

**ZANZIBAR LINKS PROJECT, FEBRUARY 2009.**  
**OBSERVATIONS ON THE MENTAL HEALTH SERVICE IN ZANZIBAR.**

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## **1. INTRODUCTION**

- 1.1 Two doctors from Musgrove Park Hospital in Taunton have established and maintained links with Health Services in Zanzibar for 17 years. They, as well as other staff, have been supporting the hospital services there in a variety of ways.
- 1.2 Edward Colgan, Chief Executive, Somerset Partnership NHS Foundation Trust, accompanied staff from Musgrove Park Hospital on a visit to Zanzibar in December 2007. The purpose of Mr Colgan's visit was to make contact with mental health services. Mr Colgan was made aware during the visit of a range of challenges facing people providing this service. He also made contact with representatives of DANIDA (Danish International Development Agency, an organisation based in the Ministry of Foreign Affairs in Denmark, set up to provide humanitarian help and assistance in developing countries). DANIDA are a substantial donor for the Health Service in Zanzibar, in particular in funding the provision of essential medicines.
- 1.3 Mr Colgan and the team at Musgrove Park Hospital jointly established the Zanzibar Links Project with a view to developing joint working between Taunton and Somerset NHS Foundation Trust, Somerset Partnership NHS Foundation Trust and the health services in Zanzibar.
- 1.4 Mr Colgan put together a project team comprised of Christopher Mortimore (Consultant in Adult Psychiatry and Deputy Medical Director), Helen Phillips (Head of Occupational Therapy Services and Service Manager) and Tim Young (Ward Manager, Rowan Ward). The project team undertook a visit to Zanzibar in February 2009. This Report summarises observations and recommendations from this visit.

## **2. TERMS OF REFERENCE**

- 2.1 The terms of reference for the visit in February 2009 were as follows:
  - To observe practice and assess the environment in Kidongo Chikundu Hospital (KCH) in Zanzibar City. This is the psychiatric hospital that serves the people of Zanzibar. Although there was some remit for also assessing community services the main focus of the visit was to be on the hospital service.
  - To assess arrangements for medicines management in the hospital and in mental health services in general.
  - To make contact with the Non Government Organisation (NGO) SWAZA (Saidia Watu Wenye Matatizo ya Afya yo Akili Zanzibar). SWAZA is comprised of interested members of the local community as well as mental health professionals. It is a voluntary group, which has a role in fund raising and advocacy for people with mental health problems. It was planned for the

project team to make links with SWAZA and explore opportunities for joint working.

### **3. BACKGROUND INFORMATION**

- 3.1 Zanzibar is comprised of two islands: Unguja and Pemba. Unguja is located 25 miles off the coast of Tanzania in East Africa. The two islands of Zanzibar are separated by 30 miles of ocean. Unguja is larger and more densely populated than Pemba.
- 3.2 A national census in 2002 estimated the total population of Zanzibar at 984,625 with an annual growth rate of 3.1%. Two thirds of the people live on Unguja (622,459) with most living in the more densely populated western part of the island where Zanzibar City is located. 205,870 people live in the city itself. The old quarter, known as Stone Town, is a world heritage site.
- 3.3 Poverty is widespread with half the population living beneath the poverty line. Most people in Zanzibar subsist on less than US \$0.5 per day (US \$1 = 1,100 Tanzanian Shillings). There are high rates of unemployment. Infant mortality is high at 83 in 1000 live births. It is estimated that 1 in 3 of the population is malnourished. Life expectancy at birth is 48 years.
- 3.4 About 2/3 of the population live in a rural environment where houses are typically built of mud and thatch. These dwellings often consist of two rooms with a latrine outside. Food is cooked on an open fire with solid fuel. There is typically no mains power in rural areas. Women and children are often forced to carry water long distances because of a lack of local drinking water. It is common for extended families to live in two rooms with perhaps ten children.
- 3.5 The indigenous language is Kiswahili. Medical records are however written in English. 95% of the population are Muslim with a small population of Christians and Hindus. There is a long tradition of religious tolerance in Zanzibar City.
- 3.6 Zanzibar maintains its own semi-autonomous government within the United Republic of Tanzania. The President of Zanzibar is the Vice-President of Tanzania. The Revolutionary Government of Zanzibar is comprised of the Revolutionary Council and the House of Representatives (50 seats directly elected by universal suffrage to serve 5 year terms). The government has full powers to run its internal affairs and therefore has its own Ministry of Health and Social Welfare.
- 3.7 After World War II Britain gradually allowed the people of Zanzibar to become involved in the island's government. However, serious inter-racial rioting between African, Arab and Asian factions marred the establishment of a local democracy. Britain granted self-government in June 1963 and Zanzibar became an independent sultanate. However the sultanate was short-lived. On 12 January 1964 the

Zanzibari government was overthrown in a violent revolution. More than 70,000 Arabs and Asians were killed in one night; these groups fled the country and their property was confiscated. In order to fill the vacuum caused by the departure of these skilled people the President of the Revolutionary Government (Sheikh Karume) attracted technical and military assistance from Cuba, China and Eastern Bloc countries including East Germany. A socialist one party state ensued, which was diplomatically isolated and internationally criticised for human rights violations. State control over exports and prices contributed to the collapse of the economy.

- 3.8 Zanzibar ceased to be a one-party state in 1992 and for the first time the Chama Cha Mapinduzi (CCM) Party was faced with opposition from the Civic United Front (CUF). Although the election in 1995 passed off peacefully, there were allegations of serious voting irregularities in the 1998 election. Amani Karume (son of the original President who had been assassinated in the 1960's) came to power in 2000 in an election characterised by rioting and violent protests, especially in Zanzibar City. Trouble simmered on and in January 2001 the authorities shot live ammunition into crowds of protesters killing 35 and injuring 600. Violence erupted again in 2005 after another contested election. Susequent negotiations aiming at the long-term resolution of the tensions as well as a power-sharing accord suffered repeated setbacks, and in April 2008, the CUF walked away from the negotiating table following a CCM call for a referendum to approve of what had been presented as a done deal on the power-sharing agreement. Meanwhile the CCM and President Karume have remained in power. Further elections are likely in July 2009.

#### **4. OVERVIEW OF MENTAL HEALTH SERVICES**

- 4.1 The Revolutionary Council introduced the Mental Health Act in 2001. This sets out a legislative framework for mental health services in Zanzibar and contains a number of aspirations about the development of services. Few of these have been achieved. The central aim of the Act is to guarantee that “any person who suffers with mental disorders should be provided with health care under conditions that maintain and guarantee human dignity”. This basic right of mental health patients did not seem to be in place at the time of our visit. The Act includes guidance on budgetary allocations and proposes that a Mental Health Board be established. However, at the time of our visit in February 2009, the Board had never met because of the lack of funds. There is a Mental Health Programme with a number of targets and interventions. This receives limited external support and the programme is severely underfunded.
- 4.2 Mental Health Services fall within the Directorship of Curative Services within the Ministry of Health and Social Welfare. The National Mental Health Co-ordinator, Mr Suleiman, reports to the

Director of Curative Services within the Ministry. The Mental Health Plan has a budget for TS 28 million (Tanzanian Shillings). At the time of our visit we were informed that only c. TS 1.5 million had been provided.

