil
2021/22	Nil	Nil
2022/23	To conduct outreach on the identification of mentally ill patients at Chamabanda	240,000
	To conduct outreach on the identification of mentally ill patients at Kasomeka	211,190.84

Source: *Quarterly combined Technical and Financial Report from Sengerema DC (2018/19-2022/23)*

Analysis of CCHP 2018/19 to 2022/23 of the visited LGAs revealed insufficient funding for social welfare services for the identification of mentally challenged individuals as the result of inadequate planning and budgeting. Hence, the social welfare officers at lower levels are unable to identify individuals with mental health issues in their respective communities.

Further, the analysis conducted by the CCHP in the visited district councils noted that Kondoa DC and Urambo DC did not plan for the activity regarding identifying mental healthcare services issues in connection to psychosocial care services in the community from the financial year 2018/19 to 2022/23. These district councils did not allocate a budget to support social welfare in the identification process of mental health.

Also, the review of the Comprehensive Council Hospital Plan (CCHP) under code C19S01 from the visited District Hospitals revealed that the District Hospital set aside funds to identify mentally challenged individuals, but no fund was evidenced to be executed; thus, no activity was implemented. Moreover, the Sengerema District Council showed that the funds were allocated for the identification of mental individuals, but no activities were conducted concerning mental case identification; instead, the funds were not disbursed, and in some cases, no fund was allocated for mental illness services at all as can be seen in **Table 3.7.**

Table 3. 7: District Council CCHP Budget for NCD Activities 2022/23

	Facility	Activity	Budgeted (TZS)	Disbursed (TZS)
Sengerema DC	Chamabanda	Identification	240,000	0
	Kasomeko	Identification	211,190	211,190
Dar Es Salaam CC	Nil	Nil	Nil	Nil
Urambo DC	Nil	Nil	Nil	Nil
Mbeya CC	Nil	Nil	Nil	Nil
Kondoa DC	Nil	Nil	Nil	Nil

Source: Auditors' Analysis of the CCHP of the visited District Hospitals *(2023)*

Table 3.7 reveals that only one out of five visited Councils in their health section budgeted for identification activities even though they were not done due to non-disbursement of funds.

Ineffective identification of individuals with mental challenges was the result of inadequate mainstreaming of the national guideline on the provision of psychosocial services into plans and budgets, which would facilitate the identification of services to be available at the community level and those in need of psychosocial support would be attended. Without proper screening and assessment at the community level, many individuals with psychosocial issues may go undetected and untreated. This leads to an increase in mental illness and suicides in the community.

Also, inadequate identification of mentally challenged individuals was the result of the absence of social welfare officials at the lower level, as detailed in **Table 3.8**.

Table 3. 8: Availability of Social Welfare

Level	Designation	Needed	Available	Difference Gap (%)
Region	SWO	26	36	0
District	SWO	736	575	21
District Hospital	SWO	184	163	11
Health Center	SWO	745	76	89
Ward	ASWO	3,956	114	97.2
Village	SWA	6,974	0	100
Street	SWA	3,542	0	100
Total		**16,163**	**964**	**94**

Source: Auditors' Analysis from PO-RALG Social Welfare Staffing Statistics *(2023)*

Table 3.8 indicates that the availability of social welfare officers at the ward level is 2.8% nationwide. In contrast, LGAs did not have Social Welfare Officers at the village and street level. Thus, the shortage of Social Welfare and Community Officers who were tasked with the identification of the mentally challenged individuals in the community at lower levels, from ward to street levels, hinders their effectiveness in meeting the current demand for the provision of social welfare services at the community level.

3.3.2 Ineffective system for the provision of referral to the appropriate service point

According to Section 2.1.4 of the PSS guideline at the Point Level, it is required to provide advice on referral cases that require more advanced psychosocial care and support or medical attention.

The Audit team noted no evidence in place for referrals to mentally challenged individuals from the point level to appropriate service points. Additionally, no records or documents were maintained to monitor their progress.

However, the patients received at tertiary facilities were self-referral and from home, indicating that the referral system for Mental Healthcare Services is non-functional. The Audit noted that the social welfare officials only identify and refer drug abusers to the appropriate service point for further care, unlike the mental health-challenged individuals.

Reports extracted from the District Case Management System (DCMS) showed that the cases which were tracked included gender-based victims, elderly, violence against children, children in conflict with the law and compliance with child protection regulations. There were no details on the number of people who were identified with mental challenges and received psychosocial services and whether they were referred to the health centres or being monitored closely by the social welfare. It was noted that there was a presence of mentally challenged people in Dodoma and Dar es Salaam streets who had not been identified and were not being given Psychosocial Support Services.

This can be attributed to insufficient collaboration and coordination between service providers due to a lack of reporting structure and implementation reports for referring patients. This impedes the referral process and the shortage of trained professionals for mental health at lower levels. When service points (health facilities, ward social welfare officers) have limited information sharing, it can be challenging to ensure seamless referrals and track the progress of patients.

Patients who do not receive appropriate referrals may experience poor health outcomes, as their conditions may worsen before they receive the

necessary care. Also, an inadequate referral system often indicates poor communication between healthcare providers, which can compromise the continuity of care.

3.4 Unavailability of Psychosocial Care and Support Services at the Community Level

According to the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency settings, public health criteria such as population coverage, expected caseload of service users with severe disorders, the potential sustainability of service should be used to determine the locations for establishing mental health care Centers. Further, it states that utilising the Mobile PHC or community mental health teams may effectively establish emergency care at different places within an area.

Section 3.0.5 of the National Guideline on the Provision of PSS at the Village/Mtaa level states that the provision and coordination of PSS services occurs at the Village/Mtaa level. Social welfare officers at this level provide PSS services and play a crucial role in ensuring that all other service providers adhere to the National Guidelines for Psychosocial Care and Support Services. They also play a crucial role in determining the responsiveness of PSS services and responding to specific community members' (beneficiaries') concerns.

The audit team noted the unavailability of psychosocial services at the community level. This is the responsibility of Social Welfare Officers. Also, the WEO and VEOs did not provide Psychosocial Support Services and track the number of mentally ill individuals in the respective jurisdictions, as evidenced by the following.

3.4.1 Psychosocial Care and Support Services were not Timely Available at the Point Level

According to the National Guideline for the Provision of Psychosocial Support Services, the service point level includes but is not limited to social welfare offices, community rehabilitation centres, health facilities, children’s homes, crisis centres for emergencies, one-stop centres, schools, police gender and children desk, retention homes, and approved schools.

Social welfare service providers in these service points should coordinate and support providing PSS services to the clients.

A review of the annual performance reports from MOCDGWSG and the PSS Committee showed that psychosocial support services were not readily available. It is provided to individuals in need due to a shortage of social welfare officers, insufficient funds for PSS and inadequate follow-up and feedback on PSS services from LGAs.

The audit noted the absence of infrastructures such as readily available offices that would provide confidentiality regarding the issues being discussed with the social welfare responsible for providing PSS Services. For instance, during visits to the Local Government Authorities (LGAs), the audit team observed that social welfare officers providing Psychosocial Support Services (PSS) had to share rooms with other officers. This arrangement necessitated vacating the room whenever a client required counselling to ensure privacy and space for the session.

Individuals who require psychosocial support but cannot access it experience a deterioration in their mental health. This led to increased levels of stress, anxiety, and depression, thus escalating to mental illness that required medical attention, as was noted in the trend and record on the increasing number of patients.

The unavailability of community-level psychosocial services had broader public health implications, as untreated mental health issues led to increased substance and alcohol abuse. Timely access to psychosocial support is essential for early intervention and prevention of more severe substance abuse and alcohol abuse.

3.4.2 Psychosocial Care and Support Services were not Effectively Mainstreamed into Plans, Budgets, Policies, Programs, Interventions and Strategies at all Levels

According to the National Guideline for the Provision of Psychosocial Support Services, 2020, an effective and sustainable approach to addressing psychosocial issues requires interventions to be integrated downstream, upstream, and across all programs and procedures, spanning various levels

and organizations. This should involve plans and budgets, programs and intervention design and activities, capacity building and human resource development, monitoring and evaluation systems, and research and development.

The audit team noted ineffective mainstreaming of psychosocial services into the plans of PO-RALG. This ineffectiveness became evident when reviewing the Medium-Term Expenditure Framework (MTEF) for the Local Government Authorities (LGAs) visited, which indicated that not all groups were covered in the provision of Psychosocial Support Services (PSS).

At the LGAs level, the Audit noted that the PSS Services were provided yearly, but they did not cover all the groups needing the services, as detailed in **Tables 3. 9**, **3.10**, and **3.11.**

Table 3. 9: Allocated Budget to Support Social Welfare in the Provision of Psychosocial Care and Support Services (PSS) at Dar es Salaam CC

Financial Year	Activity Name	Budget Amount (TZS)
2018/2019	NIL	NIL
2019/2020	To conduct one day of training on psycho-social care and support to 100 children's careers and owners of Day Care Centers by June 2020.	6,300,000
	To provide psycho-social care and support to 200 incidences of violence against children cases (VAC) from Msongola, Chanika, Zingiziwa, Mzinga, and Kitunda and provide Psycho-social care and support to children quarterly by June 2020.	5,400,000
2020/2021	To provide psycho-social support to 162 SWO to rescue 1500 victims of child abuse and MVCs quarterly by June 2021	19,440,000
2021/2022	Nil	Nil
2022/2023	To facilitate quarterly 26 Social Welfare Officers, provide psycho-social care and support to 100 victims of natural hazard incidences by June 2023	5,400,000

Source: *Social Welfare Budget from Dar es Salaam City Council (2018/19-2022/23)*

Table 3. 10: Allocated Budget to Support Social Welfare in the Provision of Psychosocial Care and Support Services (PSS) at Mbeya CC

Financial Year	Activity	Budget Amount (TZS)
2018/2019	Nil	Nil
2019/2020	Nil	Nil
2020/2021	Nil	Nil
2021/2022	To provide PSS to 200 families during an emergency involving 10 Social Welfare Officers by June 2022	6,905,000
2022/2023	To provide PSS to 100 families during emergencies involving 14 Social Welfare Officers for four days by June 2023.	3,030,000

Source: *Quarterly Social Welfare Report from Mbeya City Council (2018/19-2022/23)*

Table 3. 11: Allocated Budget to Support Social Welfare in the Provision of Psychosocial Care and Support Services (PSS) at Sengerema DC

Financial Year	Activity	Budget Amount (TZS)
2018/2019	Nil	Nil
2019/2020	Nil	Nil
2020/2021	Nil	Nil
2021/2022	Nil	Nil
2022/2023	Mental Health psycho-social care support to conduct 3-day school health education to 200 primary school children on mental health disorders at Kagunga by June 2023	320,000
	Mental Health psycho-social care support to conduct outreach services to patients with mental health disabilities at Katunguru by June 2023	1,020,000
	Mental Health psycho-social care support to conduct one day of Health education on mental disorders and drug abuse to communities during the World Mental Health Day at Nyantakubwa by June 2023	322,000

Source: *Quarterly combined Technical and Financial Report from Sengerema DC (2018/19-2022/23)*

Tables 3.9, 3.10, and 3.11 indicate that the psychosocial activities were not effectively mainstreamed into plans and budgets. Also, as revealed

through a review of the MTEF, the psychosocial activities were not mainstreamed adequately to capture all the aspects highlighted in the guidelines, such as capacity building, research and development and not all groups were prioritized, such as elders and most vulnerable children for the provision of the psychosocial care.

The following drawbacks contributed to the inadequate mainstreaming of the psychosocial activities into plans and budgets:

Insufficient Communication of the Key Performance Indicators for the Provision of PSS Services

The audit noted that the review of the strategic plans for the MoCDGWSG noted that the prepared Key Performance Indicators did not adequately cover the provision of Mental Healthcare Services, as shown in **Table 3.12.** MoCDGWSG did not communicate the key performance indicators for adequate provision of PSS Services to the PO-RALG and the lower levels[5] to ensure that they had been considered while preparing LGAs' plans.

Through interviews with the officials from the Directorate of Health & Social Welfare, the audit found that while the MoCDGWSG is the sectoral ministry that produced guidelines and policies regarding the provision of psychosocial services, it did not communicate the key performance indicators to the stakeholders nor provide funding to capacitate the social welfare officers at lower levels to meet their targets as detailed in **Table 3.12.**

Table 3. 12: Assessment of the Prepared KPI

Aspect	Coverage	Established KPI	Established Timeline
Capacity building	Communities (ward/village/street)	Not stated	Not stated
human resource recruitment	Not stated	Not stated	Not stated
Monitoring and evaluation	PSS clients are satisfied with the quality of PSS services provided	Not stated	Not stated

[5] Primary Healthcare Services

Aspect	Coverage	Established KPI	Established Timeline
Research and development	Not stated	Not stated	Not stated

Source: *Auditors Analysis from the MoCDGWSG Strategic Plan (2023)*

Table 3.12 shows that the four categories that the Ministry could consider in improving the Psychosocial Services to the community by including them in the strategic plan were not adequately covered. The audit team noted that two (2) out of the four (4) categories were not mainstreamed to ensure they communicated to the implementers what should be covered for PSS implementation. However, the audit team noted that the remaining two (2) out of four (4) KPIs covered a narrow scope for PSS in general. They only covered capacity building and general Monitoring and Evaluation improved systems but did not mention psychosocial care services.

Inadequate Monitoring by MoCDGWSG & PO-RALG on the Implementation of PSS Services

The audit team noted that MoCDGWSG & PO-RALG did not monitor the implementation of PSS Services. They have not effectively identified the challenges towards adequate implementation of the PSS Services and have not developed a plan of action.

However, the regions conduct supportive supervision on providing PSS Services, as detailed below in **Table 3.13.**

Table 3. 13: Supportive Supervision of the PSS Activities

Financial Year	Planned Supportive Supervision	Conducted Supportive Supervision	Availability of the Checklist	Percentage difference (%)
2018/19	3883	2877	Unavailable	26
2019/20	2120	1199	Unavailable	33
2020/21	6498	5051	Unavailable	22
2021/22	6100	4753	Unavailable	22
2022/23	Nil	Nil	Nil	Nil

Source: Auditors' Analysis of the Annual reports on the social welfare services Reports from PO-RALG (2022)

Table 3.13 reveals that although they conduct supportive supervision, no checklist exists. Furthermore, Monitoring and Evaluations were not 100%

due to a significant shortage of Social Welfare Officers at the regional, district, ward and village levels. Also, there was a shortage of transport options for the social welfare officers to conduct their activities. This was evidenced by reviewing performance reports from PO-RALG for the Financial Year 2018/19-2022/23.

