Insights into psychiatric practice in a tertiary hospital in Tanzania

Psychiatry has many ethical issues woven into the fabric of its practice; within day-to-day practice, psychiatrists are faced with ethical dilemmas pertaining to confidentiality, professionalism, safeguarding and patient autonomy. The laws regulating psychiatric practice are founded on ethical principles. However, different cultures have differing interpretations of these ethical pillars and as such, different interpretations of relevant laws. While in Tanzania, I sought to better understand their mental health act and its implications on psychiatric patients. Furthermore, I wanted to appreciate how different cultural and ethical beliefs can shape psychiatric practice. I was fortunate to join the psychiatric department at the Kilimanjaro Christian Medical Centre (KCMC) in Moshi, particularly because they are launching mental literacy programme. It aims tackle local stigma surrounding psychiatric patients and treatments, and educate other medical professionals about psychiatric illness.

Tanzanian approach to mental health

The Tanzanian Mental Health Act (TMHA)[1] is the primary legislation governing mental health in Tanzania. Its overarching principles are analogous to that of the UK MHA, and it emphasizes the need for obtaining informed consent for any treatment or intervention. However, one key difference between Tanzanian and UK legislation is that the TMHA does not explicitly outline criteria for the detention of individuals with mental health conditions. In addition, it lacks information on patient safeguarding and rights. This shortfall allows for a wider scope of interpretation by healthcare professionals. I wanted to understand how the TMHA was interpreted and implemented at KCMC.

I was surprised to learn that, at KCMC, only psychiatric doctors knew the details of the mental capacity and health acts; when surveyed, no final year medical students knew the name of the MHA or its specifics. The act is seen as legislation specific to the psychiatric profession rather than something all healthcare practitioners should understand. Given this reduced knowledge, it was unsurprising that the TMHA is rarely used in day-to-day practice. I seldom observed discussions around consent, despite its emphasis in the TCMA, instead treatments were prescribed, and patients were expected to follow them. This also matched my observations that the general medical structure was more paternalistic than I was accustomed to in the UK.

Despite the UK and Tanzanian MHA's having many similarities, I was beginning to understand that culture, laws, and medicine in Tanzania combine to produce a different healthcare practice to the UK. The community-oriented structure of Tanzanian society means that support for psychiatric patients comes from their families. Recent reports found that 1/3 of Tanzanians believed that 'mental illness is not a real illness' and ¼ believed that ill-mental health is driven by 'demons' or 'witchcraft'[2], therefore I expected patients to be isolated from their communities. However, at KCMC, I observed that patients were looked after by their families until much later stages in their illness than in the UK; it was common to see catatonia, psychotic depression, and severe psychosis as first presentations. This delay in seeking treatment was not just because early-stage psychiatric illness goes unrecognised, but mostly because adaptations were made by communities to support family members, despite beliefs mental ill health is a curse.

Cultural differences in Tanzania also impact which conditions are seen as psychiatric illnesses. ADHD is one example of this since definitions of normal functioning and development change with lifestyle and beliefs. The hyperactivity-impulsivity that defines ADHD in western communities is better tolerated in Tanzanian communities due to more active, outdoor lifestyles; hyperactivity is accepted as a functional state. However, at the other end of the spectrum, many psychiatric illnesses are defined by extreme symptoms that are incompatible with a functional life in society.

Whilst participating in the mental health literacy programme at KCMC, I further understood how cultural differences can impact psychiatric practice. I learnt that when I had concluded there was poor understanding of consent, I was misinterpreting a large cultural difference. In Tanzania, most sick patients first seek treatment from local community healers. Hospital medicine is viewed as a last resort and is poorly understood in the community due to low health literacy. As such, doctors are more likely to formulate and execute a management plan without engaging patients to make informed decisions. In fact, when I had the opportunity to counsel a patient myself and asked him which treatment for his depression he would prefer, he expressed concern that I, his doctor, "didn't know what to do". I had to consider that the patients may be choosing to not be part of medical decisions, rather than physicians excluding them from decision making.

A final difference I observed between KCMC and the UK was in the use of restraints. They were mostly for patients with delirium, dementia or psychosis, so not dissimilar conditions to when I have seen restraints used in the UK. However, staff at KCMC used them more liberally. A large contributor to this may have been crowded wards and need to keep nursing staff free to care for other patients. The frequency and method of restraint initially shocked me; staff often used improvised ties from bed sheets. However, I realised this was the best available option due to the scarcity of both equipment and staff. Furthermore, patients and their families seemed to accept the use of restraint more readily, which is perhaps another cultural difference.

Final thoughts

It is clear from my time at KCMC that psychiatric practice in Tanzania is a complex intersection of ethics, law, and culture. I cannot hope to have fully understood the intricacies of local psychiatric practice in just 6 weeks, however, I hope my reflections can offer some insight into these practices and the cultural and ethical challenges surrounding mental healthcare in Tanzania.

I would like to close my report by thanking the Institute of Medical Ethics. Their support allowed me the opportunity to explore this topic by immersing myself in psychiatric practice in Tanzania. Thank you also to the Ethox centre for helping me to approach the topic in a rounded and culturally sensitive manner.

1) ***Tanzanian mental health act:*** *"*THE MENTAL HEALTH ACT", 2008. https://www.lrct.go.tz/uploads/documents/sw-1602519267-21-2008%20Mental%20Health%20Act.pdf

2) *Carmen León-Himmelstine, Emma Samman, Esther Kyungu, José Manuel Roche, Charles Festo, Georgia Plank, Edward Amani, Fiona Samuels and Arnaldo Pellini* ***Mental health and psychosocial well-being among adolescents in Tanzania. Findings from a mixed-methods baseline study.*** *December 2021*