- 4.3 Kidongo Chekundu Hospital (KCH) is located on the outskirts of Zanzibar City and provides mental health services at tertiary care level for the people of Zanzibar. There are 120 beds located in 3 wards, 2 of which are male and 1 of which is female.
- 4.4 At the time of our visit there were 32 patients on Male Ward 1, 9 patients on Male Ward 2, and 16 patients on the Female Ward. Outpatient services at the hospital are provided 3 times a week.
- 4.5 Despite a plan to locate mental health services in the community close to people's homes, in reality the bulk of mental health provision is provided at this hospital and certainly most registered mental health contacts for community patients take place here. Community services, in contrast, are very poorly established. There is no psychiatric hospital in Pemba. There are 8 beds allocated within Chake Chake Hospital for psychiatric patients but the ward is in a bad state of repair and is never or rarely used.
- 4.6 General medical services are provided at Mnazi-Mnoka Hospital, also located in Zanzibar City. This falls under the same directorship as mental health services.
- 4.7 There are 2 Cottage Hospitals on Unguja: Kivunge, located in the north, and Makunduchi, located in the south. The former is well placed in a relative centre of population but the latter is remote and poorly located. A small number of psychiatric patients attend these hospitals on an outpatient basis. However this has declined in recent years and at the time of our visit in February 2009, only 3 new patients had registered in this calendar year. In contrast, at KCH c. 240 – 300 patients attend each outpatient clinic 3 times a week. There is apparently a single room which can be used at Kivunge for short-term psychiatric admissions but it is unclear when this was last used.
- 4.8 Primary Care services on Unjunge are located in 83 locality based Primary Health Care Units (PHCUs), located in 6 districts under the auspices of the District Health Management Teams (DHMTs). We were not fully able to clarify the role of the DHMTs in relation to funding, organising or directly providing services at the PHCUs. There is a limited Community Mental Health Service comprised of monthly clinics delivered by a single mobile Community Psychiatric Nurse (Mr Mohammed Joel). This is described in more detail later in the report. This service is currently established at 8 of the PHCUs. However there are problems with regular availability of medication and also of petrol leading to the service breaking down. Patients therefore fail to attend clinics at the PHCUs because of unreliability. This contributes to the large number of outpatients who regularly attend KCH. Patients therefore have to travel by bus (Dalai Dalai) to KCH and this places a significant financial burden on most of the families (with the transport

costs of TS 2000 being approximately equivalent to 1 week's wages for a large proportion of the population). This leads to restricted access for the most deprived portion of the population.

- 4.9 In Zanzibar, in keeping with the rest of Africa, mental health services include learning disability, mental illness and also epilepsy. Epilepsy is common in Zanzibar because of the high rate of obstetric complications and also the prevalence of cerebral malaria. A large proportion of the workload of mental health professionals is therefore involved in the assessment and management of epilepsy. The coordination of services for substance misuse is administered separately through the Department for Substance Abuse and Rehabilitation (DSA). This is despite the substantial overlap at clinical level: a relatively high proportion of male inpatients at KCH are admitted for problems associated with substance misuse, often at the request of the Court.
- 4.10 There are no specialist psychiatric services for children and no other sub-specialities. A relatively high proportion of outpatients are children. Children are admitted to the adult wards; there is space to accommodate the mother for girls on the female ward and the father for boys on the male ward 1.
- 4.11 DANIDA is the main donor for the purchase of medication for both general medical problems and mental health problems. DANIDA pays for essential medicines based on a nationally modified World Health Organisation (WHO) list. When available, medicines are provided free of charge to patients using the public health service. However there are severe problems of availability (see medicines management below), which means the patients often have to purchase their own medications. These are often only available in pharmacies in Zanzibar City. The cost of medicines and travel therefore puts them out of reach of a large proportion of the population, particularly on a consistent basis.
- 4.12 Mental Health services appear to have a low priority both politically and within the general population. There is a culturally instilled fear and superstition about mental illness and learning disability. There are belief systems based on notions of demonic possession which also extend to epilepsy, which is similarly stigmatised. Use of traditional healers is widespread and many people will consult local healers before seeking help from mental health services. There is recognition of the importance of statutory services working in partnership with local healers. Some training days for traditional healers have been undertaken.
- 4.13 People employed in mental health services are on low wages and struggle to manage on their salaries. Despite this, because of the poor level of provision of services and equipment, they do at times provide assistance directly out of their own pockets. Family members often provide financial incentives for nurses in the general medical service but these opportunities are seldom available to those working in

mental health because of the deprivation and poverty of most people who use their service.

## **5. A NARRATIVE DIARY OF THE VISIT**

- 5.1 In preparation, prior to the visit, we had access to a detailed report prepared by Euro Health Group at the request of DANIDA and the Zanzibar Ministry of Health and Social Welfare: 'The Status of Mental Health in Zanzibar' (Review, November 2008).
- 5.2 We also had access to a report from Vanessa Abrahamson, an occupational therapist who had previously spent a 3 month period at KCH working with the head of occupational therapy, Mr Mohammed Sharif.
- 5.3 Also in preparation there were some discussions with RETHINK, in particular relating to the potential for joint working with SWAZA. Some members of the project team attended an evening meeting with others involved with the Zanzibar Links Project including Edward Colgan. Furthermore there were 2 meetings with Ruth Jennison, a community psychiatric nurse who had spent 2 years working alongside the community psychiatric nurse, Mr Mohammed Joel on Unguja. Ms Jennison also provided a number of written reports to assist in preparing for the visit. One member of the project team (HP) attended a talk at Wells Cathedral on 10<sup>th</sup> October 2008 as part of World Mental Health Day; this included a presentation by Ruth Jennison regarding Mental Health Services in Zanzibar. The Project Team were presented with a candle which was subsequently given as a gift to Kidongo Chekundu Hospital. Posters were prepared jointly between staff at KCH and Somerset Partnership based on events on World Mental Health Day. These were used to raise awareness prior to the visit.
- 5.4 Day 1 (4<sup>th</sup> February 2009) There was an initial meeting with the Mental Health Co-ordinator for Zanzibar, Mr Suleiman, and the other members of staff at KCH (Mohammed Sharif and Mohammed Joel). The Project Team undertook an orientation tour of the hospital which included all the inpatient wards, the outpatient facilities, the administrative offices, laboratory, kitchen and the medical records and statistics department. The Project Team met the nursing superintendent Mr Omar and his assistant Mr Sahid and had the opportunity to ask in detail about the management structures and procedures within the hospital. The Project Team then divided and worked separately for the rest of the day. CM observed inpatient medical processes including the admission and management of a patient to the female ward. There was opportunity to observe the administrative processes, handover procedures, and inspect the medical records. HP met Mr Sharif. She observed and participated in a cooking session. TY spent the day with Mr Omar, the nursing superintendent and was able to enquire in detail about the nursing

management structure, the staff establishment and issues relating to recruitment and management of staff.

5.5 Day 2 (5<sup>th</sup> February 2009) There was a further initial meeting with Mr Suleiman. The Team then divided. CM spent a 5 hour period in an outpatient clinic working alongside the psychiatrist Dr Idrina. CM and Dr Idrina jointly saw 16 of the c. 100 patients attending the clinic that day. CM had opportunity to observe the structure of the clinic, assessment processes, note-keeping arrangements and arrangements for the prescribing and dispensing of medications. HP observed and participated in an occupational therapy art group and subsequently sat on the female ward for a period of 2 hours observing the inpatient processes, including the interaction between staff and patients. TY spent the day on Male Ward 1 and the Female Ward and had the opportunity to talk to both Assistant Managers and staff nurses. He participated in a depot clinic and had opportunity to observe the procedures in the clinic. There was time to assess the ward physical environment as well as observe procedures and interaction between staff and patients.

5.6 Day 3 (6<sup>th</sup> February 2009) The day was dedicated to a tour of community services. The Team were accompanied for the day by Mr Suleiman, Mr Omar and Mr Joel. We were also accompanied by a GP from Bristol (Dr Eginton) who had been working for the previous 2 weeks at Makunduchi Hospital. When we visited Makunduchi Hospital we were also able to meet Anthony and Mary Rackham who had been also working at the hospital for a number of weeks as part of the Health Improvement Programme for Zanzibar (HIPS). This contact led to plans to re-establish a Mental Health Clinic at the hospital run by Mr Joel. We had opportunity during the day to visit both cottage hospitals (Makunduchi and Kuvunge) as well as 6 primary health care units. We learned of partnership working between the public health service and NGO Zanzibar Action for People with Developmental Disorders (ZAPDD). As a consequence of time spent travelling throughout the island of Unguja on that day we were able to witness first hand the living conditions of the rural population. At the end of the day the Project Team met with Mr Suleiman, Mr Omar and Mr Sharif and expressed our thanks for their help and assistance. The Team then attended a meeting of the SWAZA Board and had opportunity to explore the possibility of partnership working.