3.4.3 PO-RALG and MOCDGWSG did not Ensure that the Provision of PSS Services was of the Required Standards as Directed by the Guideline

According to the Standard Operating Procedures for the Provision of Psychosocial Care and Support Services, three of the intended objectives were to improve the quality of PSS provided to all individuals, enhance the quality of PSS provided to all families, and improve the quality of PSS provided to communities across the country.

The audit highlighted a lack of oversight by PO-RALG and MoCDGWSG, as they failed to ensure adherence to targets set for providing PSS (Psychosocial Support Services).

This lack of oversight is evident in the Ministries' absence of data regarding trained PSS personnel, including information on delivering quality PSS Services, the number of individuals served by trained PSS Providers, and the improvement assessment of individuals who received services from trained PSS Providers.

Furthermore, in the review of MoCDGWSG & PO-RALG training reports and supportive supervision reports, compiled service point reports and quarterly performance reports for the Financial Year 2018/19-2022/23, the audit team noted that the MoCDGWSG did not ensure the provision of Standard Psychosocial Support Services as stipulated by the SOP and National Guideline on the provision of PSS. The conducted supportive supervision did not have a checklist in place to follow up on the set indicators to ensure the provision of standard PSS services was adhered to.

Table 3. 14: Indicators for PSS Standard Operating Procedure

Target	Indicators	Means of verification	Status
PSS providers trained on standard procedures for the provision of quality PSS services	Percentage of PSS service providers appropriately delivering PSS services	Assessment/supportive supervision reports	Partially evaluated
Individuals with PSS need to be served by trained PSS providers on standard procedures.	Percentage of individuals served by trained PSS service providers	Quarterly reports	Not evaluated
PSS clients served by trained PSS providers with improved wellbeing	Percentage of clients with improved well-being after receiving PSS services from trained PSS service providers	Evaluation reports	Not evaluated
PSS clients are satisfied with the quality of PSS services provided	Percentage of clients satisfied with services provided by trained PSS service providers	Evaluation reports	Not evaluated

Source: Auditors Analysis on the Monitoring Reports from MoCDGWSG (2023)

Table 3.14 shows the status of the targets and indicators that the ministries have not evaluated and those partially evaluated that would provide a position of the quality of the PSS services provided.

Without adhering to standardized services, the quality of psychosocial care can vary widely, leading to inconsistencies in the level of support provided to the individuals.

3.4.4 Inadequate Follow-up on the Referral Cases done to ensure that they were properly Attended to and Feedback was Provided to Psychosocial Care and Support Services Providers

Section 2.1.4 of the National PSS Guideline, 2020 states that social welfare service providers in these service points should provide guidance on referral cases and follow up the provision of PSS in the community to ensure that they are provided in line with this guideline through documentation. Furthermore, they should follow up on the referral cases to ensure that they are properly attended to and that feedback is provided to psychosocial care and support services providers.

The audit team noted that the social welfare officers at the point level did not provide referrals of mentally ill individuals as stipulated in the PSS guidelines. So, no feedback was stipulated in the PSS guidelines, and therefore no feedback was given to the Social Welfare Officials. This was due to non-identification of the mental health-challenged individuals at the community level, and thus no referrals were done at the lower levels.

The absence of clear and organized systems for tracking and managing referrals can make it difficult to ensure that each case is properly attended to and that feedback is provided for continuous patient monitoring at the community level. The audit also noted that for the patients with self-referrals to the hospitals, inadequate feedback was still given to social welfare officials for continuous monitoring of the patients.

Failure to provide feedback to psychosocial care and support service providers means they may be unaware of the available patients who need their interventions and may not be integrated well into the community after their treatment.

3.5 Insufficient Resources to Facilitate Availability of Mental Healthcare Services

As elaborated below, the Audit noted insufficient resources (experts, infrastructure, medical equipment, and medicines) to facilitate Mental Healthcare Services.

3.5.1 MoH and PO-RALG did not Ensure the Availability and Adequate Distribution of Experts at all Levels for the Provision of Mental Healthcare Services

According to Section 2.2.1 of the Basic Standard for Health Facilities of 2017, authorized healthcare professionals should always be at the health facility during all operational hours. This requirement is tailored to each facility's specific types of services, ensuring that patients receive appropriate and expert care at all times.

Also, Section 6.1.8.1 of the Basic Standard for Health Facilities, 2017 requires the zonal, national, specialized, and super speciality hospitals to have facilities and specialized personnel who can provide secure mental services that address the client's safety.

The audit team reviewed the status of the staff establishment for mental hospitals at national, zonal, regional, district and community levels to assess the fulfilment of staff in delivering mental healthcare services in the country. It was noted that there was no record of the availability of a number of staff members who were required to contribute to the provision of services in comparison to the number of staff required by the National Guidelines, 2017. The audit team noted the following discrepancies at all hospital levels.

The inadequate number of staff for the provision of Mental Healthcare Services in the country has been noted to be partly due to the lack of adequate records of all the mental health workers in all healthcare facilities.

The audit team reviewed the documents from the Ministry of Health and conducted interviews. It was noted that the Ministry of Health didn’t have records for all the healthcare practising personnel in all the healthcare facilities registered under it.

This was further evidenced through the following analysis of the levels of the National, Zonal and District hospitals, as elaborated below.

(i) Inadequate Number of Staff at National Level Hospitals for the Provision of Mental Healthcare Services

The Audit team reviewed the staff establishment at Mirembe National Mental Hospital and Muhimbili National Hospital. It noted an inadequate number of experts for Mental Healthcare Services in these visited national hospitals. At Mirembe National Mental Hospital, 3 out of 9 specialist categories, equivalent to 30%, had at least one specialist compared to the required categories by the Basic Standard for Health Facilities, 2017. The audit team noted that the Ministry of Health did not establish the doctor-patient ratio to guide itself in assessing the required number of patients to be treated by one doctor. This ratio would have assisted in recruitment and human resources development.

The audit also noted that Mirembe National Mental Hospital did not have an addiction specialist or forensic psychiatrist. Also, there were no Pediatric Neurologists and few Psychiatric Nurses. However, the hospital managed to have an adequate number of Psychiatrists.

Table 3.15 shows the available mental health professionals at Mirembe National Mental Hospital as of the financial year 2022/23.

Table 3. 15: Available Mental Health Professionals at Mirembe National Mental Hospital as of Financial Year 2022/23

Cadre	Requirement (staffing level 2019)	Available	Percentage Gap
Addiction Specialist	1	0	100
Forensic Psychiatry	2	0	100
Psychiatric Nurse	2	5	0
General Psychiatrist	3	5	0
Psychologist	1	1	0
Clinical psychologist in Mental Health & Addiction	3	0	100
Occupational therapist (MH)	2	0	100

Source: *Auditors' Analysis from the Staff Establishment of the National Hospitals (2023)*

Table 3.15 shows that Mirembe National Mental Hospital had a 100% gap in forensic psychiatrists, clinical psychologists, occupational therapists and addiction specialists.

Furthermore, The audit revealed that Mirembe National Mental Hospital was operating with staffing levels established for 2014-2019, which are now outdated. Reviewing the summary of the Mirembe National Mental Hospital Board meeting held on 18 & 19 July 2023, the Audit noted that Mirembe National Mental Hospital discussed the new draft of Staffing level requirements. It was noted that the current status of experts was still insufficient for the provision of adequate Mental Health Services since Speech & language therapists, Social welfare officers in Mental Health & Addiction, Geriatric psychiatrist, Clinical pharmacist in Mental Health & Addiction, Child & adolescent psychiatrist, Clinical pharmacist in Mental Health & Addiction and Child & adolescent psychiatrist had 100% gap as detailed in **Table 3.16.**

Table 3.16: Analysis of the Proposed Establishment of Mental Health Specialist at Mirembe National Mental Hospital July 2023

Designation	Required	Available	Shortage	Percentage Shortage
Speech & language therapist	2	0	2	100
Social welfare officer in Mental Health & Addiction	6	0	6	100
Geriatric psychiatrist	3	0	3	100
Clinical pharmacist in Mental Health & Addiction	4	0	4	100
Child & adolescent psychiatrist	3	0	3	100
Clinical pharmacist in Mental Health & Addiction	4	0	4	100
Child & adolescent psychiatrist	3	0	3	100
Msc. Psychiatric Nurse	16	3	13	82
Neuropsychologist	2	0	2	100
Neuropsychiatrist	3	1	1	66
Clinical Neurologist	3	2	1	33
TOTAL	**49**	**6**	**42**	89.18

Source: Auditors' Analysis from the Proposed Staff Establishment of the Mirembe National Mental Hospitals *(2023)*

Table 3.16 shows a shortage of more than 50% of the proposed mental health specialist establishments to address the professionals needed to provide mental healthcare services adequately.

Similarly, Muhimbili National Hospital lacked an adequate number of mental health specialists, as shown in **Table 3.17.**

Table 3. 17: Available Mental Health Professionals at Muhimbili National Hospital

Cadre	Required	Available	Difference	Percentage Gap
Clinical Psychologist	12[6]	5	7	58
Addiction Specialist	1	3	0	0
Psychiatric Nurse	38[7]	2	36	95
Psychiatrists	14[8]	11	3	21

Source: *Auditors' Analysis from the Staff Establishment of the National Hospitals (2023)*

Table 3.17 shows that the Psychiatry Nurses' cadre had a deficiency of 95%, and Psychiatrists had a 21% deficiency from the required number.

The review of the guidelines for the establishment of healthcare facilities revealed that the Ministry of Health did not manage to define the service provider-to-patient ratio to ensure effective supervision and enhance service delivery performance.

However, the audit team noted that there was no guide regarding a lower patient ratio to be attended per day per medical specialist.

(ii) Inadequate availability of staff at Zonal Level Hospitals for the Provision of Mental Healthcare Services

The Audit team reviewed the psychiatry staff establishment at Zonal Hospitals at Mbeya, Mwanza (Bugando Hospital) and Dodoma (Benjamin Mkapa Hospital). It was noted that, among the three visited zonal hospitals, only Bugando in Mwanza had mental health personnel, where five (5) psychiatrists, three (3) mental health nurses, and one (1) occupational therapist provided mental healthcare services. There were no experts at

[6] Provided staff requirements from Muhimbili National Hospital (2023)
[7] Page 26 of the Staffing Levels for Ministry of Health Facilities, 2014-2019
[8] Page 46 of the Staffing Levels for Ministry of Health Facilities, 2014-2019

the other zonal hospitals, which was contrary to the requirement by the Basic Standard for Health Facilities, 2017.

Similarly, among the four (4) required categories, both Mbeya and Dodoma zonal hospitals had only two (2) psychiatrists. The remaining categories were lacking in the chain of service provision. This increased the risk since there was a broken chain of referral systems during the implementation of the provision of Mental Healthcare Services.

(iii) Insufficient number of staff at Regional Level Hospitals for the provision of Mental Healthcare Services

The Audit team reviewed the number of staff to assess their adequacy in the provision of mental healthcare services, including Psychiatrists, Psychiatric Nurses, and Occupational therapists. It noted that there was an inadequate number of Psychiatry Specialists at the Regional Level Hospitals, as shown in **Table 3.18.**

Table 3. 18: Status of Specialists in Regional Hospitals

Cadre	Required Number	Tabora		Dodoma		Mwanza		DSM		Mbeya	
		Avail	Gap	Avail	Gap	Avail	Gap	Avail	Gap	Avail	Gap
Psychiatrists	1	0	1	0	1	1	0	2	0	0	1
Psychologist	1	0	1	0	1	1	0	0	0	1	0
Psychiatric Nurse	2	3	0	2	0	2	0	5	0	1	1
Occupational therapist	1	1	0	0	1	1	0	0	1	2	0

Source: *Auditors' Analysis from the Staff Establishment of the Regional Hospitals (2023)*

Table 3.18 shows that there were no psychiatrist specialists in the visited Regional Hospitals except in Dar es Salaam and Mwanza. The remaining three Regional Hospitals, namely Kitete RRH, Dodoma RRH and Mbeya RRH, had clinical psychiatrists.

However, for Psychiatrist Nurses, in the five visited regions, only one Regional Hospital, namely Mbeya Regional Referral Hospital, was noted to have a 50% gap in staffing compared to the required number of experts. Moreover, for Occupational Therapists, in the five visited regions, only three Regional Referral Hospitals, i.e. Tabora, Mwanza and Mbeya, were noted to have adequate Occupational Therapists. The rest of the regional-level

hospitals, i.e. Dodoma Regional Referral Hospital and Amana Regional Referral Hospital, had a 100% gap in Occupational Therapists.

(iv) Inadequate number of staff at District Level Hospitals for the provision of Mental Healthcare Services

The Audit team reviewed the number of staff at five visited District Hospitals. It was noted that there was an inadequate number of experts at these visited hospitals compared to the required categories and number by the Basic Standard for Health Facilities, 2017, as shown in **Table 3.19**.

Table 3.19: Status of Needed Personnel at District Hospitals

Cadre	Required Number	Urambo		Kondoa		Sengerema		Kivule		Igawilo	
		Avail	Gap	Avail	Gap	Avail	Gap	Avail	Gap	Avail	Gap
Medical Officer	1	1	0	1	0	1	0	1	0	1	0
Psychiatric Nurse	1	0	1	0	1	1	0	0	1	1	0

Source: *Auditors' Analysis from the Staff Establishment of the District Hospitals (2023)*

Table 3.19 shows that there were no psychiatrist Nurses in the three (3) visited District Hospitals, i.e. Urambo, Kondoa and Kivule District Hospital. Moreover, the mental healthcare services were provided by medical officers who were available in all the five visited District hospitals.

