Arusha Mental Health Trust

Facilitating quality mental health care in Arusha, Tanzania

Sixteenth Annual Report

January 2013

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HIGHLIGHTS OF THE YEAR

In January, guided by the statistics of the previous year, Arusha Mental Health Trust began a community outreach program. We are pleased to have two new staff members, Niyimpaye Kataze and Nembris Manangwa who increase our capacity to serve the community through a new social work program. The social work program was based in the ESSO office, and work continues through youth leadership programs and group therapy as well as coordination with community members and government staff in the ESSO area. At present, the social work program includes: intake interviews for new clients in the government psychiatric clinic; support group meetings for families of people suffering with serious mental illness; follow up for clients who drop out of our service; and home visits to patients unable to attend the hospital clinic. Recently established youth groups serve as a forum to share information about important issues such as mental health, substance abuse, and reproductive health.

AMHT remains focused on service provision, and are a model of quality care in an integrated and multidisciplinary structure. The social work component, combined with psychiatric service and psychology provides comprehensive treatment and support for our most vulnerable clients.

Rebecca Tyrer returned to our department to complete our research project on Voluntourism, which was completed and presented in September of 2012. Musarrat Khalfan, a student intern, began a three month work placement with us and assisted in the research as well as developing clinical skills as an observer. Both of them are now pursuing graduate degrees.

Gretchen Mills continued the Leadership Development program, and added fundraising to her job description, coming into the organization on a full time basis. A major contribution through Gretchen was the video project, which is beautifully and professionally done by the Kilimanjaro Film Institute, describing the work of AMHT.

In April, AMHT worked together with the Interpretive Guide Society to develop curricula for helping guides manage their own stress and serve clients well. AMHT has had an opportunity to support the private sector through the guides, extending mental health awareness in the community to 75 men and women working in the safari business. The Interpretive Guide Society is a vehicle for local networking, visibility, and community awareness in preventive mental health activities, and supports this important group of people who serve at the base of the Arusha economy.

AMHT provided a two week Trainer of Trainers Program for developing child protection policies in a variety of health, education, social welfare, and religious organizations. Twenty one individuals were given training in human development, national and international law, research based support for child protection policies, practice in teaching skills, alternative forms of

discipline, interviewing skills, and curriculum development for helping other organizations design culturally specific and contextually appropriate policies for organizations.

As is our usual practice, AMHT developed and delivered a variety of programs to support partner organizations, an Islamic Women's group, and Catholic religious orders. These programs include the Enneagram and Meyers-Briggs personality typing systems, human development, human sexuality, stress management and life balance workshops.

As the monitoring and evaluation program develops, AMHT has been asked to assist two other organizations in evaluating their own projects, with a view to more effective strategic planning. This is challenging work, and provides an opportunity to work with other organizations for the benefit of vulnerable people.

Dedication

This report is dedicated to the Congregation of Medical Missionaries of Mary as they reach the milestone of a Diamond Jubilee in 2012. This program is rooted and was founded by the Medical Missionary of Mary through Sr Sheila Devane MMM. We have been supported for so many years by the local area and congregational leadership. We congratulate and thank you for all your services worldwide and in Tanzania over many years.

Our History in Brief

The Arusha Mental Health Trust was founded in 1996 by Dr Sheila Devane under the auspices of the Medical Missionaries of Mary (MMM). It grew out of a great need to offer basic mental health care to this growing population. There were no active mental health services available and AMHT continues to be the only facility of its sort. AMHT is connected by friendship, tradition, and gratitude to MMM who remain supportive and are represented on our Board of Directors. In 2004 AMHT became a Company Limited by Guarantee in Tanzania and a Registered Trust in 2006, legally autonomous.

Clinical Work at AMHT

Personnel

Full-time Trust personnel are:

- Mr. Emmanuel Bujulu, Mental Health Practitioner and Program Director
- Mr. Boniface Kisi, Counsellor and Administrative Officer
- Dr Robin Peterson, Clinical Psychologist and Program Development Coordinator

- Ms Gretchen Mills – Leadership and Organizational Development and Fundraising
- Ms Nembris Manangwa, Social Worker and Trainer
- Mr. Richard Matei, Driver, Messenger, Store-keeper and Office Assistant.