## **6 ASSESSMENT AND OBSERVATIONS RELATING TO KIDONGO CHEKUNDU HOSPITAL**

### **6.1 Environment**

6.1.1 The hospital is located on the northern edge of Zanzibar City. It is situated within spacious grounds with a surrounding perimeter wall. There is a mosque immediately outside the hospital gates; more

severely ill patients pray on the ward but as they improve some patients use the mosque. Within the perimeter there is a relatively large area of undeveloped grassland although there are plans for construction of a new outpatient / administrative block and a new kitchen (including a modern and also a traditional kitchen) on this land. Small parts of the grounds are given to staff for the cultivation of crops.

- 6.1.2 There are two male wards. Male Ward 1 is also called the “Out” ward and is used for less disturbed patients as they improve and progress to discharge. It is also used for the admission of male children. Male Ward 2 is also known as the “In” Ward and is used for acute male admissions. Although this is a locked ward the door at the entrance is detached from its hinges and, for the most part, patients are locked in a garden/courtyard area through the day. There is one female ward. Previously there were female “In” and “Out” wards with a similar configuration to the male wards but one of the female wards is in such a bad state of repair that it is too dangerous to be used as accommodation for patients. It is instead used as the female nursing office.
- 6.1.3 The majority of male patients are located in the locked ward 2. At the time of our visit there were 9 patients on Male Ward 1, 32 on Male Ward 2, and 16 on the Female Ward.
- 6.1.4 Male Ward 2 is entered through a broken metal door. This leads to a bare unfurnished hallway from which the nursing office, dormitory and garden courtyard are accessed. The large garden courtyard area contains a concrete platform and shelter where patients sit or lie during the hours from 7.00 a.m. to 6.00 p.m. Patients are locked outside during this period. The grass area is approximately 150 feet by 150 feet square. There are outside latrines and showers. The toilets are of traditional African design. All toilets appeared clean although there was evidence of excrement in one toilet area. There was no soap, towels or toilet paper. There was no offensive smell in this area or elsewhere in this or any other inpatient ward. There is a single seclusion cell with iron grid window located off the central hallway. This was occupied at the time of our visit by a man who was said to be at risk of repeatedly absconding. He engaged in conversation with the Project Team in English and enquired about our visit in a coherent manner. All shower facilities appeared functional and one patient was using the showers when we visited. The dormitory is made up of a single long room with approximately 8 beds on each wall. The beds are rather old and of metal construction. The majority of beds had mattresses. These were of simple foam construction; they were dirty and in very poor condition with many large holes. There were no sheets or mattress covers. Some beds did not have mattresses. There were no mosquito nets over the beds, nor over the windows which were open with iron grilles; we were informed that nets would be impractical given the disturbed nature of some of the patients. The wards were in reasonable condition although with very poor décor. There was some graffiti. There was no evidence of

any personal possessions belonging to any of the patients. There were no lockable cabinets for personal use by patients. Overall there was no capacity for privacy. There was a large area of unused space at the far end of the male dormitory, used as a toilet and store-room. There were large holes in the ceilings. The ceilings are of poor construction and have been damaged, in part by patients attempting to escape. The roof has been repaired with galvanised iron sheets. The ward office is located centrally and has minimal furnishings although there is a table and sideboards. Medication is kept in pots on the table in the ward office and there is no apparent lockable cabinet. There are exposed electrical switch boxes adjacent to the ward office.

- 6.1.5 There are no chairs or other soft furnishings for patients to use. There are no pictures or other forms of aesthetic décor. There is no radio or television for patients to use.
- 6.1.6 On the day we visited, although some patients were peering in from the courtyard, most patients were sitting or lying on the platform either asleep or immobile. However, it is possible that there is more activity earlier in the morning. There appeared to be no staff outside with the patients. There is no structured therapeutic activity available on the ward and no patient on the ward had opportunity to participate in therapeutic groups or occupational therapy or any other structured routine on the days we visited. There is ward round once a week, currently undertaken by a psychiatrist (see below).
- 6.1.7 The general condition of Male Ward 1 was better. This is an open ward and during the day patients can use the hospital grounds. There are mosquito nets on most beds and blankets on all beds. The ward is divided into two separate bedroom areas; the main bedroom area contains c. 20 beds and side room contains c. 8 beds. There were large holes in the ceiling. There was evidence of vermin and a rat was observed in the nursing office during the visit. There is a television but it is not in working order because the antenna has needed repair for some considerable time.
- 6.1.8 Both male wards have a shelter for visitors. Visitors are not permitted to stay on the inpatient unit. The visiting area for female patients has been decorated with murals and is painted.
- 6.1.9 The female ward has a high perimeter wall with a lockable gate, partly for security against intruders. Overall it is in better condition than the male wards. The exterior walls have recently been painted, the roof is in better condition, the interior walls have also been decorated and the ceilings have been repaired with no evidence of holes. The ward is entered through a gate leading to the garden courtyard area. This is smaller than that in Male Ward 2 and is perhaps 80ft x 80ft square. There is a concrete platform with a shelter and this area is decorated with murals. There are two female latrines in the courtyard which appeared to be in a poorer state of repair than the male ward with one of the doors apparently detached. There is an outside tap for drinking water. The female staff tended to congregate under a smaller shelter located adjacent to the gate and close to the patient's shelter. The

only personal property was two chickens belonging to an older female patient. The dormitory area runs alongside one side of the courtroom. Once again this is a long room containing 14 beds. There are no mosquito nets on the beds or the windows. There are mattresses on the beds some of which have plastic covers and overall these are in a better condition than in Male Ward 2. There are however no sheets or blankets. There are two plastic bowls for washing up. On the adjacent perimeter of the courtyard is a further room containing perhaps 3 single seclusion cells. These are currently in use and the Team witnessed one patient being placed in seclusion following an incident of minor physical aggression. Some of these single cells are used as stores.

- 6.1.10 Once again during the visit the patients tended to congregate under the shelter and were mostly lethargic, either sleeping or unoccupied for long periods of time. There was however opportunity for interaction between staff and patients and there was evidence of pleasant conversation with warmth and laughter between the women.
- 6.1.11 There is a small laboratory in the hospital. This contains an electric microscope. There are reagents for testing for HIV, TB and Malaria. No other tests are possible at the hospital site and therefore inpatients have no access to any other form of investigation. There is no X-Ray, clinical chemistry or haematology. However urine and stool microscopy is available.
- 6.1.12 The pharmacy store was locked throughout the visit and the Project Team did not have opportunity to inspect arrangements for the storage of medication.
- 6.1.13 There is a medical records room with two staff. The files are in poor condition but there appears to be an effective filing system and it is possible to quickly and efficiently locate patient's medical records. It seems this room is locked outside of office hours and therefore there is no access to the medical records for nursing staff if patients present for admission at other times.
- 6.1.14 There is a statistics office with two statisticians who collect activity data including basic demographics and diagnostic information.
- 6.1.15 The occupational therapy department is comprised of two rooms, one for general activities such as craft, painting and drawing and another dedicated to carpentry. There is also an ADL kitchen which contains a sink, cupboard and an oil stove. The OT department is in a poor state of repair with numerous large holes in the ceilings. There are tools for carpentry but the project team did not witness any patients using this facility at any time during the visit. The OT Assistant was using this facility himself. The general activity area had pictures on the walls created by the patients. However these dated from October 2006 (during Vanessa Abrahamson's visit to the department). There were some wooden games. The equipment for use by patients was very limited and had to be used very sparingly. There is a cultivated garden adjacent to the OT department. There is a small library and a

computer and printer; these are in working order but are unreliable and slow. There is email but no internet access. The head of occupational therapy Mr Sharif has an office adjacent to the OT rooms. Mr Suleiman's office is also located here.

- 6.1.16 The hospital kitchen is comprised of a lean-to shelter with two open fires using solid fuel. Food is prepared in large pans directly over the open fire. There was a store for wood and dry food adjacent to the kitchen. There is a cook who is assisted in food preparation by a patient.

## 6.2 Management structure.

- 6.2.1 The Nurse Superintendent of KCH reports directly to the Director of Curative Services in the Ministry of Health and Social welfare. He has an Assistant Nurse Superintendent who is supported by three Assistant Ward Managers. The staffing levels recorded by the Project team include 31 registered nurses working in the hospital, 5 of whom are midwives. The assistant ward manager for the female ward is a midwife undergoing conversion to a psychiatric nurse. However, the DANIDA report records significantly less registered nurses. In addition, there appear to be 49 orderlies.