Factors Contributing to Unavailability of Mental Health Experts at all levels

The following were the reasons for the unavailability of mental health experts at all levels;

Lack of Recruitment Plan for Mental Health Professionals by the Ministry of Health

Section 5.4.1, Human Resources for Health of Health Sector Strategic Plan V, states that the Placement of staff according to workload and patient needs will be used in preference to fixed establishments. Priority for employment permits and funding for HRH positions will be given to completed health facilities, regions with a low HRH per population ratio and tutors for HTI. The budget will be allocated for the redistribution of HRH

within LGAs, which has huge inequalities between health facilities. Guidelines for non-financial incentives and a policy for volunteers in the health sector have not been developed.

The audit noted that there is no comprehensive and detailed recruitment plan for mental health professionals by the Ministry of Health that assesses the patient's needs and workload to the health professionals. This lack of assessment of recruitment needs significantly impacts the delivery of Mental Healthcare Services across the healthcare system. This concern is indicative of potential challenges in addressing the growing demand for mental health care, especially considering the increasing prevalence of mental health issues globally.

In addition, it has contributed to a lack of motivation to attract new recruitment to facilitate the effective provision of Mental Healthcare Services in the country. The presence of an inadequate number of graduates to increase the number of specialists to meet the need was evidenced through a review of the Register of Muhimbili University of Health and Allied Sciences (MUHAS), which showed a shortage of students specializing in mental health-related studies, i.e., psychiatrists, clinical psychologists, and occupational therapists.

Muhimbili University and Health Allied Science (MUHAS) only produced 39 graduates in the last seven years. This indicates that MUHAS, the university producing specialists in the mental health sector, could not meet the growing demand for the needed specialities in Mental Healthcare Services, which was 82. The growing demand for the required specialists to attend to the population with mental illness in the country each year increased at a low rate. In other years, it has been noted that there were no graduates, especially in the financial year 2019/20. However, the MoH was required to coordinate with universities to ensure they recruit more professionals to rescue the existing gap.

Absence of Scheme of Service to Accommodate Graduates for the Psychiatrists Services

The audit team reviewed the scheme of service for the health sector and noted that postgraduates on mental health were not considered. The scheme of service outlines employment, including salary scales, job descriptions, and benefits for employees in a particular organization or

sector. The Professional and Operational Public Service Management Scheme (PO-PSM), typically used in government or public service organizations, did not outline the terms and conditions of employment for Mental Healthcare Services professionals (especially psychiatrists) and operational staff involved in public service management roles.

According to interviews conducted with the clinical psychologists and the director of administration and human resources from the Ministry of Health, this is one of the leading causes of shortage among psychologists because there are no incentives in the public sector, and the scheme of service does not recognize them.

This has contributed to the following drawbacks in providing Mental Healthcare Services in the country.

Limited Access to Care

A shortage of mental health professionals, such as psychiatrists, psychologists, and licensed therapists, can result in limited availability of Mental Healthcare Services. The interviews with the health secretaries noted that individuals in need may have to wait longer for appointments. For example, on average, in the visited healthcare facilities, patients had to wait to receive services or could not access care at all.

However, the patients and their respected guardians may struggle to seek better service from the upper level. Instead, they decide to stay at home and even use different approaches that are not medically approved to find a solution.

3.5.2 Inadequate Infrastructures to Attend both Adults and Children Inpatients during Mental Healthcare Services Treatment

Annex 2 (a) of BSHF, 2017 states the number and functional spaces for various blocks for level one (I) and (ii) hospitals concerning the mental health wards. Also, Sections 8.3, 8.4, 8.5, 8.6, and 8.7 of the BSHF, 2017, provide the requirements for physiotherapy services in a Level III hospital in terms of human resources and equipment.

The audit team reviewed Health Sector Annual Performance Reports for 2016/17 to 2022/23 to establish the needed number of wards in the country.

It was noted that the ministries did not have actual data on the needed versus available number of wards in the country based on the national, zonal and regional levels.

However, the audit noted insufficient wards at the National Zonal and Regional levels through the site visits to the selected healthcare facilities, as elaborated below,

The audit team noted that at the national level, there were no acute wards for Children and Adolescents at Mirembe National Mental Hospital and Muhimbili National Hospital. Similarly, no female acute wards were at Muhimbili National Hospital, as elaborated in **Table 3.20**.

Table 3. 20: Status of Wards at National and Super specialized Level Hospitals

Regional Assessment	Male	Female	Children and Adolescents	Acute		
				Male	Female	Children and Adolescents
Mirembe	v	v	x	v	v	x
Muhimbili	v	v	x	v	x	x

Source: *Auditors' Analysis of the Presence of Wards at Muhimbili National Hospital and Mirembe National Mental Hospital (2023)*

Key
x- Not Available
v- Available

Similarly, the audit noted the same anomalies at zonal level hospitals regarding the availability of mental healthcare wards. The audit team noted an absence of children's and Adolescents' wards in the zonal level hospitals, as detailed in **Table 3.21**.

Table 3.21: Status of Wards at Zonal Level Hospitals

Zonal Hospitals	Male	Female	Children and Adolescents	Acute		
				Male	Femal e	Children and Adolescents
Bugando	v	v	x	v	v	x
Mbeya	v	v	x	v	v	x
Benjamin Mkapa	x	x	x	x	x	x

Source: Auditors' Analysis of the Presence of Wards from Zonal Hospitals (2023)

Key

x-Not Available
V- Available

Table 3.21 shows that Benjamin Mkapa Zonal Hospital had no wards for males, females, children, and acute patients. As detailed through the interviews, it resulted from being close to Mirembe National Mental Hospital.

Similarly, the audit team visited the regional-level hospital to assess the availability of wards. It was noted that no children's and adolescents' wards were available at the regional level hospital, as detailed in **Table 3.22**. The audit noted further that Kitete Regional Hospital had wards for the admission of mental health patients.

Table 3. 22: Status of Wards at Regional Level Hospitals

Regional Referral Hospitals	Region	Male	Female	Children	Acute		
					Male	Female	Children
Sekou Toure	Mwanza	x	x	x	x	x	x
Kitete	Tabora	v	v	x	v	v	x
Dodoma	Dodoma	x	x	x	x	x	x
Mbeya	Mbeya	x	x	x	x	x	x
Amana	Dar es salaam	x	x	x	x	x	x

Source: *Auditors' Analysis on the presence of wards from Regional Hospitals site visit (2023)*

Key
x-Not Available
V- Available

Table 3.22 shows that out of 5 visited regional hospitals, 4 had no inpatient facilities. The four hospitals were Dodoma, Mbeya, Sekou Toure and Amana Regional Hospitals. None of the visited regional hospitals had acute wards.

The following aspects have contributed to this:

(a) Funds were not allocated for the construction of Wards

The audit team noted through the review of the budget and the disbursed funds by the Ministry of Health and PO-RALG that no budget was allocated for the development of mental health wards between the financial years

2018/19 to 2022/23. The government did not put effort into accommodating the mental health patients required to be admitted at the respective hospital levels. Through the reviewed MTEF for plans and budget allocation, the audit noted a lack of plans specifically for the development of mental healthcare services wards. However, it could not be well established since their plans were generic and not specific for the activities.

(b) Lack of Plans for the construction of Wards for Mental health

The audit team reviewed the budget prepared by the Ministry of Health. It was noted that there was no plan to develop mental healthcare services in the available hospitals.

This deficiency implies a potential gap in understanding the unique requirements and nuances of designing spaces dedicated to mental health treatment. The absence of specialized plans may compromise patient safety and security, overlooking essential features such as anti-ligature fixtures and secure access controls.

Furthermore, the therapeutic environment, a crucial component of mental health facilities, may be compromised without detailed plans. The discovery underscores the need for engaging mental health experts and other multidisciplinary experts, such as architects and healthcare planners, in the design process to ensure that layouts and environments are conducive to patient recovery. Compliance with legal and healthcare-specific regulations becomes a concern, as the lack of tailored plans may result in facilities falling short of required standards.

3.5.3 Insufficient Availability of Medical Equipment and Medicines to Facilitate Effective Service Provision of Mental Healthcare Services by Practitioners.

Objective 3 of the MoH Non-Communicable Diseases Strategic Plan 2016-2020 aims to ensure adequate availability of medical equipment and supplies concerning non-communicable diseases, including mental health.

The audit noted that the ministry did not ensure adequate medical equipment, supplies, and infrastructure.

(i) Inadequate Availability of Beds for Mental Inpatients at Zonal and Regional Referral Hospitals

During the site visit, the audit team noted that there was an inadequate number of beds for admission of mental health patients based on their category (gender) at the Zonal and Regional Referral Hospitals.
The audit team noted the scarcity of beds at the zonal level, as detailed in **Table 3.22**.

Table 3. 23: Availability of Beds for Mental Health Patients at Zonal Level

Zonal Hospital	Region	Required number of beds	Available Male Ward	Available Female Ward	Percentage Available (%)
Mbeya	Mbeya	54	16	9	46
Bugando	Mwanza	54	30	26	100
Benjamin Mkapa	Dodoma	54	0	0	0

Source: *Auditors' Analysis from the MoH Basic Standards for Health Facilities, 2017 and conducted site visit (2023)*

From **Table 3.22,** the Audit noted that all the visited Zonal Referral Hospitals had insufficient beds for the provision of Mental Healthcare Services. Dodoma Zonal Referral Hospitals did not have beds because they do not provide Mental Healthcare Services. The audit team noted that only Bugando and Mbeya Zonal Referral Hospitals managed to have 100% and 46% of the required number of beds, respectively. The audit team conducted the site visit and noted an inadequate number of beds at the regional level, as elaborated in **Table 3.23**.

Table 3. 24: Availability of Beds for Mental Healthcare Services at Regional Level

Regional Referral Hospital	Region	Required number of beds	Available (Male)	Available (Female)	Percentage Availability (%)
Mbeya	Mbeya	36	0	0	0
Kitete	Tabora	36	14	10	67
Sekou Toure	Mwanza	36	0	0	0
Amana	Dar es salaam	36	0	0	0
Dodoma	Dodoma	36	0	0	0

Source: *Auditors' Analysis from the MoH Basic Standards for Health Facilities, 2017 and conducted site visit (2023)*

Table 3.23 revealed that 4 out of 5 visited Regional Hospitals had no beds for mentally challenged individuals. It was noted that Tabora Regional Referral Hospitals had bed unavailability of 33%.

However, at the national level, during the site visit, the audit team noted that Mirembe National Mental Hospital had an adequate number of beds for the admission of mental health patients, as shown in **Table 3.24**.

Table 3. 25: Availability of Beds for Mental Healthcare at the National Level

Healthcare Facility	Required number of beds	Available	Percentage Availability
Muhimbili	72	66	92
Mirembe	250	200	80

Source: *Auditors' Analysis on the Availability of Beds from the conducted site visit (2023)*

Table 3.24 shows that Muhimbili National Hospital had 92 per cent availability of beds despite the fact that during the Site visit, the beds were fully occupied, and they still needed more to cover the demand in place; this revealed that they did not conduct a thorough need assessment of the bed.

The provision of mental healthcare services for inpatients requires hospitals to have beds for admission to ensure clear and close monitoring of patients.

(ii) Inadequate Availability of Diagnostic and Treatment Equipment for Mental Healthcare Services

Objective 3 of the Ministry of Health NCD strategic plan 2016-2020 states that the health system will be strengthened to address NCDs by 2020 by providing hospitals, health centres, and dispensaries with the equipment for quality NCD services.

The required equipment included Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG) and Electroconvulsive Therapy (ECT), which are important in the study of brain injury and activity and structure linked to some mental disorders such as bipolar disorder and Schizophrenia.

Table 3. 26: Availability of Equipment at All Levels

Cadre	National		Zonal		Regional	
	Required	Available	Required	Available	Required	Available
ECT	2	0	5	0	31	0
EEG	2	2	5	1	31	0
MRI	2	1	5	3	0	0

Source: *Auditors' Analysis from the National Guidelines for Healthcare Facilities and also Documents from the Ministry of Health (2023)*

Table 3.25 shows that the Ministry of Health did not have actual records of equipment for planning and development purposes across the country.

The audit team noted that the medical equipment diagnostic and treatment were insufficient at Mirembe National Mental Hospital, as shown in **Table 3.26**.

Table 3. 27: Availability of Medical Equipment at the Mirembe National Mental Hospital

Equipment	Mirembe NMH		
	Required	Available	Difference %
Modern ECT machine	2	0	100
EEG	1	1	0
MRI machine	1	0	0
Mobile/Portable EEG machine	1	0	100
Transcranial magnetic stimulation device	1	0	100
Transcranial Direct Current stimulation device	1	0	100
EMG machine	1	0	100
CT machine	1	0	100

***Source:** Auditors' Analysis of the Available Equipment at Mirembe Mental National Hospital (2023)*

Table 3.26 shows that out of the nine (9) needed equipment, Mirembe National Mental Hospital only had an electroencephalogram (EEG). Magnetic Resonance Imaging (MRI) equipment and Electroconvulsive Therapy (ECT) equipment were not in place during the date of the site visit.

Table 3. 28: Analysis of the Availability of Medical Equipment at the Muhimbili National Hospital

Cadre	MNH		
	Required	Available	Difference %
ECT	1	0	100
EEG	1	1	0
MRI	1	1	0

Source: Auditors' Analysis of the Available Equipment at Muhimbili National Hospital *(2023)*

Table 3.27 shows that Muhimbili National Hospital had only Magnetic Resonance Imaging (MRI) equipment and Electroencephalogram (EEG) and lacked Electroconvulsive Therapy (ECT) equipment. The audit team noted that all three visited Zonal Referral Hospitals had Magnetic Resonance Imaging (MRI) equipment, as detailed in **Table 3.28**.

Table 3. 29: Availability of Medical Equipment- Zonal Level Hospital

Name of the Equipment	Required	Benjamin Mkapa		Mbeya		Bugando	
		Avail	Gap	Avail	Gap	Avail	Gap
ECT	1	0	1	0	1	0	1
EEG	1	0	1	0	1	1	0
MRI	1	1	0	1	0	1	0

Source: Auditors' Analysis from Site Visit*(2023)*

In the visited zonal hospital, the audit team noted that one Zonal Referral Hospital, i.e. Mbeya Zonal Hospitals, lacked Electroencephalogram (EEG), and all three Zonal Referral Hospitals lacked Electroconvulsive Therapy (ECT) equipment.