Volunteer personnel:

- Mrs Lisa Stevenson and Mr. Graham Stevenson, Counsellors
- Rebecca Tyrer, BSc (Hons), Clinical Psychology

Part-time personnel:

- Mr. Niyimpaye Kataze, Social Worker and Trainer

Student Interns:

- Musarrat Khalfan, BSc (Hons), Applied Psychology and Management Studies

Advisory Members:

- Fr Oliver O'Brien SCA - Policy and Planning
- Erneus Rutta (lawyer) – Law and Human rights

Government Staff:

- Mrs Angela Gurty – Psychiatric Nurse and Regional Mental Health Coordinator
- Mrs Asha Semdele – Psychiatric Nurse
- Mrs Catherine Lyatuu – Psychiatric Nurse

Inputs

Donor support
Government partnership
Trained Staff in psychiatry, psychology, social work, teaching and training, administration, fundraising, and leadership development
Professional development
Computers, printers and Software
Consumables
Office space & equipment
Reliable transportation
Fundraising
Publicity and Signage
Access to up to date research
Information technology and communication
Teaching materials
Photocopier and Projector
Curriculum development
Reporting system
Monitoring and Evaluation

Outputs

Reception
Resource Center
Translations
Crisis Response Capability
Out of Clinic Visits
Esso Parish Clinic
Social Work Outreach
Group Therapy
Training Programs
Networking
Youth Leadership Development
Partnerships
Teaching
Professional Training and Supervision for new professionals and partner organizations
Assessment
Psychiatric service
Psychological service
Consultation services

Participants

Individuals of all ages, both sexes, all socioeconomic strata, across ethnic and cultural groups

Organizations in need of support, education, information, training, and supervision

Local, national, and international stakeholders working for social and legal change to care for and protect vulnerable populations

Outcome: Short term:

AMHT is well represented by caring and knowledgable professionals.

Increase knowledge, skills, and awareness
Quality service provision.
Accurate information
Improved quality of life and work performance for individuals
Develop and maintain partnerships
Trainer of Trainers extends the work of AMHT
Assessment and Research results provide data for specific purposes and specific goals
Manage appointments efficiently
Provides welcoming, friendly, comfortable environment
Enhances personal understanding
Supports individuals, families, and organizations in times of trauma
Easy access, visibility, and influence
Increased awareness, skills, and knowledge
Generates income
Establishes and maintains professional relationships
Individuals have educational opportunities

Outcome: Medium Term:

The Arusha community benefits from the work of AMHT.

People feel comfortable and welcome in our services
Reduces stigma about mental health department and mental health issues
Research data collection and analysis
Provides information about partner organizations
Provides resources for organizations or businesses in times of crisis E
Establishes and maintains partnerships with community
May generate income
Support groups with common interests/goals/problems
Increased quality of life and work performance in the private sector for economic development
Capacity building in other organizations
Improved quality of education and vocational placements
Improved care of patients and their families
Guidance for future treatment
Support for integrated health care
Allows opportunities of information exchange, learning, support, and supervision.

Outcome: Long Term:

Improved mental health in Arusha, specifically:

Improved mental health care for people needing treatment.

Support for families and caregivers of mentally ill patients.

A model of quality mental health care in an integrated and Interdisciplinary structure.

Sustainability achieved through government partnership.

Community awareness of mental health problems and alternatives for treatment.