- 6.2.2 The National Mental Health Coordinator for Unguja and Pemba, Mr Suleiman also reports to the Director of Curative Services. It appears that the head of Occupational Therapy (Mr Sharif) reports to Mr Suleiman. Mr Sharif is supported by three OT assistants. It appears that the Community Psychiatric Nurse Mr Joel also reports to Mr Suleiman. Mr Suleiman is responsible for the coordination of mental health services in general in Zanzibar and does not have direct managerial responsibility for the hospital. He has not been provided with an office at the Ministry and therefore remains at KCH.

## 6.3 Financial management

- 6.3.1 The budget for the hospital and indeed all mental health services is held centrally by the Ministry of Health and Social Welfare. Staff at KCH appear to have no knowledge of the scale of this budget. No information is available to the hospital staff regarding expenditure against this budget. The project team did not have access to the accounts.

- 6.3.2 The nursing Superintendent and indeed no staff at the hospital have virtually no control over expenditure. Although money is provided directly for the purchase of food this fund varies without warning from month to month leading to fluctuations in the availability of food. Relatives bring food in for inpatients. There appears to be no budget for repair or maintenance although building work is planned as stated above. Equipment, stationery, fuel and other materials are purchased directly by the Ministry of Health and Social Welfare. Wages are paid directly by the Ministry. The Community Nurse is not able to claim

expenses for petrol. Petrol is provided by requisition order. Often fuel is not made available and this leads to substantial disruption to the community service. There is no budget for occupational therapy equipment and the provision of basic materials for drawing and art work is exceptionally limited and sometimes not available at all. There is no budget for paying overtime or for working unsocial hours. Staff regularly purchase items for patients if they lack resources themselves.

#### 6.4 Human Resources

- 6.4.1 The recruitment of staff is managed by the Ministry. The Nursing Superintendent has no authority to appoint or dismiss staff. He is able to promote staff nurses to Assistant Ward Manager. The hospital staff have no involvement in any interview process. The employment of orderlies and non-professionally qualified staff comes mostly from unskilled individuals with no previous mental health experience. The opinion of staff working at the hospital is not sought or taken into account in any way when new staff are appointed.
- 6.4.2 There is no medical school on Zanzibar and the number of registered medical practitioners is relatively small. The service is run predominantly by nursing staff. Nurses regularly supply medication and recommend medication without any involvement from a registered medical practitioner. Pre graduate nurse students undergo training over a three year period at the college of health science. A further year's training is required to be registered as a psychiatric nurse. Similarly a further year's training is required to become a midwife. There is a gender bias with female nurses tending to midwifery and male nurses to psychiatry. There is no post graduate training and no budget for ongoing personal development. Psychiatric Nurses that trained several years ago have therefore had little or no access to any training to update their skills or knowledge.

#### 6.5 Staffing levels

- 6.5.1 There is no permanent psychiatrist at the hospital. A Cuban psychiatrist, Dr Idrina has been working on a temporary basis at KCH for the last 18 months and will be leaving and returning to Cuba in May 2009. There are also two visiting doctors (see below) one of whom acts as the Medical Superintendent (Dr Abdi); the scope of this role is unclear and he is present in the hospital on only two ½ days a week primarily engaged in clinical tasks.
- 6.5.2 There is one qualified Occupational Therapist who previously trained as a psychiatric nurse (Mr Sharif); he is the Head of OT. There are three OT Assistants and also a volunteer gardener.

- 6.5.3 There is a Nursing Superintendent (Mr Omar) whose role appears equivalent to that of a bed manager (although the hospital does not appear to ever be at full occupancy) with some additional managerial functions. His role does not appear to be equivalent to that of a Ward Manager in Somerset Partnership as he has not direct involvement in the maintenance of the wards, supervision / appraisal of staff or clinical governance. His work is conducted solely from his office which is not located on any of the inpatient wards. There is one Assistant Nursing Superintendent (Mr Sahid) who is involved clinically in all three wards occasionally working nursing shifts. There are 31 registered nurses, the majority of whom are psychiatric nurses. Five members of nursing staff are in fact midwives and four have undergone nursing but not psychiatric nurse training.
- 6.5.4 There are 49 orderlies working across all three wards. There is one cook. There are two statisticians. There are two members of staff in the medical records. There are appear to be three pharmacy assistants. There is one laboratory technician. Overall the hospital employs about 100 members of staff.

## 6.6 Clinical data

- 6.6.1 The hospital has two staff employed to collect activity data. Data reported to the Ministry includes basic demographic details and primary diagnosis. Although there is one computer in the hospital in the library this is not used for organising clinical activity data and a paper based system is used which appears relatively labour intensive. There is a laptop which was a gift to the OT department but this is not used for clinical activity data.
- 6.6.2 The project team were able to view returns from 2006. In this year there were 996 new outpatients of whom 580 were female and 416 were male. There were 12,109 follow up contacts of whom 6,433 were female and 5,676 were male.
- 6.6.3 For new patients the following diagnosis were recorded;  
**Male:** Epilepsy 129, Delirium 0, Dementia 0, Alcohol related disorders 0, substance misuse 0, schizophrenia 6, acute psychosis 57, bipolar disorder 5, depression 8, generalised anxiety 42, unexplained somatic symptoms 0, mental retardation 7, childhood disorders 0, enuresis 67 (most of whom were children) unclassified 95.  
**Women:** Epilepsy 126, Delirium 0, Dementia 0, Alcohol related disorders 0, substance misuse 0, schizophrenia 8, acute psychosis 63, bipolar disorder 6, depression 42, generalised anxiety 122, unexplained somatic symptoms 0, mental retardation 15, childhood disorders 0, enuresis 108, unclassified 90.
- 6.6.4 For follow up patients the following primary diagnosis was recorded;  
**Men:** Epilepsy 2,529, Delirium 0, Dementia 0, Alcohol 0, Drug Use 0, Schizophrenia 472, Acute Psychosis 1,096, Bipolar Disorder 177, Depression 128, Generalised Anxiety 138, Unexplained Somatic

Symptoms 0, Mental Retardation 199, Childhood disorders 0, Enuresis 148, Unclassified 789.

**Female:** Epilepsy 2,159, Delirium 0, Dementia 0, Alcohol Related disorders 0, Substance Misuse 0, Schizophrenia 542, Acute Psychosis 1,006, Bipolar Disorder 225, Depressive Illness 224, generalised Anxiety Disorder 767, Unexplained somatic symptoms 0, Mental Retardation 164, Childhood disorders 0, Enuresis 320, Unclassified 829.

- 6.6.5 Although many patients have alcohol or illicit drugs problems this is not systematically recorded as only the primary diagnosis is included. We did not take a similarly detailed record of inpatient admissions but the DANIDA Report suggests that in 2007 there were 246 admissions, 174 of whom were men and 72 were women. The report also records similar outpatient activity in 2007 with 891 new attendances and 12,244 follow up visits. Furthermore the commonest outpatient diagnosis, as in 2006, was epilepsy.
- 6.6.6 The project team reviewed activity data for community outreach in 2006. In total there were 801 patients seen. The primary diagnoses were Epilepsy 337, Schizophrenia 196, Mental Retardation 124, Bipolar Disorder 40, Depression 19, Substance Misuse 6, and Unclassified 77. The DANIDA Report identifies community outreach to 788 patients in 2007 with a predominantly rural distribution.
- 6.6.7 In contrast, the majority of admissions to the inpatient unit and the majority of outpatient contacts at KCH are from the Urban West district. This suggests that although improved community services in non urban districts will provide access to mental health services for a population who, in reality, are currently denied such services, the impact on numbers of outpatients and admissions at KCH may be limited unless resources are also put into substantial community services in the Urban West district.

## 6.7 Observations on nursing practice

- 6.7.1 There appears to be a good nursing management structure in place within the hospital with clear line management arrangements. There is very effective rostering on the wards given the relatively limited number of nursing staff. However, wards tend to run most shifts with only one registered nurse and so there are significant risks of being unable to consistently maintain a safe nursing presence on the ward. There is flexibility to move staff around between wards during periods of sickness. The Project Team observed staff, in particular orderlies but also registered nurses, wandering from ward to ward sometimes appearing to leave individual wards short of staff. Nurses run three shifts a day with similar hours to those in the UK. Nursing staff are responsible for the cleaning of wards but have limited input into the wider ward environment.