(iii) Inadequate Availability of Psychiatric Medicines

According to Section 3.9, the expected outcomes of the NCD Strategic Action Plan 2016-2020, it is stated that by 2020, the Ministry of Health improvement to facilities care must ensure that there is a 50% increase from baseline access to essential medicines for those diagnosed with the NCDs.

The review of the developed NCD strategic plan 2021 - 2025 noted that the Ministry of Health did not establish the threshold for the availability of medical equipment as the key performance indicator to generate monitoring performance of the supply of mental healthcare services medicines.

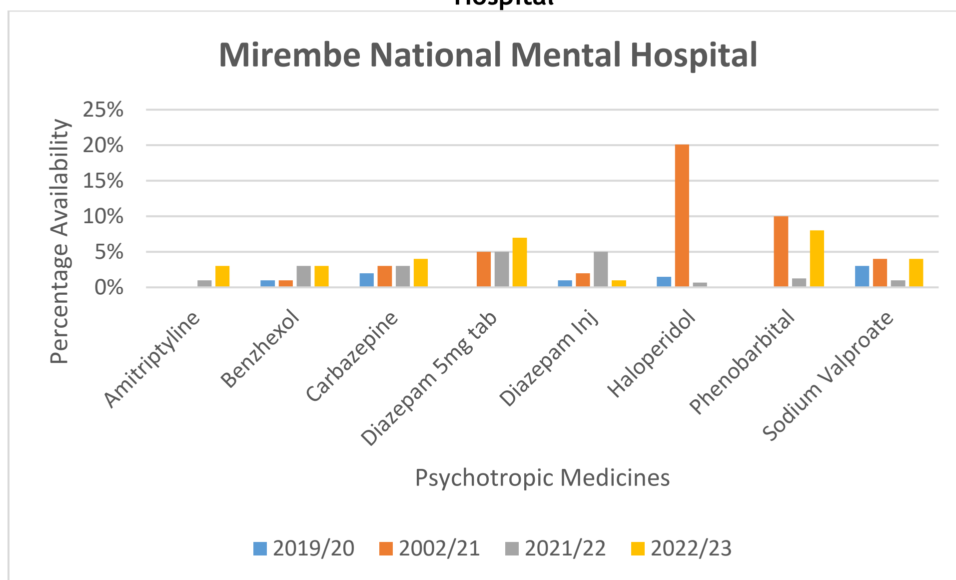
However, the audit team reviewed the availability of eight psychiatric medicines, including Amitriptyline, Benzhexol, Carbamazepine, Diazepam 5mg tab, Diazepam Injection, Haloperidol, Phenobarbital and Sodium Valproate. It was noted that there was an inadequate supply of medicines for mental health treatment at all levels of health facilities.

The audit team noted from two National Hospitals visited that provide the treatment of Mental Healthcare Services whereby in the past five years, from 2018/19 to 2022/23, the highest medical supply achieved was 20%, which was less than the proposed rate of increase of 50% as shown in **Figure 3.1** below. However, the audit team noted that only Muhimbili National

Hospital was receiving a full supply of the medicines requested by the Medical Stores Department (MSD).

The audit team noted that the Ministry of Health's highest supply of psychiatric medicines to Mirembe National Mental Hospital was 20%. This was noted in the financial year 2021/22 and only for Haloperidol medicines.

Figure 3. 1: Analysis of the Availability of Medicines at the National Level Hospital



Source: *Auditors' Analysis from the MSD sales invoices at the respective Zonal Hospitals (2023)*

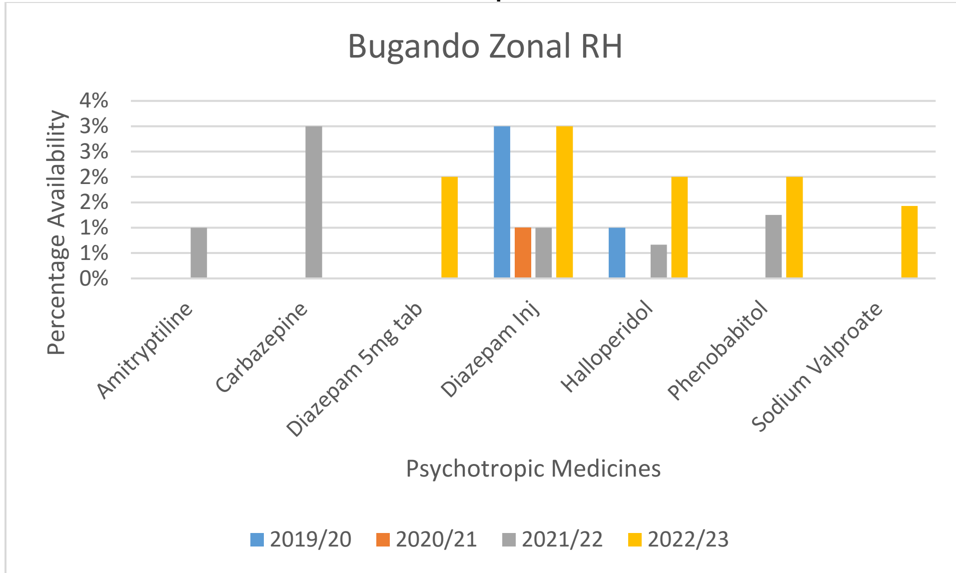
Figure 3.1 shows that despite those medicines being supplied, haloperidol was well managed only in three years, but in the financial year 2022/23, there was no supply of medicines at all.

However, the Audit team visited the hospitals at the zonal level. It was noted that among the three visited hospitals, the highest stock level was five per cent in the financial year 2022/2023, as noted in Mwanza Zonal Hospital, as shown in **Figure 3.2**. The audit team noted that only the Mbeya Zonal Hospital had an adequate supply of mental health medicines in the same quantity the healthcare facility requested.

Central Zone Hospital (The Benjamini Mkapa Hospital) was not providing mental healthcare services as of the audit date of December 2023. The

discrepancy was only noted at Mwanza Zonal Hospital (Bugando) among the sampled hospitals at the Zonal level.

Figure 3. 2: Analysis of the Availability of Medicines at Bugando Zonal Level Hospital

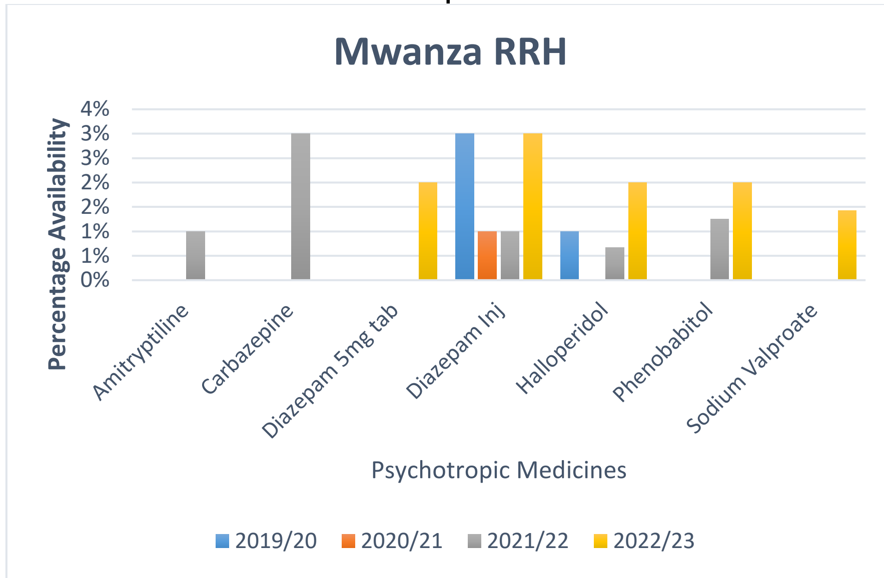


Source: *Auditors' Analysis from the MSD sales invoices at the respective Zonal Hospitals (2023)*

The audit team noted that there was also scarcity in supply by the Medical Stores Department at Mbeya zonal referral Hospital, with a highest of 3% in supply, as elaborated in **Figure 3.2**.

Similarly, the Audit team visited the four hospitals at the regional level. It was noted that among the selected hospitals, the highest supplied stock was 3% of the ordered quantity, as shown in **Figure 3.3** for the Mwanza and Tabora regions. However, in contrast to these observed shortages, the audit team noted a significant supply of medicines at Mbeya and Dar es Salaam (Amana) Regional Hospitals.

Figure 3. 3: Analysis of the Availability of Medicines – Mwanza Regional Level Hospital

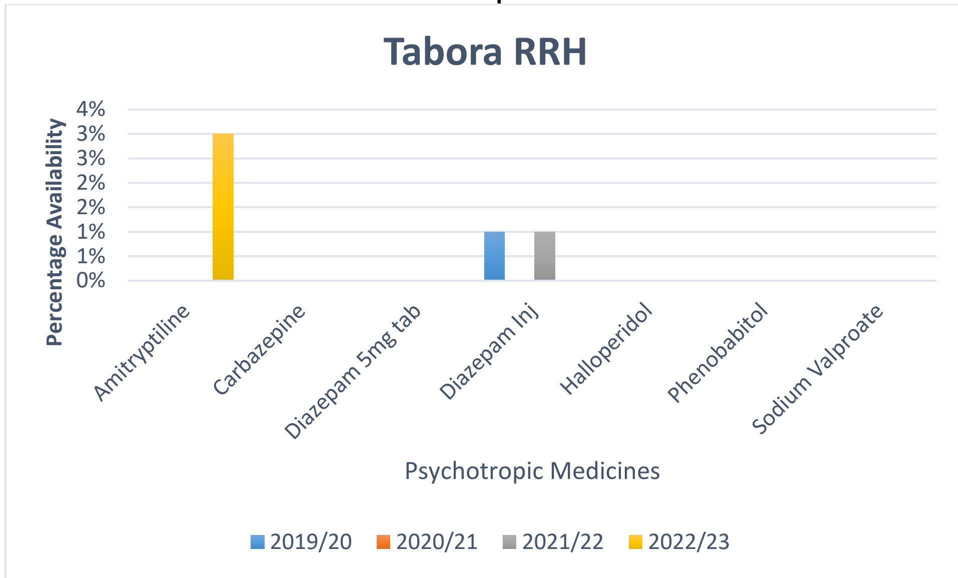


Source: *Auditors' Analysis from the MSD sales invoices at the respective Regional Hospitals (2023)*

The audit team noted that diazepam injection has been frequently supplied in the requested quantities. It has been reported that despite that supply of medicines, the highest supply of medicines has been a low of 3% in 2019/20 and 2022/23. Similarly, it has been noted that carbamazepine has been supplied in the same quantities at a low of 3% of the requested quantities. However, on the overall assessment, there was an inadequate supply of medicines as requested by the service providers for mental healthcare services.

Furthermore, the audit team noted that Tabora Regional Referral Hospital had not been supplied medicines except for Amitriptyline and Diazepam Injection. MSD did not supply the rest among the top ten upon the requested quantity.

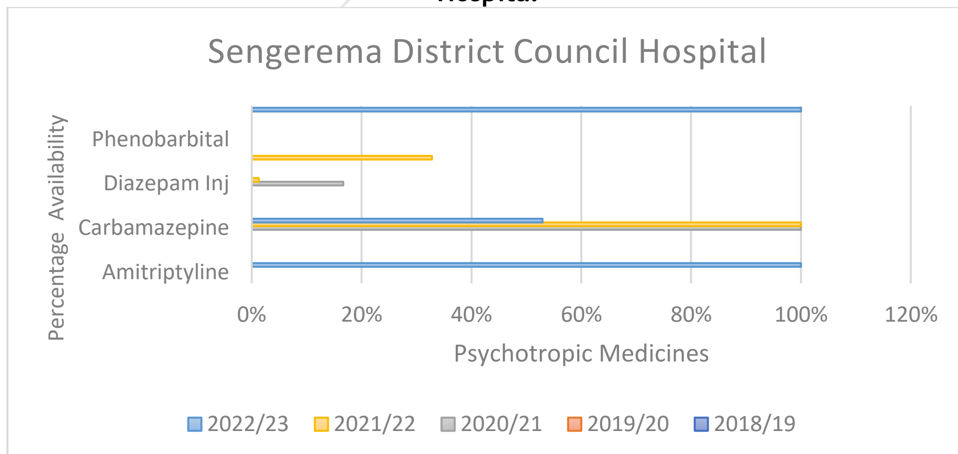
Figure 3. 4: Analysis of the Availability of Medicines - Tabora Regional Level Hospital



Source: Auditors' Analysis from the MSD sales invoices at the respective Regional Hospitals (2023)

It was also noted in the five (5) visited District hospitals that the supply rate of psychiatry medicines was below the planned medical supply of NCD diseases, as shown in **Figure 3.5**.

Figure 3. 5: Analysis of the Availability of Medicines - Sengerema District Level Hospital

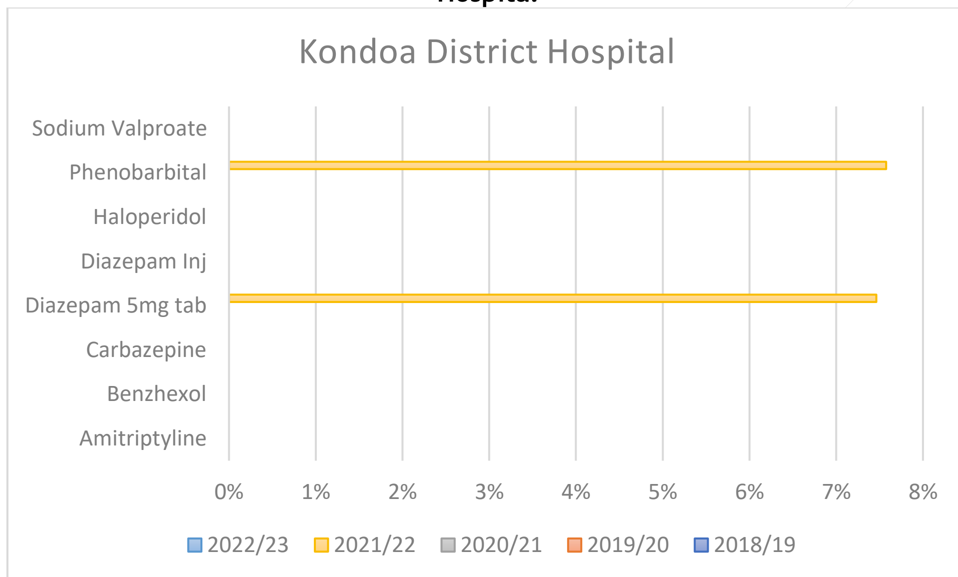


Source: Auditors' Analysis from the MSD sales invoices at the respective District Hospitals (2023)

Figure 3.5 above shows that for Sengerema District Hospital, the Ministry of Health managed to supply 100% of 3 out of 8 requested drugs. This achievement was noted in the financial year 2022/2023 for amitriptyline and sodium valproate and in the financial year 2021/22 for Carbamazepine.