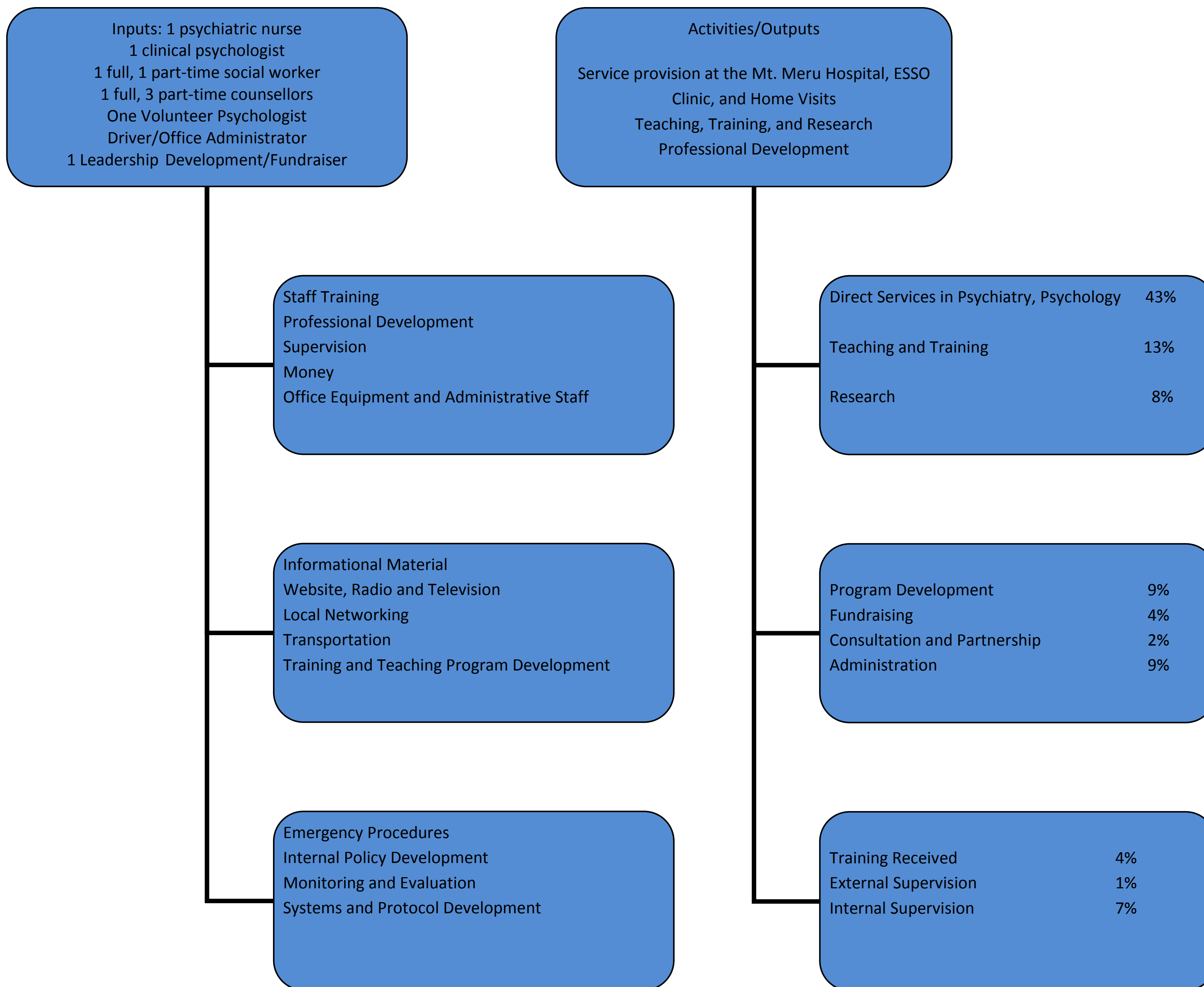
Increased knowledge about mental health problems and treatment options in partner organizations, schools, and government agencies.

Increased skill in counselling, identifying mental health problems, and accessing treatment.

Understanding and developing preventive and protective measures for vulnerable people.

Reduced stigma.

Logic Model and Time Spent by AMHT Staff on Specific Activities



Clinical Statistics

Direct Service Provision

As part of the Monitoring and Evaluation program, the 2012 statistics described the referral means for clients to AMHT. We are pleased to note that 20% of our clients were referred to us from the government psychiatric service. This was the highest number of referrals from any source, and we feel is an indication of the level of cooperation we have developed with the government service providers.

Seventy-six clients (or 18%) of the referrals have come from AMHT staff members' social and community contacts. This is an indicator of the reputation and the community's perception of our staff and the work that we do on a personal and professional level.

A significant percentage, 14% of our clients, is referred by former and current clients. We believe that this is an indication of the quality of our work and that clients find AMHT services valuable. 10% of our clients who are referred by partner organizations, which are groups of people with whom we work and who are mutually supportive colleagues in improving mental health in Arusha.

The rest of the referrals come from the following sources: medical doctors (6%), school administrators (6%), social work outreach programs (4%), local advertising and local business organizations (each 2%) and research contacts.