- 6.7.2 There was little evidence of nurses interacting with patients on the Male “In” ward. This did appear to be much better on the female ward partly because of the location of the staff shelter adjacent to the patient shelter.
- 6.7.3 Staff meetings are held on a regular basis (monthly according to the Nurse Superintendent and three monthly according to the ward staff). There are no community meetings involving patients.
- 6.7.4 Medication rounds are irregular, ad hoc and do not consider patient confidentiality. Medicines are stored on a tray in the nursing office and not in a lockable cupboard. When staff undertake medication rounds they take tablets on a tray with a bucket of water from which the patients can drink to assist in swallowing medication.
- 6.7.5 Depot clinic for outpatients takes places on Mondays, Tuesdays and Thursdays coinciding with outpatient clinics. This takes place in the nursing office. There was little or no respect for privacy and the injection tended to be administered with the office door open. There was no use of Z tracking. Nursing staff did not wear gloves (it was explained that patients might find this unacceptable as they might believe the nurse did not want to touch them). No plasters or cotton wool was available. There is a consistently good supply of needles and syringes, which are delivered together as a single unit (the hospital has run out on only one occasion).
- 6.7.6 There is no evidence of nursing care planning integrated into clinical care. Some good sample care plans were seen, undertaken by student nurses, but this was not translated into routine clinical practice. There is no structured stationery or guidance for care planning. There appears to be no regular evaluation of nursing interventions. There is no evidence of formal or structured risk assessment although there did appear to be some awareness of the risk of absconding. The project team were informed that there had been no inpatient suicides for many many years; there are incidents of self harm and equipment for suturing is available. Nursing staff do appear to have a patient centered approach to some degree. They will often purchase items such as medication or exercise books (used as a personal medical record – see below) for patients who have no funds themselves.
- 6.7.7 Nurses were clean and well presented in neatly laundered uniforms which they purchase themselves.
- 6.7.8 Orderlies have no access to any training. Registered Nurses have no access to training or personal development after qualification.
- 6.7.9 Nurses reported an inability to deal with standard clinical interventions such as anxiety management, coping with depression and also assessment of psychosis. There is no evidence of any audit or clinical governance initiatives to improve the standards of care. There is a lack of availability of equipment to carry out regular observations (such as lack of sphygmomanometers).
- 6.7.10 The Project Team noted concerns identified by a number of staff at the hospital that some employee who did not seem fully capable of

performing their roles. Although the Nursing Superintendent has made attempts at local performance management at KCH and has written to the Ministry there has been no constructive response. There is no evidence of supervision or appraisal structure.

6.7.11 Areas of good nursing practice:

- Effective rostering
- Single use needles
- Staff support from the manager
- Patient interaction on the female ward
- Evidence of care planning being taught during nurse training

Areas where practice could be improved:

- Injection techniques
- Infection control
- Medication administration
- Storage and supply
- Record keeping
- Risk assessment
- Loss of motivation
- Poor morale
- No clinical updates post qualification
- Lack of basic privacy and dignity, in particular on Male Ward 2 where patients were locked outside during daylight hours.
- Lack of techniques for prevention of aggression and use of seclusion at an early stage
- Limited interaction between staff and patients on Male Ward 2
- Annual leave arrangements
- Low staffing
- Care planning not translated into practice

6.7.11 Observations are taken irregularly during the day although there is a scheduled observation at least hourly during the night to check for patients who have absconded. Although there were reports of “close observations” for some patients considered to be at risk there is no apparent structure for allocation to individual members of staff and no records are kept.

6.7.12 Cleaning is reported to be undertaken once a day on the male wards and three times a day on the female wards but no records are kept. This procedure is undertaken by both qualified and unqualified staff.

6.7.13 Patients who abscond and are vulnerable are reported to the Police although generally this is not followed up.

6.7.14 There are some opportunities for multi-agency working in the community supported by NGOs. However this approach does not routinely exist within KCH itself. An example of this was observed in the outpatient clinic; there was no consideration of child protection issues or liaison with education services in the case of a child with school refusal; the child was overworked and subject to corporal punishment at school.

## 6.8 Observations on Occupational Therapy

- 6.8.1 The Occupational Therapist Mr Mohammed Sharif has struggled to implement an occupational therapy service. He has introduced, together with visiting OTs, activities including art groups, teaching women to henna their hands and feet, a gardening project and games on the wards. There is a woodwork department endowed by an American OT department which does not appear to be significantly used by patients. There is also an ADL kitchen. Mr Sharif had introduced basic referral form for nurses and other professionals to use and had provided training but this is not in regular use. The key opportunity for productive activity appears to be between 9 – 11 a.m. In the art group patients became visibly tired at 11 a.m. and asked to return to the ward.
- 6.8.2 Mr Sharif has three Occupational Therapy assistants. They do not appear to be motivated to work with patients or able to sustain the activities initiated and developed by Mr Sharif. Mr Sharif also has a number of other roles in the mental health service which limit his time.
- 6.8.3 There is no OT budget. Mr Sharif has very limited money for resources for example food for patients to do their own cooking, basic art materials, gardening equipment etc. He informed the Project Team that he has to subsidise activities out of his own pocket.
- 6.8.4 An American University supports the OT service by sending OT students over from the United States. When they come they often bring resources with them including money for activities. They also provide expertise and energy to initiate new projects.
- 6.8.5 The Occupational Therapy assistants are employed by the Ministry of Health. There is no job description and there is no evidence of a performance management framework for the hospital. There is no evidence of multi disciplinary working. Although some OT assessment takes place this is recorded in a separate record and there is no attempt to use this information on the ward.

## 6.9 Observations on Medical Staff

- 6.9.1 There is no permanent psychiatrist at KCH. A Cuban Psychiatrist is currently working at the hospital for a period of 2 years (presumably the links with Cuba are historic – see background above). She is due to leave in May 2009. There does not appear to be any clear plan as to the provision of medical services after this date.
- 6.9.2 There are no Clinical Officers at the hospital. Clinical Officers undergo three years basic training. Although they are often referred to as “doctor” they are not registered medical practitioners. Three student clinical officers were present at the hospital on attachment during the period of our visit and the psychiatrist Dr Idrina appeared to be taking the lead role in their training.

- 6.9.3 The psychiatrist conducts one ward round a week on Male Ward 2 on Wednesday mornings. She also conducts one ward round a week on both Male Ward 1 and the Female Ward on Friday mornings.
- 6.9.4 A retired Psychiatrist Dr Wakil has previously assisted the hospital on a voluntary basis but currently does not have any regular input.
- 6.9.5 Dr Idrina participates in three outpatient clinics a week. These are conducted in the mornings (currently with the three student clinical officers and at least one member of nursing staff). She is assisted by a nurse acting as a translator. Two visiting doctors also appear to participate in outpatient clinics. Dr Abdi runs a clinic on Tuesdays and Saturday mornings and also appears to act as the Medical Superintendent although his role in this regard was obscure to the Project Team. There was an inconsistent view that another medical practitioner, Dr Abraman also undertakes outpatient activities on Monday and Wednesday mornings. Both these doctors are not psychiatrists and indeed have no specialist training but appear to work as general physicians at Mnazi-Mnoka Hospital.
- 6.9.6 There is no community medical presence at all outside of the hospital site.
- 6.9.7 Medical staff have no systematic or structured involvement in decisions over admissions although can become involved on an ad hoc basis. They do appear to have regular involvement over decisions about discharge and transfer from Male Ward 2 to Male Ward 1 in their weekly ward rounds.
- 6.9.8 There is a medical practitioner from Zanzibar undertaking training as a psychiatrist in Cuba although this will take a period of five years.
- 6.9.9 Dr Idrina's experience is in adult psychiatry. She has no specialist experience in the management of children and certainly not in management of epilepsy. She is currently undertaking a lead role in management of epilepsy, mental health problems in children and also learning disability and forensic matters which fall outside of her area of professional expertise and most probably outside of her competence. Children are likely to be particularly poorly served by this arrangement, especially children with epilepsy and learning disability.
- 6.9.10 There was evidence of friction between Dr Idrina and the two visiting doctors. There is no clear line management structure, they often share cases and treatment plans determined by the psychiatrist are often amended without discussion or consultation. Some of these decisions by the general physicians did appear to be highly questionable (for example there was discontinuation of oral antipsychotics immediately on initiation of depot medication leading to deterioration in one case).
- 6.9.11 No records of prescriptions are kept. There is no stationery for prescriptions. Medicines are supplied direct from the hospital without the need for a prescription although a record is made in the patient file.