However, for Kondoa District Hospital, it was noted that a small supply of 7.5% for 2 out of 8 drugs was attained in the financial year 2021/22 only. For the rest of the financial years, there was no supply of medicines, as shown in **Figure 3.6**.

Figure 3. 6: Analysis of the Availability of Medicines - Kondoa District Level Hospital



Source: *Auditors' Analysis from the MSD sales invoices at the respective District Hospitals (2023)*

Furthermore, the audit team reviewed the supply status of mental health medicines. It has been noted that there was no supply of medicines for Urambo, Kivule and Igawa district hospitals. It was further noted that the MSD had declared that these medicines were out of stock (OS).

The review of the Ledger books prepared by the respective visited health facilities noted that despite the supply of the ordered medicines not being met by the MSD, the hospitals, through their therapeutical committee, sought rescue from private vendors. Payment for such supply of the needed medicines was met through their annual collections from patients.

The following factors contributed to the insufficient availability of medicine and medical equipment for mental healthcare services.

I. Prioritization of Mental Health was Still Inadequate

WHO Mental Health Action Plan 2013-2020 states in its Objective 1 the need to strengthen effective leadership and governance for mental health by planning according to measured needs and adequately allocating a budget.

The audit team reviewed the budgetary status prepared by the Ministry of Health. It noted that the plans and budget for ensuring stable public health were successfully categorized into divisions. Still, in the case of the Non-Communicable Diseases (NCD) division, it was identified that they were not properly broken down to ensure that all the categories under the NCD division were well identified for budgeting. Mental health, amongst the other diseases under NCD, may not be well reinforced due to the budget distribution not being properly predetermined. This has implications for allocating resources, including funding for the procurement of medical equipment.

II. Unavailability of Mental Health Board as required by the Mental Health Act

According to Section 17(1) of the Mental Health Act, 2008, on the establishment of the Mental Health Board, one of its functions is to supervise and monitor the provision of mental health care services and assurance of quality by inspecting facilities within the mental health care facilities in Mainland Tanzania. Quality assurance in mental health facilities ensures patients receive appropriate and effective care.

If the proposed mental health board had been in place, it could have played a vital role in overseeing and ensuring the adequate supply of medical equipment in Mental Healthcare Services by conducting a thorough needs assessment to identify the specific medical equipment required for mental healthcare services. Also, by ensuring that sufficient budgetary resources are allocated to procure, maintain, and upgrade medical equipment and collaborate with mental health professionals, including psychiatrists, psychologists, and other specialists, to understand their equipment requirements.

III. Inadequate Market Research for the Availability of Medical Supplies

This has been attributed to the Ministry's lack of Market Research and Demand Forecasting to establish a solution to the gap identified in the inadequate supply of mental health medical supplies. This shows that the Ministry of Health did not collaborate with other relevant stakeholders to find solutions for acquiring mental health medicines easily.

The Ministry of Health showed weakness in collaboration among the relevant stakeholders to ensure that medical supplies were adequately managed. This has been noted through the review of the ledgers from individual medical ledgers that private vendors managed to supply the missing medical needs. In contrast, the designated Ministry of Health’s Medical Stores Department (MSD) failed to supply.

The impact of non-availability of medicines and medical equipment are such as:

(i) Risk of Varied High Price of the Medicines from Private vendors

The audit team noted that there was different management of medical supplies whereby the therapeutical committees from different health centres pursued vendors in different locations and sought competitive bid prices through procurement procedures. The selected vendor may still have a high price for the items compared to the MSD prices. Although the Ministry of Health allocated funds for medical purchases from MSD, it is still difficult for the respective healthcare facility to use the funds on unsupplied medicines. That situation requires the respective health facility to use the collected funds from patients to purchase the medicines.

(ii) Risk of Delay of Supply of Medicines and Medical Equipment

The audit team noted that a lack of coordination to ensure a timely medical equipment supply may disrupt the continuity of treatment for patients with chronic illnesses or acute conditions. This interruption may lead to worsening health conditions, increased complications, and decreased overall patient well-being. However, patients relying on timely medication may experience increased suffering, pain, or discomfort during periods of supply delay.

The delay in pursuing the medicines may also lead to a forceful supply of unregistered medicines by TMDA (Tanzania Medicines & Medical Devices Authority), which may impact the quality of medical services provided by the service providers.

3.6 Insufficient and uncomprehensive Rehabilitation Services for Skills Development, Community Integration and Recovery-oriented Supports

The National Rehabilitation Strategic Plan of 2021-2026 states that national clinical practice guidelines are an important way to ensure that the rehabilitation interventions provided have been proven effective and standardize care across the country. However, up to December 2023, no national clinical practice guidelines for rehabilitation had been developed.

The Audit noted that the rehabilitation services provided were not comprehensive enough to cover all the aspects of rehabilitation. Also, there was an absence of guidelines and standard procedures for skills development in the respective rehabilitation category. There were no national clinical practice guidelines for rehabilitation services that can guide the provision of rehabilitation services of Mental Healthcare Services. Standard operating procedures have not been defined for use in day-to-day activities; instead, they are using different best practices, such as training them to be self-dependent and able to participate in community work to run the rehabilitation services of Mental Healthcare Services.

3.6.1 Unavailability of Rehabilitation Centres

According to the Ministry of Health Basic Standards for Health Facilities Volume 1 Household and Community Level (2017), the village or Mtaa government shall maintain existing rehabilitation centres that will facilitate the integration of chronically ill patients into society. New centres may be built whenever there is an expressed need.

Furthermore, according to the National Rehabilitation Strategic Plan of 2021 - 2026, Rehabilitation should be available at all levels of healthcare, from tertiary care to primary healthcare settings. When needed, it should be available in community settings such as homes and schools.

The audit noted that out of 26 regions, only 5 have rehabilitation centres. The five rehabilitation centres are located in Kilimanjaro (Longuo), Mwanza (Bukumbi), Dar es Salaam (Vikuruti), Dodoma (Hombolo) and Kigoma (Marimba). Only three out of five rehabilitation centres are government-owned: Vikuruti, Hombolo and Longuo. The remaining two are charity rehabilitation centres. These urban centres provide a gap or barrier for the patients, especially those in rural communities who must travel long distances to access national, zonal or regional hospitals with rehabilitation centres. **Table 3.29** depicts the current state of rehabilitation centres in zonal hospitals.

Table 3. 30: Availability of Rehabilitation Centres - Zonal Level

Zonal Hospitals	Required Number	Available Number	Difference	Status
Benjamini Mkapa	1	0	1	Not Available
Mbeya	1	1	0	Inactive
Bugando	1	1	0	Active

Source: Auditors Analysis on the Availability of Rehabilitation Centers *(2023)*

Table 3.29 shows that of the visited 3 Zonal Hospitals, two had rehabilitation centres, i.e. Mbeya and Bugando Zonal Hospital. However, only the one at Bugando Zonal Hospital was functioning. Benjamini Mkapa Zonal Hospital had no rehabilitation centres, as Mirembe National Mental Hospital is close to their hospital, just 12 km away. They fully depend on it for the provision of rehabilitation services.

The Rehabilitation Facilities were not in a Satisfactory Condition

According to the Ministry of Health Basic Standards for Health Facilities Volume 1 Household and Community Level (2017), "the village or Mtaa government shall maintain existing rehabilitation centres that will facilitate the integration of chronically ill patients into society. New centres may be built whenever there's an expressed need".

Through physical verification, two of the four visited rehabilitation centres, i.e. Hombolo in Dodoma and Vikuruti in Dar es Salaam, were in poor condition and have not been maintained and developed to cope with day-to-day activities that would support patient recovery orientation as detailed in **Photo 3.1.**

Photo 3. 1: Facilities (wards/cottages) of Vikuruti rehabilitation village under Muhimbili National Hospital show the condition of the accommodation area that needs to be renovated. The Photo was taken by the auditor on 26/09/2023.

At the Vikuruti Rehabilitation Centre, the audit evidenced that, mattresses for the patients with epilepsy were kept on the floor since the beds were not designed to accommodate them, as detailed in **Photo 3.2**.

Furthermore, out of the four visited rehabilitation centres, the audit noted that two rehabilitation centres, i.e. Hombolo in Dodoma and Vikuruti village in Dar es Salaam, had no fence, which compromised the security of the rehabilitation centres. Also, most rehabilitation centres lacked other supporting facilities. For example, the lack of a medical laboratory at Vikuruti rehabilitation village made it necessary to travel a distance of 20 kilometres to Muhimbili National Hospital to get the service. Likewise, for Hombolo Rehabilitation Village to get laboratory service, they travel a long distance of 66 kilometres to Mirembe National Mental Hospital.

Photo 3. 2: *Design of beds at Vikuruti rehabilitation village. The photo on the left shows mattresses on the floor for epilepsy patients. Photos were taken by the Auditors on 26/09/2023.*

The audit noted that the Mbeya Zonal Rehabilitation Centre located at Uyole Mbeya was abandoned, so people living around it have invaded the place with agricultural activities, as shown in **Photo 3.3**.

Photo 3. 3: Abandon facilities of Mbeya zonal rehabilitation village under Mbeya Zonal Hospital show no fence to surround the facilities, which led to citizen intervention. Picture taken by Auditor on 04/10/2023.

Photo 3. 4: Abandon facilities of Mbeya zonal rehabilitation village show building that needs to be renovated to function; picture taken by Auditor on 04/10/2023.

The Audit noted that the facilities at Mbeya Zonal Rehabilitation Village were abandoned due to a lack of priority given to rehabilitation services.

Through physical verification, the audit noted that the buildings at Hombolo and Vikuruti were very old with poor kitchen facilities and that the environment was not conducive to patients' recovery since they felt abandoned. Despite that, a new kitchen was constructed at the Vikuruti centre, which was not completed. As detailed in the photos below, the toilet facilities at Hombolo and Vikuruti were old and not renovated and, therefore, not conducive to creating peace and harmony for the patients.

Photo 3. 4: Facilities (Washrooms) of Vikuruti rehabilitation village showing the washroom condition that needs to be renovated with no supply of water. This picture was taken by the Auditor on 26/09/2023.

Photo 3. 5: Facilities (Kitchen area) of Vikuruti rehabilitation village showing the condition of the cooking area that needs to be constructed. The photo was taken by the Auditor on 26/09/2023.

The Audit noted that the kitchen facilities at Hombolo were not of good standards, as detailed in **Photo 3.6**

Photo 3. 6: Facilities (Kitchen area) *of Hombolo rehabilitation village that need to be demolished and rebuilt. Photos were taken by the Auditors on 15/09/2023.*

The following were the reasons for the unsatisfactory facilities of the rehabilitation centres:

Absence of a standard guide for the design of rehabilitation Infrastructure

The Audit noted the absence of a standard guide for the design and necessary infrastructure in the rehabilitation centres. Having Standard Guidelines in place would assist in developing the rehabilitation centres' infrastructure designs.

Absence of Monitoring and Evaluation of the Rehabilitation Centres

The audit noted that the Ministry of Health had not monitored the rehabilitation centres because they were given little priority.

3.6.2 Insufficient Allocation of Resources

The Audit noted insufficient allocation of resources as analyzed through experts, rehabilitation facilities, and funding to support comprehensive rehabilitation services.

(a) Insufficient Allocation of Mental Healthcare Services and Rehabilitation Experts

A review of the National Rehabilitation Strategic Plan of 2021-2026 revealed that Tanzania has a restricted capacity to produce a qualified workforce nationally. The available experts have expertise only in physiotherapy (diploma and bachelor), occupational therapy (diploma), and prosthetics and orthotics (diploma and bachelor).

In part due to the restricted capacity of education and training institutions and issues relating to attraction and retention, the number of rehabilitation workers in Tanzania is very low, especially when compared to several neighbouring countries. The National Rehabilitation Strategic Plan 2021-2026 states that there are only 0.07 physiotherapists, 0.03 occupational therapists and 0.02 prosthetists and orthotists per 10,000 people. Other core rehabilitation disciplines, including speech and language therapy, audiology, and psychology, have been largely missed, and there are no rehabilitation specializations within nursing or medicine. Community-based rehabilitation workers are not officially recognized but are utilized by a small number of non-governmental services.

Moreover, according to Basic Standards for Health Facilities Volume 4 guidelines, Hospitals at Level III and IV and Specialized Clinics at Level III must employ a specific minimum number of health workers at the health facility.

The audit team noted that a total of 10 psychologists, physiotherapists, occupational therapists, and speech and language therapists in the whole country are allocated as detailed below;

Table 3. 31: Analysis of Mental Healthcare Services Rehabilitation Experts

Cadre	Muhimbili			Mirembe		
	Needed	Available	Gap	Needed	Available	Gap
Clinical Psychologist	12	2	10	12	1	11
Occupational therapist	12	6	6	12	5	7
Speech and Language Therapist	5	0	5	5	1	4
Total	**29**	**8**	**21**	**29**	**7**	**22**
Percentage Gaps (%)	**100**	**27.5**	**72**	**100**	**24**	**75.8**

Source: Staffing Level at the National Level (2023)

From the above analysis, the audit noted that the 72% gap between the required experts at the Muhimbili National Hospital and Mirembe National Mental Hospital had a gap of 75.8%. The available experts are only 27.5 per cent at Muhimbili National Hospital and 24 per cent at Mirembe National Mental Hospital.

Table 3.32: Analysis of Mental Healthcare Services Rehabilitation Experts at Zonal Level

Cadre	Benjamin		Bugando		Mbeya	
	Needed	Available	Needed	Available	Needed	Available
Clinical Psychologist	4	0	4	0	4	2
Occupational therapist	2	0	2	0	2	0
Assistance Speech and language therapist	2	0	2	0	2	0

Source: Staffing Level in the visited Zonal Hospital (2023)

Also, the Audit noted that Zonal Hospitals do not have the experts needed for rehabilitation centres since they do not have the rehabilitation centres as required.