Individual Therapy Groups and Hours Spent

	Individual	Groups	Family	Couples	Career	Crisis
Emmanuel	982	0	47	32	3	8
Boniface	633	1	21	23	9	0
Robin	355	0	5	0	0	8.5
Lisa	125.25	0	0	84.5	0	0
Amandi	19	0	0	0	0	0
Niyimpaye	144	49	0	0	0	0
Nemburis	20	1	0	0	0	1
Total	2,319	51	73	139.5	12	17.5

Aside from actual therapy, client care consists of email and phone follow-up, research on therapy options, treatment planning, case management, and consulting with other professionals in order to provide the best possible care for each client. As a team, AMHT staff spends 43% of their time in direct service provision to clients, 13% of the time teaching

and training, and 30% of the time working to improve services offered through innovation and program development.

World Mental Health Day pavilion by AMHT 10th October 2012

Teaching and Training

Groups which request training generally identify the subject matter and AMHT staff design the programs to meet the specific needs of a particular group. This may mean language requirements of Swahili or English; it may mean age-appropriate material and delivery, as for youth groups or teachers. Religious groups comprised 278 individuals and 290 hours in 2012, and mixed community member groups comprised 180 individuals and 151 hours of training. Tour Guide Training in Adaptive Human Behavior and Client Care was delivered to 74 individuals in 120 hours of instruction.

Client Demographics and Statistics

Our statistics and other monitoring and evaluation activities lead us to determine our goals for 2013, and evaluate our performance in 2012. The demographic information suggests that AMHT is on target, serving men and women equally, and serving vulnerable people and other “target groups” appropriately. Clients under 15 years old have increased, mostly due to the research in orphanages and increased awareness in the community of our availability to children. In addition to this, the population demographics in Arusha show that 50% of the people in Tanzania are under 18 years of age so we expect to see an increase in that population as we raise awareness of mental health concerns. Our social work programs are particularly targeting youth in supportive programs designed to provide accurate information, enhance resilience and good decision making, and enhance mental health. We have seen a 4% increase in people over 60 years old so far this year, again we believe that

this is in response to the awareness raising we have done in the community, most effectively through radio programs.

The Social Work program is new, so the low number of referrals from the program is reflected in the statistics. We are learning, and changing our approach to community outreach as we assess what works well. In the first three months of the new program, we concentrated on community leadership, did awareness raising and education on mental health concerns and received precisely '0' new clients as a result of those efforts, in spite of diligent follow up. We learned that this is not the most effective means of outreach, and then began developing a more youth-centred program which has recently begun. The social work staff, Nemburis and Niyimpaye, were heavily involved in the research program, and spent nearly two full months collecting data. During that time, they carefully and graciously offered help to the government staff and proved their value in client care, which is clearly working according to the statistics. Ties to the government service are strong and mutually supportive.

The client population in 2012 was almost exactly half men and half women.

Age distribution and percentage

Age	2010	2011	2012
0 – 14 years	10.5%	6%	**14%**
15 – 19 years	11.5%	21%	**15%**
20 – 40 years	51%	57%	**50%**
41 – 60 years	5%	19%	**15%**
61 – 75 years	5%	1%	**5%**
Over 75	**<1%**	**<1%**	**1%**

Diagnoses of clients attended and percentage of each diagnosis.

Please note: these are main diagnoses and do not include secondary mental health concerns. Many clients have more than one diagnosis which is clinically significant.

Main diagnosis	Total Number of Clients	Percentage of Client Population
Schizophrenia or related psychosis	85	18.4%
Substance abuse/misuse	52	11.2%
Anxiety disorder (OCD, GAD, Phobia)	49	10.6%
Assessment (Clinical or Academic Concerns)	47	10.2%
Trauma and stress-related disorders	36	8.1%
Depressive disorder	33	7.2%
Somatoform Disorders	18	4.0%
Marriage problems	16	3.5%
Work related problems	16	3.5%
Epilepsy	14	3.0%
Parenting Concerns	12	2.6%
Relationship Problems	10	2.2%
Psychosocial problems (poverty)	10	2.2%
Diagnosis not clear	10	2.2%
Bipolar disorder	8	1.7%
Dementia	8	1.7%
Attention Deficit /Disruptive Behaviour Disorders	8	1.7%
Bereavement	7	1.5%
Mental Retardation / Developmental Delay	5	1.0%
Organic Illness	4	<1%
Learning disabilities	4	<1%
Adjustment disorder	3	<1%
Nocturna enuresis	3	<1%
Sexual dysfunction and Sexuality	2	<1%
Sleep disorder	1	<1%