- 6.9.12 Assessment and evaluation follows a predominantly medical model but diagnosis is made both by medical staff and non medical staff many of whom have inadequate clinical skills to make an accurate diagnosis. Misdiagnosis is likely to be common. Once a diagnosis is made, with the exception of the psychiatrist Dr Idrina, there appears to be no questioning or challenging of this subsequently.
- 6.9.13 There are no structured protocols or clinical guidelines for the management of common disorders, even those which fall outside of the competence of most adult psychiatrist (for example epilepsy in children).
- 6.9.14 There is no evidence of any form of medical audit to improve or assess clinical practice.
- 6.9.15 There appears to be poor understanding of legal processes relating to admission and inconsistent views were expressed by different professional staff. It appears that virtually no patients are admitted to the hospital voluntarily although no legal framework is in place to preserve patient rights. There is no equivalent of the Mental Health Act Commission or the Mental Health Review Tribunal. There is no right of appeal for patients admitted. Although the psychiatrist felt that the verbal consent of a family member was adequate she believed this needed to be made by someone over the age of 25 years (based on her experience in Cuba); members of nursing staff believed that patients could be admitted without the authority of a relative and others with the authority of a relative over 18 years of age.
- 6.9.16 The outpatient clinics are exceptionally busy and crowded with up to 120 patient presenting at least 3 days a week. Since her arrival the psychiatrist has established a system for identifying new and complex cases which she must see herself. Other cases are allocated to the student Clinical Officers or nursing staff. There appears to be no planning for any system when she leaves. It is of course difficult to predict problems from the medical records and sometimes complex cases are seen by non medical staff. The skills of the permanent staff at the hospital seem exceptionally limited with regard accurate diagnosis and management. It is likely that cases not seen by the psychiatrist have a poor quality of service.
- 6.9.17 The outpatient clinics are conducted with little regard for privacy and confidentiality. All patients arrive early in the morning and wait for long periods without an appointment time. Consultations take place with other patients in the room and cases are discussed within the earshot of other patients. The psychiatrist is constantly interrupted by other members of staff entering the room during consultations to ask for advice.

## 6.10 Medical record keeping

- 6.10.1 The project team viewed the medical records archives and met the two staff who worked there. Files are stored in piles on basic

shelving. However, there does appear to be an effective system of filing. Identification of medical records was seen to be rapid and effective both for outpatients and patients presenting to the ward. Some of the medical records were in poor condition and appear to have been damaged by water. When patients are admitted to the ward the files are transferred from the archive to the ward and kept in the nursing office. Similarly when patients come for outpatient attendance there appears to be an effective and efficient system for registration of cases (despite the absence of any appointments) and medical records are quickly located and are available prior to the start of the clinic.

- 6.10.2 Each patient file does obtain a social history at the front taken by a nurse. There is often then a free text new evaluation, sometimes entered by a registered medical practitioner but often by another member of staff. The record tends to be dominated by events not symptoms and is therefore often inadequate as a basis for diagnosis. There is no structured clinical record. There is no audit or performance management of the medical record. Signatures are often illegible and records are difficult to accurately attribute to a professional group.
- 6.10.3 The records are fragmented. In addition to the patient file there is a register kept in the clinic which contains basic demographic data and first diagnosis. This is used for collection of activity data. On the wards the nursing report for handover is kept separately. This contains some relatively detailed information which is not integrated or archived in the individual patient record. Arrangements for verbal handover between nursing shifts are vague. In addition it is common practice both in mental health and general medical services for patients to carry their own exercise book which very often contains clinical information but also the record of current medication.
- 6.10.4 Medical records are written in English and therefore it is substantially easier for people from the UK to work there. Some official documents, for example from the Court were noted to be written Kiswahili.
- 6.10.5 There is no structured assessment tool for risk assessment nor for care planning.

## 6.11 Medicine's management

- 6.11.1 There are serious problems in the safe and consistent supply of medicines to patients and these impair the effectiveness and safety of the mental health service.
- 6.11.2 Although sufficient funds are available from the principle donor DANIDA there appears to be poor administration or neglect at a variety of levels in the health service. Medicines are supplied from medical stores in Dar es Salaam, Tanzania and sent to a central medical store in Zanzibar. Drugs are then mechanically allocated in a

60:40 ratio between Unguja and Pemba without any further assessment of need. It appears that although funds are received in Dar es Salaam medicines are not consistently supplied to the medical store in Zanzibar, apparently because of lack of availability. It is of note that many of these drugs are available from private pharmacies in Zanzibar itself. There are serious logistical problems regarding the distribution of medication. Essential medications are frequently unavailable at many locations both at KCH and the cottage hospitals and in primary care.

- 6.11.3 The project team were informed that medications are held in excess supply in Pemba and expire. This also occurs in some PCHUs.
- 6.11.4 We were informed that the inpatient wards at KCH were without any psychiatric medication for a period of four months in 2008. Inpatients and their families were given notes to obtain tablets from private pharmacies.
- 6.11.5 There is no system of stock control either in the hospital itself or in any other part of the mental health service. There are no systems for the redistribution of medication according to need.
- 6.11.6 The only psychiatric medications the project team saw available on Zanzibar were:
- Chlorpromazine 100mg tablets
  - Haloperidol 5mg tablets
  - Diazepam 5mg tablets
  - Benzhexol 1mg tablets
  - Carbamazepine 200mg tablets
  - Phenytoin 100mg tablets
  - Phenobabitone 30mg tablets
  - Amitriptyline 25mg tablets
  - Modecate depot injection 25mg per 1ml
  - Lorazepam 2mg tablets (recently available at KCH).
- 6.11.7 All of these drugs were available at KCH at the time of the visit. Availability in cottage hospitals PCHUs was patchy (See community services below).
- 6.11.8 There appears to be no recent specialist psychiatric advice as to which drugs would actually be useful in current clinical practice.
- 6.11.9 Once again children are poorly served and many of the medications are available in formulations providing too high a dose for safe use.
- 6.11.10 A number of drugs on the WHO essential list are not available at all including Imipramine, Clomipramine and Lithium. There are no effective medical treatments for obsessive compulsive disorder. Use of Lithium is in fact impractical because of lack of availability of necessary drug tests.
- 6.11.11 There is very limited availability of general medical drugs for treatment of concurrent physical health problems for in patients at KCH.

- 6.11.12 There is no equivalent of the BNF and therefore no availability for clinical staff of advice about maximum advisory dose limits in particular for children.
- 6.11.13 Systems for stock control, storage and checks on medication are virtually non-existent. This leads to waste of a limited resource.
- 6.11.14 Drug trolleys are not available nor are lockable cupboards. Medicines which have expired are still supplied to patients (as observed at Jambiani PCHU).
- 6.11.15 There are no prescription forms used in the community. There are no prescription charts for inpatients. Therefore there is no system for recording administration of medication on the ward. Although clinical notes contain instructions from the psychiatrist about administration at specific times of day, medicine rounds are in fact conducted on an irregular and unsystematic basis.
- 6.11.16 Medications are supplied and prescribed by non-medical staff and the training for this role is almost certainly inadequate. Certainly there is no assessment of competence to undertake this role.
- 6.11.17 Medicines are supplied to patients in bags with no written advice on dose or when tablets should be taken through the day. There is no written information about likely therapeutic effects or side effects. There is however some instruction / information in the exercise book which patients purchase and keep themselves. This is entered by a health care professional however little attempt is made to ensure that patients refer to this information or even understand it. Adherence to treatment is therefore likely to be exceptionally poor, another source of waste.
- 6.11.18 On the positive side medications are provided free by the public health service including KCH nevertheless difficulties in availability and access lead to lack of availability of free medication on a consistent basis, especially in rural areas.
- 6.11.19 In the outpatient clinic the Project Team observed no single instance of enquiry into side effects. There are no guidelines or protocols for physical monitoring for prescribed medications and in fact no relevant laboratory tests are available. Little or no regard appears to be given to the effect of medication in pregnant women or women of childbearing potential. There were a number of issues relating to clinical practice in the depot clinic, which are described above (see nursing practice). A sharps box was available in this clinic.