(b) Unavailability of Rehabilitation Equipment

The National Rehabilitation Strategic Plan of 2021-2026 states that rehabilitation infrastructure and equipment are inadequate, especially within public facilities. The shortage is demotivating to the rehabilitation workforces, who consider the lack of investment in their workspaces and tools devaluing their contribution.

Moreover, according to the National Rehabilitation Strategic Plan of 2021-2026, the provision of assistive products such as wheelchairs, walking aids, hearing aids and other devices for activities of daily living was inadequate, with many people facing financial barriers to accessing the products they needed. There were significant inconsistencies between facilities in how medical insurance and government subsidies for products are applied and inefficiencies in procurement and distribution charges, resulting in higher costs for services and end-users. There were no national quality specifications for assistive products which could have been used.

(c) Insufficient Budget to Support Provision of Comprehensive Rehabilitation Services

The National Rehabilitation Strategic Plan of 2021-2026 states that rehabilitation must be integrated into the care packages within health financing mechanisms. It should be included in multiple packages that address various health conditions as a highly integrated health service.

A review of the National Rehabilitation Strategic Plan of 2021-2026 revealed that rehabilitation does not have an allocated budget line within the MoCDGWSG administrative structure, and further integration into health financing mechanisms is required. Rehabilitation requires adequate resourcing to implement and sustain the actions of the National Rehabilitation Strategic Plan.

Moreover, the Medium-Term Expenditure Framework for the Ministry of Health (2018/19 – 2022/23) showed that no budget was set aside for the rehabilitation. During the site visit at the rehabilitation centres, the Audit noted that no budget was set aside for them. Still, the rehabilitation centres had domestic activities that contributed to income, such as animal keeping

and poultry; however, this was enough to run the patients' daily lives and not conduct major maintenance of the centres.

3.6.3 Absence of Follow-up Programs

According to Basic Standards for Health Facilities Volume 1 Household and Community Level, individual follow-up ought to be tailored through home-based care, for example, in the case of handling individuals who have mental health conditions.

The Audit noted no follow-up programs for monitoring and supporting community integrations of those who had undergone and completed rehabilitation programs. A review of the follow-up registers at the visited Rehabilitation Centres, i.e. Vikuruti and Hombolo, showed no evidence of the patients being under follow-up. This was largely contributed by the absence of the mechanism set for proper follow-up of the patients with the limited resources available and the absence of a proper patient database.

The Audit noted that rehabilitation data was not integrated into the HMIS at any level. Crude Information, such as rehabilitation workforce numbers at health facilities, was generally available at local levels but was not centralized. In hospitals, rehabilitation professionals record their clinical notes in a patient's health record, but no data is collated or analyzed to inform decision-making. The lack of collected and collated rehabilitation information was underpinned by the absence of national indicators built on rehabilitation data.

3.7 Ineffective Implementation of Mental Healthcare Services Awareness Campaigns

According to Section 31(1) (a) of the Mental Health Act, 2008, the functions of the National Council for Mental Health shall be to review and monitor the status of mental health in Mainland Tanzania and related problems, mental health promotion, prevention programs for substance abuse and advice the Minister.

The Audit noted ineffective implementation of Mental Healthcare Services awareness in providing mental healthcare services, as revealed below.

3.7.1 Insufficient Awareness Campaign Mechanism and Strategies

According to Section 31(1)(c) of the Mental Health Act, 2008, the functions of the National Council for Mental Health shall be to encourage and facilitate community involvement and non-governmental organizations in the promotion of mental health and prevention of substance abuse and mental disorders.

The Audit noted insufficient awareness campaign mechanisms and strategies on mental health. MoH used World Mental Health Day, done on 10th October every year, and World Suicide Prevention Day, observed on September 10th every year, to increase awareness. The awareness campaigns were conducted at this time due to the absence of a national council for mental health that would have organized, influenced and promoted the identification and implementation of mechanisms and strategies to promote awareness for mental healthcare services.

Moreover, the Audit noted insufficient implementation of awareness programs on mental healthcare services, especially on the Mental Health Day Campaign. These campaigns were mainly done in the urban areas. This led to a gap or barrier in society, especially in rural communities where people do not get a chance to secure knowledge on mental health. A review of the statistics revealed that rural areas also have patients with mental health challenges, but no awareness programs were undertaken in the rural areas.

Furthermore, the Audit noted that due to low prioritization of mental health, low allocation of the budget and absence of the national council for mental health, the only opportunity they use is the national holidays such as sickle cell day, diabetes day etc., where they conduct some campaign to give people awareness; This lack of strategies led to the dissemination of inadequate awareness on the state of mental health at the community level and increase of stigma.

Table 3. 33: Sengerema DC allocated Awareness Campaigns on Mental Health

Financial Year	Activity Name
2018/19	Nil
2019/20	Nil
2020/21	Nil
2021/22	Nil
2022/2023	To conduct outreach to 5 schools to increase awareness of non-communicable diseases (Eye, mental, dental and other NCDs by June 2023)

Source: *Quarterly combined Technical and Financial Report from Sengerema DC (2018/19-2022/23)*

3.7.2 Absence of Plans for the Provision of Awareness Programs

According to Section 31(1)(c) of the Mental Health Act, 2008, the functions of the National Council for Mental Health shall be to (c) encourage and facilitate community involvement and non-governmental organizations in the promotion of mental health and prevention of substance abuse and mental disorders.

The audit noted no plans were in place at the MoH, MOCDGWSG, and PO-RALG to provide mental health awareness. At the community level, there was no provision for awareness programs. A review of the visited LGAs MTEFs also revealed that no activities to provide awareness on mental health were identified in the budget. This resulted from inadequate planning and the absence of priority given to the provision of awareness. As a result, no budget was set aside for implementing the awareness program.

3.7.3 Insufficient Implementation of Awareness Programmes

According to Section 31(1)(c) of the Mental Health Act, 2008, the functions of the National Council for Mental Health shall be to encourage and facilitate community involvement and non-governmental organizations in the promotion of mental health and prevention of substance abuse and mental disorders.

The Audit noted insufficient implementation of awareness programmes on mental healthcare services, especially on the Mental Health Day Campaign.

These campaigns were mainly done in urban areas. This creates a gap or barrier in society, especially in rural communities that do not get a chance to secure knowledge on mental health.

Moreover, the audit acknowledge that MoCDGWSG conducted 150 radio broadcasts through MAMAKUZI and KIJADILI radio broadcast and social media platforms such as Instagram, Twitter and Facebook to air awareness on PSS. Still, there was a lack of a structured method for the sustainability of the awareness campaigns.

3.8 Inadequate coordination on the provision of Mental Healthcare Services among Government entities

The ministries, including MoH, PORALG and MoCDGWSG, must collaborate to ensure that they achieve the goal of providing quality mental healthcare services. However, there was inadequate collaboration between actors and the following anomalies were noted.

3.8.1 Absence of Defined Roles and Responsibilities between Stakeholders

The Audit noted that no defined roles and responsibilities between stakeholders allowed proper coordination among the stakeholders. This was due to the absence of a National Council for Mental Health that would have defined the roles and responsibilities. According to Section 31, (1), (b) of the Mental Health Act, 2008, the functions of the National Council for Mental Health shall be to form working links between various sectors and disciplines for coordination and promotion of mental health.

The audit team noted that no National Mental Health Council was formulated to supervise, manage and coordinate the availability and provision of mental healthcare services. This has been attributed to the lack of initiatives by the ministries since the formulation of the Mental Health Act in 2008, which established a council to manage the mental health situation in the country.

However, there were ongoing forums, one of them concerning mental health issues. The review of the mental health forum and dialogue in Tanzania was held in 2022, and among the noted challenges was that there was an

inadequate number of mental health professionals, and there was no official body to coordinate their availability and provision of clinical services.

Furthermore, it was noted that there was a failure to implement forum resolutions and recommendations to improve service provision. This has led to deteriorating quality provision and service delivery concerning Mental Healthcare Services.

3.8.2 Absence of Coordination System within Stakeholders

Objective 2 of the Ministry of Health NCD strategic plan 2016-2020 states that the Inter-Ministerial committee and multisectoral coordinating committee at national, regional and district levels will be established and meet bi-annually to discuss the progress of implementation, availability of supply and commodities for NCDs, human resource including adequate resources mobilization for NCDs.

The interviews with MoH, PORALG and MOCDGWSG officials noted that no coordination system among the stakeholders would have provided a forum for communication and discussion between the stakeholders on the provision of mental healthcare services. The audit team noted that there was a draft Technical Working Group Terms of Reference between the Ministries with the objective of providing better services that meet the mental health and psychosocial needs of individuals, families and communities, especially those of children and vulnerable populations. Better services were to be achieved by making the most of the available resources and ensuring efficiency and appropriation of interventions for these needs. Moreover, they also conducted two Joint meetings, but until December 2023, the Terms of reference were in draft form and not approved.

Further, there was no multisectoral committee at the National, Regional and District levels to discuss the provision of mental healthcare services.

This was due to inadequate preparation of plans and enforcement by the ministries to ensure that all levels of regional and district administration had forums for discussion on the provision of good quality mental healthcare services. The discussions would have created an opportunity for sharing knowledge and capacity building with and among service providers. This

affected the provision of mental healthcare services by making it an isolated service sector at different levels and areas of the country.

CHAPTER FOUR

AUDIT CONCLUSION

4.1 Introduction

This chapter draws the Audit conclusion based on the findings presented in the previous chapters. The conclusion is made with respect to the audit's overall objective and specific objectives, as presented in Chapter One of this report.

4.2 General Conclusion

Despite significant efforts to ensure the availability of mental healthcare services, the Ministry of Health, the Ministry of Community Development Gender, Women and Special Groups, and the President's Office – Regional Administration and Local Government have not ensured adequate availability of mental healthcare services in the country. In general, the Audit noted inadequate identification of individuals in need of mental healthcare services, inadequate provision of psychosocial care at the community level and non-availability of resources (infrastructure, experts, medical equipment, and medicines) for the provision of mental healthcare services., In addition, sufficient, comprehensive rehabilitation services that focus on skills development, community integration, and recovery-oriented supports are not adequately provided, and awareness programs are not in place.

4.3 Specific Audit Conclusion

4.3.1 The Process for Identifying Individuals in Need of Mental Health Care is not Functioning Properly

The Audit concluded that both the Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG) and PO-RALG had not implemented the identification of mentally ill individuals at the community level due to non-adherence to the national guidelines for the provision of Psychosocial Support Services (PSS). The guidelines stipulate that social and community health workers must identify people needing PSS at the village level and provide referrals whenever necessary.

Budget allocation for the identification of mentally ill individuals by PO-RALG appeared insufficient to meet the current demand for PSS services in the community. While funds were allocated for some groups, like people with disabilities, other vulnerable groups, such as the elderly in need of psychosocial support, mental health was overlooked. This raised concerns about equitable resource allocation.

There was a significant shortage of Social Welfare Officers at the lower levels to effectively provide identification services. The shortage of Social Welfare Officers limited the reach and coverage of identification services. Furthermore, a notable non-functional referral system for mental healthcare services at the point level was attributed to insufficient collaboration and coordination among service providers. The absence of documented referrals and the reliance on self-referral or home-based care indicates a breakdown in the formal referral process.

4.3.2 Unavailability of Psychosocial Care and Support Services at the Community Level

The Audit concluded that Psychosocial Care and Support Services (PSS) were not yet effectively mainstreamed into plans and programs at all PO-RALG (LGAs) and MoCDGWSG levels. This meant that psychosocial support was not systematically integrated into all aspects of the organization's work, from policy development to program implementation to monitoring and evaluation.

Also, the PO-RALG did not ensure sufficient funding to provide PSS in the community. The funds were sometimes reallocated for other activities apart from PSS, especially in primary healthcare settings. The inadequate funding compromises the quality of care and support provided to individuals needing psychosocial services. It limits the range of services available and the quality of interventions.

PO-RALG and the MoCDGWSG did not enforce the referral protocol at the point level as the main point linking the mentally ill individuals from the community service providers and referral facilities, i.e., secondary facilities (RRH, Zonal hospitals). Furthermore, the MoCDGWSG and PO-RALG did not adequately monitor and evaluate the key indicators of the provision of PSS Services. These key indicators, as provided by the guideline, were the number of PSS providers trained on the standard procedures for the provision of quality PSS services, the Percentage of individuals that were

served by the trained PSS services provider, and the percentage of clients with improved wellbeing after being served with the trained PSS service.

4.3.3 Resources (Infrastructure, Experts, Medical Equipment, and Medicines) for the Provision of Mental Healthcare Services are Insufficient

The Ministry did not ensure sufficient resources (experts, infrastructure, medical equipment, and medicines) to facilitate the provision of mental healthcare services. Experts were unavailable at National, Zonal, regional, district and community levels. This has been contributed by the absence of a recruitment plan that covers the need for employment to capacitate the service, leading to limited care for mental healthcare services.

However, there was insufficient infrastructure for mental healthcare services treatment, including wards for males, females, and adolescents at national, zonal, and regional levels. This is due to insufficient funds and a lack of plans for constructing wards for mental health, particularly in regional referral hospitals, leading to difficulty in attending inpatients for mental healthcare services treatment.

Similarly, the audit revealed insufficient medical equipment and medicines for effective mental healthcare services. The absence of a mental healthcare services section has left Dodoma zonal hospitals without wards for the admission of patients with mental health issues. Wards are also lacking in regional referral hospitals, including those in Mbeya, Dodoma, Mwanza, and Dar es Salaam. This was contributed by a lack of plans and budget for infrastructure specifically for mental health, leading to limited care for inpatients. This situation results in delayed diagnosis and treatment, exacerbating health outcomes and economic burdens, and intensifies social issues like homelessness and substance abuse.

4.3.4 Inadequate Provision of Comprehensive Rehabilitation Services that Focus on Skills Development, Community Integration, and Recovery-Oriented Support

The Audit concludes that the Ministry of Health did not ensure the availability of comprehensive rehabilitation services. This resulted in the absence of adequate rehabilitation centres and infrastructures, the absence of national clinic guidelines for mental health rehabilitation services that

can guide the provision of the rehabilitation services and the absence of standard operating procedures to be used in day-to-day activities.