Goals and Challenges

Developing the social work component of our program has been challenging, and we are learning from our successes as well as our other experiences. In the outreach program, our social work team identified 20 community members who were interested in training about mental health, and they were invited to spend a full day with four members of the AMHT staff. The training was done in Swahili, and the participants were very enthusiastic about the material. However, after three months there were no new referrals as a result of the training and some resistance on the part of the participants because AMHT was not willing to pay the volunteers. As a result of this lesson, the focus switched from adults to youth, to share information and knowledge about mental health and to put preventive strategies in

place; we also partnered with Roots 'n Shoots (one element of the Jane Goodall Foundation) to find a model of self-sustaining youth groups. This program will be evaluated in 2013, and further directions for development will be identified at that time. There is a perception that non-governmental organizations have a great deal of money, and instead of seeing the program as a volunteer program to benefit the community, many community members expect payment. AMHT made a policy decision not to comply with this request, and we are currently exploring other avenues with youth who are motivated and enthusiastic.

Another serious challenge is the lack of resources for treating and following up on patients needing mental health care. There is a chronic shortage of clinical practitioners and medication. This led AMHT to make a serious offer to train, supervise, and support the mental health practitioners in government service to provide more effective care and to pursue agreements with government to provide the necessary resources to take on new clients when they are identified through our outreach efforts. This is under discussion with the Municipal government, and we are optimistic that some agreement may be reached. We believe that AMHT is a model of quality service that could be replicated in other sectors, of private/public partnerships in health care.

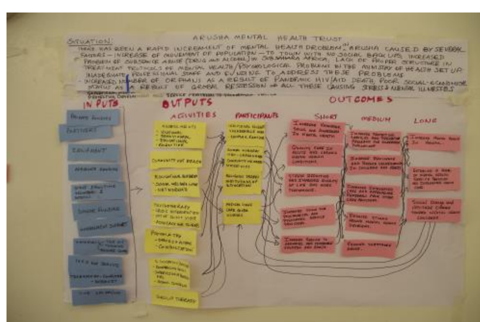
AMHT has a busy future, and many different requests for services, training, teaching, and supporting other organizations which are working toward positive development in Tanzania. In order to meet these goals, we are working to expand our knowledge through evidence based practice, our network and our donor base for a solid future, and working toward sustainability through local community support and government partnerships.

Teaching, Learning, and Networking

Teaching

New programs at AMHT include the youth leadership meetings at ESSO. These programs are targeted for 15 to 20 year old people, and are a combination of awareness raising, information sharing, and life skills groups intended to develop knowledge and skills in young people. Other new programs include Mindfulness practice, Adaptive Human Behavior and Client Care for safari guides, and comprehensive Trainer of Trainer programs for child protection policy development.

Learning



The monitoring and evaluation program offered by the Flora Family Foundation to AMHT has led to new and effective ways of evaluating our work and forming our programs to meet the needs of the Arusha community. In 2010, Emmanuel and Robin developed this with the help of FFF's facilitator, Carrie Oelberger. This modest

beginning has led us to the comprehensive and sophisticated logic model provided in this Annual Report.

Monitoring and Evaluation

The Monitoring and Evaluation programs at AMHT have been further supported by developing case studies and evaluation tools. The results of the KAP Survey, discussed below, are baseline data. We will use the same data collection materials to determine if the activities of AMHT have positively impacted the communities we are working with, and will help direct our planning for program development and service delivery.

Research

The Relationship Between Volunteer Program Structure and Psychological Health of Children Served

The research on voluntourism was certainly a highlight of our accomplishments this year. Prior to this research there were no reliable estimate of the number of children in care in the Arusha area, and no reliable estimate of the number of institutions housing children. The research provided a much more accurate estimate of this, as well as a wealth of information about the research methodology, the psychological well-being of the children in care, and the management structures of organizations with volunteers.