## 6.12 Staff morale

- 6.12.1 Staff at the hospital and elsewhere suggested that mental health work is of low status. One nurse joked that members of staff are sometimes sent to KCH as a punishment. During our community visits we observed that 8 international visitors were recorded in a visitor book in Jambiani PHCU in January 2009. In contrast the project team were informed that mental health services received much less attention.

- 6.12.2 In other health care settings staff work with patients from a range of income groups. Nurses in general medical settings appear to receive financial incentives from patients and their families. This supplements their relatively low income. These opportunities are not possible for people working in mental health because the majority of psychiatric patients are in the lowest income group.
- 6.12.3 There are virtually no postgraduate opportunities for training or personal development. Nurses have to contribute financially to any advanced training.
- 6.12.4 The Ministry of Health and Social Welfare appoints all staff at KCH. Clinical managers have no influence in the interview process or the selection of staff; managers have very limited powers to manage performance issues. Staff appear to have a job for life whatever their competence.
- 6.12.5 Resources not provided consistently. This includes petrol to develop and maintain community outreach services and also the availability of basic equipment in the OT department. This leads to disempowerment and helplessness which extends to even the most senior clinical staff.

## **7 COMMUNITY SERVICES**

- 7.1 There is a skeleton mental health community service. There is only one CPN (Mr Mohammed Joel) compared to approximately 100 staff employed at KCH. He has established a mobile clinic currently operating at 8 PHCUs on Unguja. This means that 75 PHCUs on Unguja have no mental health service integrated with primary care and the population served by these has no access to any community mental health services except the outpatient facility at KCH. There is no community service at all on Pemba.
- 7.2 Mr Joel runs a clinic at the 8 PHCUs and this is intended to operate on a monthly basis. However, regular clinics are hampered by lack of consistent availability of medication and petrol. Patient attendance at local clinics therefore tails off because of unreliability of the service. This leads to a vicious circle: a lack of regular clinical services / medication leads to a lack of regular attendance by patients giving a false impression that there is no need for a service. As a consequence drugs are not distributed or expire before they are used and new clinics are not established / existing ones are not maintained; the cycle is perpetuated and the majority of patients continue to attend KCH for outpatient services. Patients with mental health problems do also attend the PCHUs at other times and some centres have a system for registering mental health patients (which includes people with Epilepsy and Learning Disabilities).

- 7.3 The Project Team were informed that the CPN keeps his own records in a book. These are not routinely available to other staff and not integrated into the medical records at KCH or in primary care. At least some PCHUs keep a register of mental health patients. This includes primary diagnosis. Again this is not integrated into the patients medical record. Patients also bring their own exercise books. These books contain some clinical information. Clinical notes are therefore fragmented.
- 7.4 It is of note that the Ministry of Health and Social Welfare were capable of providing a vehicle and 15 litres of petrol for our visit but are not capable of consistently providing the 8 litres of petrol required to allow 8 monthly community visits. This suggests there is a lack of political will to ensure community services are established and maintained.
- 7.5 The Project Team visited 6 PCHUs where some community mental health service has been established. Two of these, including the PHCU at Matamwe, had no psychiatric medications at all at the time of the visit.
- 7.6 The clinic at Matamwe had registered 10 mental health cases in 2009 (6 of these had a primary diagnosis of epilepsy). The PHCU at Donge had drugs available but these had been supplied in a package delivered by a bus driver because of lack of availability of petrol for the community nurse to come in person to run a clinic; they were stored in small sparsely labelled sealable plastic bags in an envelope.
- 7.7 The PHCU at Jambiani had plenty of psychiatric medication available and a further delivery of medication was witnessed by the Project Team during the visit. However, medication at Jambiani is purchased by local procurement from private pharmacies via funds raised by the Zanzibar Action Project ([Zanzibar.action.co.uk](http://Zanzibar.action.co.uk)). These funds are raised by donations from international tourists; the PCHU it is located in a resort area with a number of local hotels. However, a potential problem with local procurement is a lack of quality control. One of the psychiatric medications available for use (amitriptyline) was noted to have expired in 2007 either because it was purchased from an unreliable source or because of poor stock control. Nevertheless, amitriptyline was not available elsewhere and therefore the notion of local procurement does appear to have potential. In fact, Jambiani PHCU services a population of only 5,000 and there are only 15 – 20 registered mental health patients. Despite this there is more medication available there than at the nearby Makunduchi Hospital which was operating with virtually empty shelves in the pharmacy.
- 7.8 The Project Team met Dr Khaidila, a District Medical Officer (DMO) covering the Central District. She was based on one of the most active PCHUs at Dunga. This PHCU is regularly attended by c. 62 mental health patients and one of the mobile clinics run by Mr Joel is located there; patients also attend from other PCHUs in the locality. DMOs are registered medical practitioners working in a public health role. At this PHCU there are at least occasional visits by Mr Suleiman

and students who complete social and family histories for mental health patients.

- 7.9 The Project Team also visited the cottage hospitals at Kivunge and Makunduchi.
- 7.10 At Kivunge Hospital only 3 mental health patients were registered in 2009 (compared with 40 in 1989). There was a perception that the clinic has been disrupted by a decision by the DMHT to relocate a psychiatric nurse who has established a clinic there. The only psychiatric drugs available at Kivunge were phenobarbitone, phenytoin, diazepam and chlorpromazine 100mg tablets. It is of note that the lead nurse was not aware that chlorpromazine was available despite this being virtually the only medical treatment for any mental illness within the hospital. There is no community psychiatric clinic operated by Mr Joel at Kivunge Hospital. There is an X-Ray department which is operational. There is also a laboratory able to undertake tests for TB, HIV and Malaria. Urine and stool microscopy, and blood tests for FBC, glucose and cross matching are also available. Blood was available for transfusion and was stored in the laboratory fridge.
- 7.11 At Makunduchi Hospital there were no psychiatric drugs and little evidence of any attendance by mental health patients. A locked pharmacy store for the district is located at the hospital and this contains medication; these drugs are not directly available to the hospital. More medication is available at the nearby Jambiana PHCU where there is independent local rather than state controlled procurement. Through contacts established with Dr Eginton and Mr and Mrs Rackham plans to re-establish a mental health clinic at Machunduchi were established.
- 7.12 The Project Team were informed that Mr Suleiman and Mr Sharif have contributed to multi-disciplinary assessments organised by the NGO Zanzibar Action for People with Developmental Disorders. This organisation provides services for children with special needs. Assessments are undertaken by a multi-disciplinary team also including social workers and ophthalmic / ENT specialists. There is funding to support referral to Dar-Es-Salaam for specialist treatment.

## **8 SWAZA**

- 8.1 Swaza (Saidia Watu Wenye Matatizo ya Afya yo Akili Zanzibar; P.O. Box 4844, Zanzibar, Tanzania; swaza1998@hotmail.com) is an NGO working in partnership with other agencies. SWAZA's mission statement is 'Swaza strives to improve the quality of life of people with mental health and related problems in Zanzibar through capacity building, lobbying and advocacy, prevention, rehabilitation, information generation, dissemination and networking.