Furthermore, out of the 26 regions, only 5 have rehabilitation centres. These five rehabilitation centres are located in Kilimanjaro (Longuo), Mwanza (Bukumbi), Dar es Salaam (Vikuruti), Dodoma (Hombolo) and Kigomba(Marimba). Only three out of five government-run rehabilitation centres, Vikuruti, Hombolo and Longuo, were operational. All these mental health rehabilitation centres were at the national level. They are situated in urban areas, creating a gap or barrier for patients, especially those from rural communities who must travel long distances to access them.

Moreover, there were no rehabilitation centres at the zonal level hospitals. This caused congestion of patients and increased their expenses due to the need to seek services at the national level. There was no standard guide for the design of necessary infrastructure regarding rehabilitation centres that would assist in developing the infrastructures. There were inadequate mental health rehabilitation services experts, including psychiatry nurses, occupational therapists, and speech therapists.

4.3.5 Awareness Programs on Mental Healthcare Services-related Issues at the Community Level were not Adequately Implemented

The MoH, MOCDGWSG, and PO-RALG did not ensure that awareness campaigns were implemented and in place. This is because of the insufficient awareness campaign mechanism and strategies and the absence of plans to provide awareness programs due to low prioritization of mental health. The awareness campaign was inadequately implemented due to the inadequate allocation of the mental health budget and the absence of a National Council for Mental Health. This oversight could impair stigma and misunderstanding around mental health, leading to underdiagnosis and undertreatment of mental health issues. It strains healthcare systems by increasing the complexity and cost of late-stage treatments and impacts economic productivity due to reduced workforce efficiency. Additionally, it poses significant social challenges, including an increase in homelessness, substance abuse, and criminal justice involvement.

4.3.6 MoH did not ensure that the Existing Coordination System with the Main Stakeholders was Functioning Appropriately

The ministries did not adequately coordinate the provision of mental healthcare services among Government entities. There was an absence of defined roles and responsibilities among stakeholders to allow proper coordination. Also, a lack of a National Mental Health Council led to the failure to supervise, manage and coordinate the availability and provision of Mental Healthcare Services in the country. Due to the Ministry of Health's failure to properly engage with key stakeholders, the inadequate coordination in Tanzania's mental healthcare system led to fragmented service delivery, inefficient resource use, variable care quality, and hindered policy implementation.

CHAPTER FIVE

AUDIT RECOMMENDATIONS

5.1 Introduction

This chapter provides recommendations based on the audit findings in chapter three of this report. The recommendations are to be addressed by the three Ministries audited, i.e., the Ministry of Health, the Ministry of Community Development, Gender, Women and Special Groups and the President's Office - Regional Administration and Local Government.

The National Audit Office believes that if fully implemented, these recommendations will improve the performance of the Ministry of Health, the Ministry of Community Development, Gender, Women and Special Groups and the President's Office - Regional Administration and Local Government in the provision of mental healthcare services.

5.2 Recommendations

Recommendations to the Ministry of Health

The Ministry of Health is urged to:

(i) Develop national clinical guidelines and standard operating procedures for the provision of mental health rehabilitation services and design of rehabilitation infrastructures for the provision of the mental healthcare services;

(ii) Ensure availability of competent personnel for children and adults and needed equipment for adequate availability of mental healthcare services; and

(iii) Formulate the mental health board as required by the Mental Health Act to ensure that it nourishes the mental health aspect in the country through coordination amongst the ministries.

Recommendations to the PO-RALG

The President's Office - Regional Administration and Local Government is urged to:

(i) Ensure provision of adequate implementation of PSS Guideline that includes provision of the identification at the point levels and adequate follow up on the patients; and

(ii) Develop training plans for mental health service providers at all levels of healthcare facilities to create capacity and awareness in providing mental healthcare services.

Recommendations to the MOCDGWSG

The Ministry of Community Development, Gender, Women and Special Group is urged to:

(i) Ensure that Social Welfare Officers at the village level, community case workers, and other relevant personnel are adequately trained and equipped to identify and register PSS clients. Also, provide clear guidelines for social welfare officers to follow when identifying and registering clients; and

(ii) Establish a database for the provision of PSS Services.

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7) The United Republic of Tanzania. Ministry of Health (2020)*; National Guidelines for the Provision of Psychosocial Care and Support Services*: Tanzania

8) The United Republic of Tanzania, Ministry of Health, Community Development, Gender, Elderly and Children (2020); *Standard Operating Procedures for the Provision of Psychosocial Care and Support Services*

9) World Health Organization (WHO) (2020); *Mental Health ATLAS Member State Profile:* Switzerland

10) World Health Organization (WHO) (2022); *Suicide in the WHO African Region:* Switzerland

11) World Health Organization (WHO) (2021); *Comprehensive Mental Health Action Plan 2013-2030*

12) World Health Organization (WHO) (2022); *World Mental Health Report*

13) World Health Organization (WHO) (2009); *Improving Health Systems and Services for Mental Health*

APPENDICES

Appendix 1: Responses from the Audited Entities

This appendix depicts the Responses from the Audited Entities.

Appendix 1(a): Responses from the Ministry of Health

General Comment

The Ministry of Health would like to thank the National Audit Office for preparing a performance audit report on the availability of mental healthcare services in the country. The report's findings and recommendations will help to improve mental health services care.

Specific Comments

S/N	Recommendation to the MoH	Comments from MoH	Planned actions	Implementation Timelines
1	Develop national clinical guidelines and standard operating procedures for providing mental health rehabilitation services and design rehabilitation infrastructures for the provision of Mental Healthcare Services.	Management agrees with the auditor's recommendation that the MoH has no clinical guidelines for rehabilitation and SOPs. However, the government has established the Mental Health Rehabilitation Section under the Directorate of Curative Services so that the section will closely oversee rehabilitation services, including those related to recovering mental-ill patients. Furthermore, the development of mental health rehabilitation and other services will be established after the	a) Finalize and endorse the National MH strategy. b) Review the existing mental health guidelines to include mental health rehabilitation services. c) Prepare Standard Operating Procedures for the provision of MH and rehabilitation services. d) Prepare job aids and on-the-job refresher	2024/25

S/N	Recommendation to the MoH	Comments from MoH	Planned actions	Implementation Timelines
		completion of the mental health strategy. Management also agrees with the auditor's recommendation that there is no design of rehabilitation infrastructures for the provision of mental health care services. MOH is currently reviewing infrastructure designs for rehabilitation services, including mental health rehabilitation services.	training materials for MH and rehabilitation services. **e)** Review the existing infrastructure design to include and improve Mental Health Rehabilitation at all levels.	
2	Ensure that competent personnel for children and adults are available and that equipment is needed for adequate mental healthcare services.	Management agrees with the auditor's recommendation. However, according to the health sector staffing level from 2014 to 2019, the Ministry of Health and PORLAG have done the following; Recruitment of Human Resources for mental health. For example, in 2020, there were five (5) neurologists recruited out of 33 required; In 2023, the number of neurologists will have increased to 18. Similarly, the number of	Management will continue to identify other institutions that can train mental health specialists and charge them with mental health training functions. MoH is in the process of formalizing four (4) short training courses for in-service mental practitioners.	2025

S/N	Recommendation to the MoH	Comments from MoH	Planned actions	Implementation Timelines
		graduates in psychiatry has increased from 6 to 36. In addition, over the past ten (10) years, two new courses were introduced to address the human resource gap, which includes clinical psychologists and mental health and rehabilitation officers (clinical psychiatrists). The data shows that within five years, 18 clinical psychologists and 245 mental health rehabilitation experts were produced. This increment was due to the presence of MUHAS and UDOM training programs in psychiatry of various cadres. UDOM established a training program for mental health nurses in 2010 and for psychiatrists in 2019. By 2023, we will have 25 mental health specialists (20 mental health nurses and 5 psychiatrists) in service. At MUHAS, for the past 5 years, we have 37 specialities in mental health.	These courses are; 1. Mental Health Care for Priority Mental Health Disorders for Healthcare Providers 2. Perinatal mental health 3. Psychological Management for Common Mental Health Conditions and 4. Mental health rehabilitation. Moreover, MoH, in collaboration with MUHAS, is establishing a new training program for mental health and rehabilitation services,	2024/2025

S/N	Recommendation to the MoH	Comments from MoH	Planned actions	Implementation Timelines
		Additionally, in non-specialized settings, Mental health services are provided by clinicians and nurses. MOH has provided on-the-job refresher training to 2890 Nurses and Clinicians at PHC between the years 2019 and 2023. With regard to equipment availability at national and zonal levels (ECT, EEG, MRI), Management agrees with the auditor's recommendation. However, it was noted that Mirembe had ECT but was not recorded during the audit, BMH is not designed to provide advanced mental health services, and Bugando, Mbeya and Muhimbili have no ECT machine.	including a Bsc in clinical psychology, occupational therapy, speech therapy, and four short courses in mental health. Furthermore, MOH has introduced a higher diploma course in clinical psychiatry. The additional effort which has been implemented by the MOH is the review of the Human Resource Staffing Level Guide at all levels of 2023 (draft), which is in the process of endorsement. Mental health staff. During the fiscal years 2024/25, MoH will procure one ECT for Muhimbili National	

S/N	Recommendation to the MoH	Comments from MoH	Planned actions	Implementation Timelines
			Hospital, BMH, Mbeya Zonal Hospital and Bugando Hospital.	
3	Formulate the mental health board as required by the Mental Health Act to ensure that it nourishes the mental health aspect in the country through coordination among the Ministries.	Management agrees with the auditor's recommendations; however, within the MoH, there are ongoing activities to formulate two bodies for the coordination of mental health and Epilepsy. These are the Mental Health Council and NENCC. Upon approval, they will start to nourish the mental health and also coordinate neurological conditions.	The National Mental Health Council has been formulated and is waiting to launch. MoH will collaborate with PO-RALG to establish Regional Mental Health Boards.	2024/25

Appendix 1(b): Responses from the President's Office - Regional Administration and Local Government

General Comment

The President's Office - Regional Administration and Local Government would like to thank the team from the National Audit Office for the preparation of a performance audit report on the availability of mental healthcare services in the country. The findings and recommendations of the report will help in the improvement of mental health services at all levels of care.

Specific Comments

S/N	Recommendation to the PO - RALG	Comments from PO - RALG	Planned actions	Implementation Timelines
1	Ensure adequate implementation of PSS Guideline that includes the provision of the identification at the point levels and adequate follow-up on the patients.	According to the National Guideline of PSS, the identification of clients who are in need of MHPSS was conducted during the case management/helping process that is usually done by Doctors, Social Welfare Officers, and other frontline workers. When the service is not available, he/she makes a referral to another point of service.	To conduct follow-up to 184 LGAs if they adhere to MHPSS guidelines during the provision of MHPSS services to all individuals, families, and communities who are needy According to the revised National Operational Guideline for Community-based Health Services,2021, the issue of identification of clients who are indeed of MHPSS has been accommodated. CHW will be reasonable for the identification of individuals, families,	2024/25

S/N	Recommendation to the PO - RALG	Comments from PO - RALG	Planned actions	Implementation Timelines
			and communities at the Kitongoji level who have mental health problems and will make referrals to the specific point of service. This program is expected to be launched on 25 January 2024 by President	
2	Develop training plans for mental health service providers in all healthcare facilities levels to create capacity and awareness in the provision of Mental Healthcare Services.	PO-RALG will ensure that short-term mental health and psychosocial support training in LGAs is conducted, but long-term training is the mandate of MOH MoCDGWSG. Also, MOH and MoCDGWSG should review the Mental Health Act of 2008 to accommodate the current issues of MHPSS to ensure the effectiveness of MHPSS implementation at all levels.	ALL LGAs to allocate budget for capacity building on mental health and psychosocial support (MHPSS) to all Health care workers and Social Welfare officers	2024/25

Appendix 1(c): Responses from the Ministry of Community Development Gender Women and Special Groups

General Comment

The performance audit exercise gave us a chance to evaluate ourselves and know where we need to improve. We will go through the recommendations submitted in the report to improve the implementation.

Specific Comments

S/N	Recommendation to the MoCDGWSG	Comments from MoCDGWSG	Planned actions	Implementation Timelines
1	Ensure that social welfare officers at the village level, community case workers, and other relevant personnel are adequately trained and equipped to identify and register PSS clients. Also, provide clear guidelines for social welfare officers to follow when identifying and registering clients.	Nil	Seek for the employment permit from the President Office Management of Public Services; Enrolment, capacity building and placement of community case workers at village level; Training for social welfare officers, community case workers and other relevant personnel at the village level are on place; Finalization of mental health and psychosocial support tools; Finalization of mental health strategic plan in collaboration with the Ministry of Health.	June, 2025
2	Establish a database for the provision of PSS Services.	Nil	To Develop a comprehensive Social Welfare Services information management system	June, 2025

Appendix 2: Selected LGAs for Site Visit

This part provides details of the selection of the selected LGAs to Visit.

SN	Regions	LGAs	Health Facilities	Rank	Rural /Urban	LGAs Selected
1	Dar es Salaam	Ubungo MC	259	Low	Urban	Dar es salaam CC
		Dar es salaam CC	461	High	Urban	
		Temeke MC	223	Low	Urban	
		Kigamboni MC	69	Low	Urban	
		Kinondoni MC	352	High	Urban	
2	Mwanza	Nyamagana (Mwanza CC)	157	High	Urban	Nyamagana (Mwanza CC)
		Ilemela MC	148	High	Urban	
		Misungwi DC	64	Low	Rural	
		Magu DC	68	Low	Rural	
		Sengerema DC	61	Low	Rural	Sengerema DC
		Kwimba DC	64	Low	Rural	
		Buchosa DC	42	Low	Rural	
		Ukerewe DC	44	Low	Rural	
3	Dodoma	Bahi DC	52	Low	Rural	Kondoa DC
		Chamwino DC	84	High	Rural	
		Dodoma CC	204	High	Urban	
		Kondoa TC	18	Low	Urban	
		Kongwa DC	74	Low	Rural	
		Mpwapwa DC	74	Low	Rural	
		Kondoa DC	48	Low	Rural	
		Chemba DC	51	Low	Rural	
4	Mbeya	Mbeya CC	96	High	Urban	Mbeya CC
		Rungwe DC	64	Low	Rural	
		Kyela DC	62	Low	Rural	
		Busokelo DC	30	Low	Rural	
		Mbeya DC	127	High	Rural	
		Chunya DC	50	Low	Rural	
		Mbarali DC	78	High	Rural	

SN	Regions	LGAs	Health Facilities	Rank	Rural /Urban	LGAs Selected
5	Tabora	Tabora MC	78	High	Urban	Urambo DC
		Nzega TC	28	Low	Urban	
		Kaliua DC	56	Low	Rural	
		Nzega DC	58	High	Rural	
		Igunga DC	90	High	Rural	
		Urambo DC	36	Low	Rural	
		Sikonge DC	40	Low	Rural	
		Uyui DC	63	High	Rural	

Source: *Auditors' Analysis from the Health Facility Registry (HFR) Portal[9], 2023*

[9] https://hfrs.moh.go.tz/web/index.php?r=portal%2Findex, Accessed on 6th June, 2023

Appendix 3: Detailed Main Audit Questions with Sub-questions

This part provides details of the audit and sub-audit questions used in this audit to answer each specific audit objective.