Becky headed this research team, and Nemburis and Niyimpaye collected data from children living in institutionalized care while Becky investigated the organizational structure, particularly the way volunteers were recruited, chosen, and utilized. The research was based on AMHT's experience with volunteers, and the children with whom they work. The questions that we had about voluntourism revolved around how the children are impacted by volunteer programs, particularly vulnerable children who have experience a great deal of loss and uncertainty in their lives.

Volunteer tourism or 'voluntourism' refers to people interested in carrying out volunteer work in developing countries. The frequency of this type of development aid has increased over the last decade in Tanzania, and Tanzania is the third most popular country in Africa for voluntourism. The research project invited all institutional care homes in the Arusha region of Tanzania to take part, and the data collection concentrated on children between 7 years and 11 years old. A Management Structure Questionnaire was developed to determine which elements of an organisation's volunteer structure serve to protect and enhance healthy human development, and included things like requiring a criminal convictions clearance and a child protection policy. The Child Personality Assessment Questionnaire, developed by Ronald Rohner (1996) was used to evaluate the psychological welfare of the children served. The results indicated that overall, the children sampled were much more psychologically adjusted than maladjusted. Total and individual volunteer practices measured were not related to the health of the children served by volunteers, but a great deal of interesting, baseline data was collected. For example, a few of the highlights were:

- The fewer children there are in the institution, the more well-adjusted. This argues for smaller groups of children, and higher adult to child ratios.
- The more time volunteers spent with children, the less well-adjusted they were in terms of self-efficacy, which is the ability to set a goal and accomplish that goal, or to complete a task. The reasons for this were unclear, but it is an interesting area for further study, as the tasks of the volunteers may be adjusted to help children become more competent. Another possibility is that children who have stronger bonds with volunteers suffer more when the volunteers leave.
- Organizations which had persisted with government to complete the certification system had more well-adjusted children. A piece of paper does not make healthy children, but this suggests that organizations which are ethical enough to pursue the required bureaucratic pathways may also be more conscientious in other areas of caring for children.
- Older children were better adjusted, regardless of how long they had been in the institution. This may suggest that immediate interventions be targeted at younger children first.

The research had many positive outcomes: a) good baseline data was gathered to help AMHT design appropriate interventions for the organization as well as the children, b) new relationships were forged between AMHT and institutions which may need our support, c) partner organizations, staff members and AMHT developed good working relationships which will be on-going, and d) the presentation of the research results to the community raised awareness of a sensitive issue and raised the profile of AMHT in the community.

The KAP Survey: Measuring Mental Health Awareness in Arusha

Between October and December of 2012, 156 participants were surveyed. A wide variety of people were surveyed, and they came from thirty different areas in Arusha, Dar es Salaam, and Karatu. AMHT developed the survey with assistance from the Flora Family Foundation, and the purpose of this study was to identify the level of knowledge respondents had regarding mental health concerns and where AMHT should target outreach programs in 2013.

A question which was not included on the KAP survey, and a significant problem for this survey, is how people define mental illness. In the community surveyed, there are generally three answers to this question: mental illness is understood to be confusion, substance abuse, or mental retardation. With this in mind, the results of the KAP survey are helpful to a great degree, but must be considered within the context of this definition of mental health. The vast majority of people (141/156, 90%) indicated that they had heard of mental diseases.

Causes of Mental Illness

Respondents (32%) indicated that stress was the most common cause of mental illness, and 22% of them said that people were born with the illness. Mental illness resulting from living

a bad life (i.e. sinful) or being possessed by spirits was 5% each. Only 1% of the respondents said it was a result of grief; about one third (32%) said that they did not know the cause.

Regarding vulnerability to mental illness, 61% thought that some people were more vulnerable to it than others, 19% said that everyone is equally vulnerable, and 20% said they didn't know. Of the respondents who did have a belief, 13% felt youth more vulnerable, 17% felt women more so, but the majority (36%) felt men were most vulnerable. Substance abuse was named as the most common cause of mental illness (41%), 29% felt it was life stress, and 11% felt it was specifically stress at work.