- 8.2 Swaza is a voluntary group of mental health professionals and other interested members of the local community. Members provide support in their free time.
- 8.3 Recent Swaza achievements include initiatives in improving awareness in the Community about mental illness. One project was the facilitation of football matches with staff, service users and the wider public as a tool to reduce stigma and raise awareness about substance abuse, HIV and mental health.
- 8.4 Swaza has raised funds through lobbying of local business leaders to improve the environment at KCH. This has included the construction of a borehole to provide clean and safe water supply and improvements to the water drainage / sewers.
- 8.5 Swaza works with the Ministry of Health and Social Welfare in writing mental health policy and campaigns on implementation of policy including the training needs of mental health staff.
- 8.6 On his preparatory visit Edward Colgan met Dr Wakil (then Chair of Swaza) and Mr Sharif (secretary of Swaza), also Head of OT at KCH. We were fortunate that Swaza had a scheduled meeting on 6 February 2009 and they agreed to include us in part of this meeting; they shared some of their achievements and also spoke of challenges including lack of income to support the organisation outside their own fundraising activities. They have no capacity to employ staff. They presented to us as a well informed, active group with strong leadership. Their achievements in 10 years are impressive. We had during the meeting about the possibility of partnership working with Rethink. Rethink had expressed interest in working with SWAZA to share expertise and resources. Some members of SWAZA were familiar with Rethink and its work and expressed a wish to progress this idea further, initially by sharing of information through e-mail via the Swaza secretary Mr Sharif. The Project Team agreed to forward Rethink documents including newsletters.

## **9 FEEDBACK TO STAFF AT KCH**

- 9.1 At the end of the visit the Project Team met with Mr Suleiman, Mr Omar and Mr Joel. The Project Team expressed their gratitude for the kindness and hospitality offered by Mr Suleiman and KHC staff.
- 9.2 There was feedback about the dedication and persistence of the staff at KCH in their efforts to maintain a service, despite the financial and other constraints. A number of strengths were identified and discussed some of which may be applicable to our practice in Somerset Partnership. Joint learning from the visit was discussed.

## 10 RECOMMENDATIONS

- 10.1 Resources. The hospital could benefit from financial support to improve the environment and also to facilitate the regular supply of basic equipment for patients and staff. This includes equipment to allow regular therapeutic activity within the hospital and petrol to maintain and develop community services. It will be necessary to ensure a robust audit trail to support any donations. Sufficient controls may not be available to provide assurance in this respect if funds are given direct to the hospital or the Ministry. However, Swaza have an established track record of fund raising, identifying need and supporting in patient services. They appear to adopt an ethical approach with evidence of probity.

**Recommendation** *If funding is to be made available, Somerset Partnership should develop links with Swaza. Dr Wakil and his colleagues could be asked to propose options (with costs) for how any resources could be used to provide a workable solution to improve mental health services locally. Locally generated solutions are likely to be more effective and practical.*

- 10.2 Partnership working. Swaza have an impressive record of achievements but have limited capacity and resources. Swaza and Rethink are interested in exploring partnership working including sharing of resources and expertise.

**Recommendation** *A representative of the Project Team should arrange a meeting with Gerry Wadham (Somerset Regional Manager, Rethink) to progress this.*

- 10.3 Staff development. Continuing professional development of clinical staff is critical in the generation of sustainable and effective improvements in mental health services. Psychiatric staff working in Zanzibar have to operate in an exceptionally challenging environment. In order to establish and maintain better services there is a clear need for post-graduate training for clinical staff. Priorities for training include those which focus on safe and effective practice. Training needs to be delivered with an understanding of the cultural context.

**Recommendation** *The Project Team, in conjunction with other colleagues (for example CAMHS, LD staff, clinicians with expertise in the diagnosis and management of epilepsy) should oversee the development of training for clinical staff at KCH. This will need to be done in consultation with mental health professionals locally. In consultation with staff at KCH. Training could be delivered by Somerset Partnership staff. Initial suggestions for training include:*

- *Clinical protocols for reliable diagnosis of common psychiatric disorders and epilepsy.*
- *Risk assessment.*
- *Care planning and evaluation of interventions.*

- *Prevention and management of aggression (including improved communication skills and also the use of ward based therapeutic activity to reduce boredom).*
- *Medicines management training (see below)*
- *Risk assessment .*

**Recommendation** *Somerset Partnership should consider the feasibility of advanced training bursaries for individual staff; there would be a need to ensure this lead to improved clinical services locally and not to loss of staff to the mainland after completion of any advanced training.*

- 10.4 Training resources. There is a limited selection of books available to staff and there is no internet access within the hospital. One book in particular, 'Where There Is No Psychiatrist', has been used elsewhere in Africa and may be effective in Zanzibar. This is written in English.

**Recommendation** *Consider opportunities for supporting availability of post-graduate training resources for clinical staff.*

- 10.5 Therapeutic activities There have many challenges in managing an Occupational Therapy service. Effective Occupational Therapy should provide an end product for patients. Options for further consultation with KCH and or SWAZA include:

- Supporting the hospital to keep a cow that patient could care for but also have milk to supplement their diet.
- Developing the gardening project and growing vegetables and fruit.
- Teaching female patients to henna both as a therapeutic activity and as a skill that could be used outside the hospital.

**Recommendation** *To take forward these proposals in consultation with SWAZA and KCH staff; ensure proposals are workable and sustainable.*

- 10.6 Links with DANIDA. The Project Team were fully supportive of the recommendations in the Euro Health Group report: 'The Status of Mental Health in Zanzibar', especially proposals for development of sustainable community services. There was a lot of common ground between our observations and the content of the report. Many of the fundamental problems with the organisation of the mental health service, including arrangements for financial management, humans resource issues and performance management of staff operate within a wider political context which is difficult to address from the grass roots.

**Recommendation** *A representative of the Project Team should establish links with DANIDA to explore options for co-ordination of efforts to advocate for improvements in mental health services in Zanzibar.*

10.7 Medicines management. There are substantial problems at every level of medicines management including procurement, distribution, supply and storage as well as aspects of clinical practice including prescribing, administration and monitoring of side effects. There appears to have been lack of availability of expert advice as to which medications should be available locally, including advice on suitable strength preparations for children.

**Recommendation** *The nationally modified World Health Organisation list for essential medication should be reviewed and with advice from psychiatrists with appropriate expertise, especially in prescribing for children and from neurologists with experience in the management of epilepsy. This will need to take into account local constraints in relation to costs of newer medications.*

**Recommendation** *Post-graduate training should be made available for clinical staff. This could be developed and provided by Somerset Partnership staff in consultation with clinicians locally in Zanzibar. Training should focus on:*

- *The safe and secure handling of medicines including arrangements for storage of medication and stock control to avoid waste.*
- *Improvement in systems for the prescription and administration of medication including introduction of prescription charts with an administration schedule. This would improve safety and also professional accountability in the supply of medicines to patients.*
- *Improvement in practice in administration of depot medications including z tracking techniques, use of two needles (one to draw up and one to administer), skin cleansing (if required), administration at a 90 degree angle and infection control procedures.*
- *Provision of information about maximum advisory dose limits of commonly used medications for both adults and children.*
- *Improvement in practice regarding monitoring of adverse effects including routine enquiry about side effects, physical examination for extra—pyramidal signs and the effects of medication on the foetus in pregnant women.*
- *Introduction of some auditable practice standards in consultation with staff from KCH and Somerset Partnership, particularly those that relate to patient safety. Guidance for these can be obtained from NICE and the NPSA.*

**Recommendation** *Somerset Partnership should consider joint working with DANIDA to recommend and advise on improved systems for the procurement and distribution of psychiatric medication in Zanzibar.*

10.8 Clinical Processes. There are a number of areas where clinical processes within the hospital and wider mental health service could be improved for the benefit of patient care. These include:

- Integration of care planning and evaluation processes into routine clinical care for nurses and other staff.
- Multi-disciplinary working.

- Improvements in medical records including integration of medical records.
- Inpatient admission procedures including psychiatric and physical assessment processes, clarification of legal issues and delineation of roles of different professional groups (including medical staff) in decision making.
- Line management arrangements for medical staff; communication between doctors and joint working.
- A clear supervision and appraisal structure for OT / community and inpatient nursing staff would be useful in identifying potential training needs and to address loss of motivation, performance management and if required sickness absence/stress at work.

**Recommendation** *The Project Team should consider working jointly with staff at KCH to take forward some of these initiatives, combined with training for key staff in implementation.*

**Recommendation** *There should be review of the one area of service development facilitated by the Project Team during this visit to assess whether this was taken forward and maintained locally: re-establishment of a community clinic at Machunduchi Hospital.*