Audit Question 1	**To what extent are adequate Mental Healthcare Services available and accessible to all at each level of healthcare facility?**
Sub-question 1.1	To what extent are Mental Healthcare Services effectively integrated into low-level (primary) healthcare?
Sub-question 1.2	To what extent are Mental Healthcare Services effectively integrated into high-level care settings?
Audit Question 2	**Is the Identification of mental health patients effectively done?**
Sub-question 2.1	Is there effective identification of the mental health-challenged persons at the community level?
Sub-question 2.2	Is there an effective system for providing referrals to the appropriate service point?
Audit Question 3	***Are psychosocial care and support services available and timely provided at the community level?***
Sub-question 3.1	Are p*sychosocial care and Support Services available in a timely manner to those in need at the point level?*
Sub-question 3.2	Are the psychosocial care and support services mainstreamed into plans, budgets, policies, programs, interventions and strategies at all levels?
Sub-question 3.3	Is the documentation and follow-up of the referral cases done to ensure it is properly attended to and feedback provided to service providers?
Sub-question 3.4	Does the provided psychosocial care and support services meet the required standards stipulated by the guidelines?
Audit Question 4	***Are resources (experts, infrastructure, medical equipment, and medicines) sufficient to facilitate mental healthcare services?***
Sub-question 4.1	Do the MoH and PO-RALG ensure the availability and adequate distribution of experts at all levels of the provision of Mental Healthcare Services?
Sub-question 4.2	Are there adequate infrastructures in each hospital to attend to adult and child inpatients and outpatients during the treatment based on their Mental Healthcare Service's needs?
Sub-question 4.3	Are the medical equipment, assistive devices and medicines sufficiently available to facilitate effective provision of the Mental Healthcare Services?
Audit Question 5	***Are the rehabilitation services for skills development, community integration and recovery-oriented supports available and comprehensive enough to cover all rehabilitation categories?***

Sub-question 5.1	Are rehabilitation centres for individuals with mental health conditions available and designed with a recovery-oriented approach that emphasizes personal growth and resilience?
Sub-question 5.2	Does the MoH allocate sufficient resources (staffing, funding, and rehabilitation facilities) to support comprehensive rehabilitation services?
Sub-question 5.3	Do the MoH and PO-RALG have follow-up programs to monitor and support community integrations of those who have undergone and completed rehabilitation programs?
Audit Question 6	***Are implemented Mental Healthcare Services awareness campaigns effective? and***
Sub-question 6.1	Does the MoH have adequate mechanisms and strategies to promote awareness campaigns or programs for Mental Healthcare Services?
Sub-question 6.2	Are there plans for providing awareness programs on Mental Healthcare Services at the community level in place?
Sub-question 6.3	Are awareness programs on the issues related to Mental Healthcare Services implemented sufficiently at the community level?
Audit Question 7	***Is the coordination in providing Mental Healthcare Services among Government entities adequate?***
Sub-question 7.1	Are there defined roles and responsibilities between stakeholders in providing Mental Healthcare Services and allow proper coordination among stakeholders?
Sub-question 7.2	Does the MoH ensure that the existing coordination system with the main stakeholders is functioning appropriately?

Appendix 4: Different Documents Reviewed and Reasons for Review

This part provides the documents the Audit Team reviewed to obtain appropriate and sufficient information to develop the audit findings supported by sufficient evidence.

Entity	Title of Documents reviewed	Reasons for Reviewing
Ministry of Health	• MoH strategic plans (2017/18-2022/23) • Mental Health Prevention programs (2017/18-2022/23) • Annual Operational Plan (2017/18-2022/23) • Inspection plans (2017/18-2022/23) • Monitoring plans • Budgets set aside for the prevention and promotion of Mental Health in the country (2017/18-2022/23) • Supervision plans	To assess the: • Effectiveness of MoH in the preparation of strategies and plans. • Adequacy of the inspections and monitoring plans. • Budget and priorities for the availability of Mental Healthcare Services.
	• Standard Treatment Guidelines 2021	• To assess the adherence to the medical treatment guidelines.
	• Supervision Reports conducted by the Ministry (2017/18-2022/23) • Monitoring and Evaluation Reports • Inspections Reports • Annual Internal Audit Reports (2017/18-2022/23) • Performance Reports	To assess the: • Effectiveness of MoH in supervising Health facilities when implementing its activities on the availability of Mental Healthcare Services • Effectiveness of MoH in monitoring and evaluating activities performed by HCF

	• Annual Health sector Profile reports (2017/18-2022/23) • Situation Analysis Reports (2017/18-2022/23) • Conducted research (2017/18-2022/23) • Updated database of Mental Health information (2017/18-2022/23) • Quarterly Reports (2017/18-2022/23) • Number of Healthcare facilities registration (2017/18-2022/23)	• Effectiveness of MoH in the implementation of plans for the provision of Mental Healthcare Services • The capacity of MoH in terms of human resources, guidelines, tools and funds for the availability of Mental Healthcare Services • Capacity of MOH in terms of human resources, guidelines, and funds for the provision of mental Healthcare Services
Ministry of Community Development, Gender, Women and Special Groups	• Psychosocial Care Guideline 2020 • Supervision Reports conducted by the Ministry (2017/18-2022/23) • Monitoring and Evaluation Reports • Inspections Reports • Annual Internal Audit Reports (2017/18-2022/23) • Performance Reports	• Assess the availability of psychosocial care services in the country.

PO-RALG	• PO-RALG strategic plans • PO-RALG DHIS 2 on registration of mental health (2017/18-2022/23) • Annual Operational Plan (2017/18-2022/23) • Inspection plans (2017/18-2022/23) • Monitoring plans • Budgets set aside for the prevention and promotion of Mental Health in the country (2017/18-2022/23) • Supervision plans • Supervision Reports (2017/18-2022/23) conducted by the • Performance Reports • Quarterly Reports (2017/18-2022/23) • Number of Healthcare facilities registration	To assess the: • Effectiveness of PORALG in the preparation of strategies and plans for the availability of psychosocial care and Mental Healthcare Services • Budget and priorities for the availability of psychosocial care and Mental Healthcare Services • Effectiveness of PORALG in the implementation of plans for the provision of mental health services
Super Specialized Mental Hospitals	• Strategic plans • DHIS 2 on registration of mental health • Annual Operational Plan (2017/18-2022/23) • MTEF-Budgets set aside for prevention and promotion of Mental Health in the country (2017/18-2022/23)	To assess • Effectiveness of MNMH on the preparation of strategies to promote Mental Healthcare Services in the country • Efforts in place for improvement of Mental Healthcare Services
	• Supervision Reports conducted by the Ministry of Health • Annual Internal Audit Reports (2017/18-2022/23)	• Availability of Mental Healthcare Services • Budgeting and Disbursement on the Mental Health

	• Updated database of Mental Health information • Quarterly Reports (2017/18-2022/23) • Expenditure reports • Equipment availability	• Infrastructure for the provision of Mental Healthcare Services • Adequacy of referral system in the provision of Mental Healthcare Services
Zonal Hospitals	• DHIS 2 on registration of mental health • Budgets prepared for mental health (2017/18-2022/23) • Annual disbursement from MoH (2017/18-2022/23) • Supervision Reports conducted by the Ministry of Health • Updated database of Mental Health information • Quarterly Reports (2017/18-2022/23) • Annual Reports (2017/18-2022/23)	To Assess • Availability of Mental Healthcare Services • Budgeting and Disbursement on the Mental Health • Infrastructure for the provision of Mental Healthcare Services • Adequacy of referral system in the provision of Mental Healthcare Services
Regional Referral Hospitals	• DHIS 2 on registration of mental health • Budgets prepared for mental health (2017/18-2022/23) • Annual disbursement from MoH (2017/18-2022/23) • Supervision Reports conducted by the Ministry of Health • Updated database of Mental Health information	To Assess: • Availability of Mental Healthcare Services • Budgeting and Disbursement on the Mental Health • Infrastructure for the provision of Mental Healthcare Services

	• Quarterly Reports (2017/18-2022/23) • Annual Reports (2017/18-2022/23)	
RSs	• DHIS 2 on registration of mental health • Budgets prepared for mental health (2017/18-2022/23) • Annual disbursement from MoH (2017/18-2022/23) • Supervision Reports conducted by the Ministry of Health • Updated database of Mental Health information • Quarterly Reports (2017/18-2022/23) • Annual Reports (2017/18-2022/23)	• To assess the availability of psychosocial care services in place at the RSs level • To assess the awareness of responsibilities and performance regarding the provision of Mental Healthcare Services
District Hospitals	• DHIS 2 on registration of mental health • Budgets prepared for mental health (2017/18-2022/23) • Annual disbursement from MoH (2017/18-2022/23) • Supervision Reports conducted by the Ministry of Health • Quarterly Reports (2017/18-2022/23) • Annual Reports (2017/18-2022/23)	To Assess • Availability of Mental Healthcare Services • Budgeting and Disbursement on the Mental Health • Infrastructure for the provision of Mental Healthcare Services • Adequacy of referral system in provision of Mental Healthcare Services

Source: *Auditor's Analysis on the list of Reviewed Documents, 2023*

Appendix 5: List of Officials interviewed

This part presents the list of the officials interviewed in the selected entities and health facilities visited.

Public Entity	Person Interviewed	Reason(s) for the interview
Ministry of Health (MoH)	• Director Curative Services • Assistant Director Non-Communicable NCD • Coordinator NCD • Director, DAHRM • Director Policy and Planning.	• Assess the extent to which the Ministry of Health ensures effective provision of the needed resources. • Assess to what extent the Ministry of Health ensure adequate monitoring and evaluation of the availability of Mental Healthcare Services. • Assess to what extent the Ministry of Health ensures mobilization and allocation of resources for the availability of Mental Healthcare Services.
Ministry of Community Development, Gender, Women and Special Groups	• Commissioner of Social Welfare • PSS Coordinator • Social Welfare Officers	• To assess the mainstreaming of PSS care and support • To assess the monitoring and evaluation done on the available PSS services
President's Office Regional Administration and Local Government. (PO-RALG)	• Directorate of Health, Social Welfare and Nutrition. • Director • Assistant Director Health • Assistant Director of Social Welfare and Nutrition	• To assess to what extent PO-RALG ensures adequate availability of psychosocial care and support at the community level. • To assess to what extent PO-RALG ensure adequate availability of Mental Healthcare Services to the community.

Public Entity	Person Interviewed	Reason(s) for the interview
Mirembe National Mental Hospital (MNMH)	• Executive Director • Manager, Directorate of Medical Services • Manager, Clinical Supportive Services Directorate. • Manager, Clinical Research Training Consultancy Unit • Manager, Community Rehabilitative Services Directorate • Manager, Nursing and Clinical Administration Services Directorate • Head, Procurement Management Unit • Head, Internal Audit Unit • Head, DAHRM • Head, Clinical Audit and Quality Assurance Unit	• Assess to what extent MNMH effectively ensure the availability of Mental Healthcare Services. • Assess to what extent MNMH ensure the availability of the needed resources for providing Mental Healthcare Services. • Assess to what extent MNH ensure the availability of rehabilitation services.

Public Entity	Person Interviewed	Reason(s) for the interview
Muhimbili National Hospital (MNH)	• Executive Director • Director, Directorate of Medical Services • Head, Psychiatry Unit • Head, Adult Mental Health Section • Head, Pediatric and Adolescent Section • Head, Addiction Unit • Head, Rehabilitation Medicine • Head, Social Welfare Section • Block Manager • Head Of Firms (Ilala, Ubungo Kinondoni, Temeke)	• Assess to what extent MNH effectively ensure the availability of Mental Healthcare Services. • Assess to what extent MNH ensure the availability of the needed resources for providing Mental Healthcare Services. • Assess to what extent MNH ensure the availability of rehabilitation services.
RSs	• Head of Planning and Policy • Regional Medical Officer • Regional Social Welfare • Mental Health Coordinator	• To assess the availability of psychosocial care and support in the region • To evaluate the availability of Mental Healthcare Services in the region • To determine the budget and disbursement of the provision of Mental Healthcare Services in the country • Assess to what extent RHMT ensure the availability of Mental Healthcare Services. • Assess to what extent RHMT ensures adequate monitoring

Public Entity	Person Interviewed	Reason(s) for the interview
		and evaluation of the Provision of Mental Healthcare Services.
Health Facilities (Referral Hospitals Zonal Hospitals District Hospitals Health Centers Dispensaries)	• Medical Officer in Charge • Head Psychiatry Unit • Head Social Welfare • Matron • Health Secretary • Head Pharmacy	• To obtain data on the status of mental health patients with their categories and the provided treatments.
LGAs	• District Medical Officer • District Social Welfare	• To assess the availability of psychosocial care and support in the community • To assess the availability of Mental Healthcare Services in the community • To assess the budget and disbursement on the provision of Mental Healthcare Services at the LGA • Assess to what extent CHMT ensure the availability of Mental Healthcare Services. • To assess the adequacy of monitoring and evaluation of the provision of Mental Healthcare Services by CHMT.

Source: *Auditor's Analysis on the List of Interviewed Officials, 2023*

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