Effects of Mental Illness

The majority of respondents (32%) felt that the family of a person with mental illness was stigmatized, even though 75% of the respondents said that there was no social stigma attached to mental illness. Of the very few people (13%) who said that there was social stigma, said that mentally ill people are treated badly by children and youth, community members, family and friends as well as strangers. A majority of people (60%) said that there was no stigma in the work place.

An increase in the level of poverty was a second effect (28%) and increased stress was third (25%). Interrupted or limited education was named by 9%, and 3% said that they did not know. Only 2% said that there was "very little" negative effect.

When asked what people suffering from mental illness should be able to do, 44% said that they should have treatment, 18% said that they should be allowed to go to school, and 10% felt that they should have a clean home and a normal life. Only 11% felt that they should be able to work, and 3% felt that they should be allowed children. Only one person thought they should be allowed to drive a car or ride a bike.

Treatment Options for Mental Illness

Traditional medicine was the most often mentioned treatment option for mental illness (29%), closely followed by clinics (23%). Religious services were mentioned 20% of the time, and 18% of the respondents did not know of treatment options. Government services were last on the list of options (4%).

Sources of Information

The respondents who had heard of mental illness indicated that the majority of them (33%) get their information from radio and television, 26% get information from their health care providers, and 22% get their information from family and friends. Religious leaders are the source of information for 5%, and government and NGOs comprise another 5%. Television and radio are seen to the best source of information, and health providers the second best source of information, but health providers are believed to be more credible.

Preferences in Information Delivery

A large number of people (52%) said that they like information to be communicated on posters and sign boards. One quarter (25%) of the respondents said that they prefer to get information through books and flyers. When there are groups of people in information sharing sessions, 36% said that they like presentations, 33% like peer support groups, and 18% like peer education groups. Factual discussions were preferred by 8% and informal discussions were preferred by 4%.

Recommendations for the Strategic Plan as a Result of the KAP Survey

1. Use the preferred means of communication (Radio/TV), books, posters and flyers. We are already doing well with the radio programs, but we should do more with Safina radio and pursue this more aggressively.
2. Put out information which will broaden the definition of mental health and mental illness. Our clients have a misconception about mental illness by limiting it to confusion, substance abuse, and mental retardation.
3. Information needs to be targeted towards the following people:
    a. Primary school leavers who have little or no information.
    b. Teachers who are delivering information, apparently inaccurately, about what mental illness is and how it can be treated.
    c. AMHT services should be advertised to other health care providers, including government staff, as they are seen as credible sources of information and are a good referral source.
4. Posters would be a good investment in terms of education and awareness raising. They could be used for hospitals, clinics, and other waiting areas in health care centres. These do not need to be specifically directing clients to AMHT (which could be seen as competition), but could be general information and the health care providers can give more specific information about where to find AMHT.

Networking

Networking and fundraising opportunities have come from different areas, including Islamic and Christian organizations, former volunteers from the Arusha area, partner organizations including the Jane Goodall Foundation, Arusha Rotary Club, the Florentina Foundation, and past and present donors both locally and internationally. The research on voluntourism also led to new partners and opportunities to develop new and more effective interventions for vulnerable children and the staff operating in this challenging environment.

Mental Health Day 2012 was a wonderful opportunity to tell people about AMHT, mental health problems, and treatment options. More than 200 people stopped by the blue and yellow awning decorated with balloons, and manned by our Director and AMHT staff members. The Christmas Craft Fair was another outreach opportunity for AMHT, which provided an opportunity to let people know about the existence of AMHT and mental health concerns. Our social workers have also done a fantastic job preparing presentations for

youth and have presented stress management and reproductive health concerns to about 180 young people since September.

Goals and Challenges

Developing the social work component of our program has been challenging, and we are learning from our successes as well as our other experiences. In the outreach program, our social work team identified 20 community members who were interested in training about mental health, and they were invited to spend a full day with four members of the AMHT staff. The training was done in Swahili, and the participants were very enthusiastic about the material. However, after three months there were no new referrals as a result of the training and some resistance on the part of the participants because AMHT was not willing to pay the volunteers. As a result of this lesson, the focus switched from adults to youth, to share information and knowledge about mental health and to put preventive strategies in place; we also partnered with Roots 'n Shoots (one organization within the Jane Goodall Foundation) to find a model of self-sustaining youth groups. This program will be evaluated in 2013, and further directions for development will be identified at that time. There is a perception that non-governmental organizations have a great deal of money, and instead of seeing the program as a volunteer program to benefit the community, many community members expect payment. AMHT made a policy decision not to comply with this request, and we are currently exploring other avenues with youth who are motivated and enthusiastic.

Another serious challenge is the lack of resources for treating and following up on patients needing mental health care. There is a chronic shortage of clinical practitioners and medication. This led AMHT to make a serious offer to train, supervise, and support the mental health practitioners in government service to provide more effective care and to pursue agreements with government to provide the necessary resources to take on new clients when they are identified through our outreach efforts. This is under discussion with the Municipal government, and we are optimistic that some agreement may be reached. We believe that AMHT is a model of quality service that could be replicated in other sectors, of private/public partnerships in health care.

AMHT has a busy future, and many different requests for services, training, teaching, and supporting other organizations which are working toward positive development in Tanzania. In order to meet these goals, we are working to expand our knowledge through evidence based practice, our network and our donor base for a solid future, and working toward sustainability through local community support and partnerships with government.

Unmet Needs

Throughout 2012 AMHT has worked with local Municipal government to establish a closer model of collaboration with government services. Emmanuel Bujulu, Boniface Kisi, and Angela Gurty are working to establish a Memorandum of Understanding with government to increase our staff capacity and improve services within the Arusha Municipality. This would mean a partnership through which AMHT provides supervision and training within the government structure, and which would utilize volunteer medical doctors and psychiatrists for training and supporting the existing psychiatric staff. The dream of a community based psychiatry program is still a dream, and in order to meet the needs of this population psychiatric staff need to be increased and associated with a medical facility that can meet the heavy demand of this vulnerable group. These negotiations are on-going and we are optimistic; the Rotary Club of Arusha has appropriated funding to build additional counselling rooms, and the building project will begin in February of this year. We have begun negotiations with a Dutch group of psychiatrists to establish a certified training program for psychiatry residents, and have recruited two Dutch psychiatric residents to begin in 2013.

To continue to provide service, we need to widen our donor base and expand our capacity to serve the needs in Arusha. We need more space, more staff, and opportunities for new professionals to be trained in our program. We depend on the good will of donors, both locally and internationally, to support this work.

Goals for Next Year

Outreach Program: The main goal for this year is to establish an outreach programme to address mental health clients in the community and roaming the streets of Arusha without access to consistent, quality, medical and particularly psychiatric care. Significant steps have been taken to assess the needs and work toward strong governmental and nongovernmental partnerships to achieve the ambitious goals AMHT has set for a Community Based Psychiatry Program.

Refined Monitoring and Evaluation: With the help and financing from one of our main donors, the Flora Family Foundation, AMHT will continue with monitoring and evaluation of all program activities. We hope this will help in increasing our effectiveness in our work, and help to improve the service provided to our clients and the general public.

Volunteer program: AMHT is working to develop a volunteer program which will fit the needs of the community and our clients as well as the volunteers themselves. This incorporates the knowledge gained through the research in Arusha on the volunteer tourism industry (or what is often called “Voluntourism”).

Internship and Practicum Placements: AMHT will continue actively recruiting students requiring training and clinical experience after academic qualifications have been completed. In line with the ethos and commitment of the Trust in ensuring succession and sustainability of the mental health program, we as a team are committed to sharing and

developing skills in our partners as much as possible. This year we expect a placement for a student on her final year in Master's degree in Psychiatry from Holland.

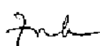
Conclusion

As I reflect on the past year, on our mission statement, overall goal and programme aims I am aware of the blessing it has been to have been able to offer mental health services here in Arusha municipality every working day of the year. This is an amazing achievement and we thank God for gifting us with all that this entailed. We hope and pray that this small, dynamic and hard-working mental health service can continue.

We are now experiencing some of the powerlessness and uncertainty of our clients and try to live with these knowing that we have done what we can and all that we can for the present.

We **thank** all of you who, in one way or another, are part of our lives and we ask you to continue to be with us as we try to improve life for those suffering from psychological and psychiatric problems and their families.

On behalf of the team at Arusha Mental Health Trust,



Emmanuel Bujulu, Director

Arusha Mental Health Trust

January 2013